

Autism Spectrum Disorder and Violence: Threat Assessment Issues

Stephen G. White

Work Trauma Services, Inc., San Francisco,
California, and University of California

J. Reid Meloy

University of California, San Diego

Kris Mohandie

Operational Consulting International,
Pasadena, California

Kristine Kienlen

Minnesota Threat Assessment and Forensic
Professionals, Inc., Minneapolis, Minnesota, and
District Court of Minnesota, St. Paul, Minnesota

Autism spectrum disorder (ASD) has a lengthy history in criminal forensic mental health but is rarely discussed in the contemporary threat assessment literature as a cause of or contributor to targeted violence. In the popular media, ASD is sometimes associated with incidents of mass murder, influencing public impressions, but begging the question of what relationship ASD may genuinely have with violence potential. Relevant research on ASD and violence is reviewed along with common methodological issues. Assessment challenges and potential case management missteps are discussed, such as distinguishing ASD from psychosis and psychopathy, and the crucial role of comorbid conditions in mediating or amplifying violence. Five cases are presented, exemplifying these issues and a range of ASD-related phenomena: an ASD college student false positive for violence, a false claim of ASD in a psychopathic defendant, a mass murder, a thwarted attack, and a rape and homicide by a psychopath paired with an ASD individual. A specific focus is the distinction between psychopathic and ASD-related motives and behaviors, and some promising research in this area. ASD characteristics of deficits in theory of mind, emotional regulation, and moral reasoning are discussed as they may contribute to either impulsive or predatory violence. Guidelines are offered for conducting ASD-related violence risk assessments, and an overview of case management strategies and issues.

Keywords: autism, autism and threat assessment, autism and violence risk, autism and psychopathy, autism and comorbid conditions

Autism, or autism spectrum disorder (ASD), encompasses neurodevelopmental disorders previously referred to as autism, Asperger's disorder, and pervasive developmental disorder.

ASD may include a range of symptoms and degrees of seriousness from mild to severe and is thus referred to as a "spectrum" disorder. Neurodevelopmental disorders are not mental illnesses or personality disorders in the usual sense of those terms, but impairments in the development of the brain or central nervous system that typically manifest in early childhood and lead to personal, social, academic, or occupational difficulties (American Psychiatric Association, 2013). ASD is usually identifiable in early childhood, most notably by pervasive deficits in social communication and social interaction, restricted, repetitive patterns of behavior or activities, and intense, nonbizarre special interests. Estimates vary, but individuals with ASD represent approximately 0.8% of the general population. The disorder persists over

Stephen G. White, Work Trauma Services, Inc., San Francisco, California, and Department of Psychiatry, University of California; J. Reid Meloy, Department of Psychiatry, University of California, San Diego; Kris Mohandie, Operational Consulting International, Pasadena, California; Kristine Kienlen, Minnesota Threat Assessment and Forensic Professionals, Inc., Minneapolis, Minnesota, and District Court of Minnesota, St. Paul, Minnesota.

We would like to acknowledge Ann Zedginidze for her assistance with research and preparation of the article.

Correspondence concerning this article should be addressed to Stephen G. White, Work Trauma Services, Inc., 3527 Mt. Diablo Blvd., Lafayette, CA 94549. E-mail: swhite@wtsglobal.com

the life span, along with the more or less predictable impairments in social and occupational functioning (Baxter et al., 2015). The phenomenon was first recognized in the 1940s (Asperger, 1944) with increasing interest and research in recent years (Volkmar, Reichow, & McPartland, 2014).

In forensic and legal contexts, a body of literature exists on how ASD contributes or may contribute to violence and crime in some individuals facing criminal charges. The offenses linked to autism are usually arson, sexual assault, stalking, and in some rare cases, homicide (Barry-Walsh & Mullen, 2004; Schwartz-Watts, 2005). Sentencing and probation conditions may also take into account diagnostic and related assessment findings (Mahoney, 2009).

However, ASD as a risk factor for targeted violence in dynamic contexts, as opposed to postincident forensic formats, is infrequently addressed in the contemporary threat assessment literature, where assessment guidelines could be improved. This article attempts to address that gap. We discuss how certain characteristics of ASD may contribute to aggression and violence, and how comorbid psychiatric conditions may combine with ASD features in accounting for violence, with special attention to psychopathy. We review research relevant to threat assessment issues, and attempt to highlight some misunderstandings about ASD and violence risk. Relevant cases studies reflecting issues and concerns germane to the threat assessor are offered, some from our own files, to illustrate critical aspects of the ASD-violence connection. We offer some guidelines for conducting ASD-related violence risk and threat assessments, focusing on adults and adolescents. The recognition of such complexities in understanding violence risk is consistent with a threat assessment model: no one “condition” or circumstance is the cause of targeted violence, or accounts for the magnitude or imminence of a threat of harm (Meloy & Hoffmann, 2014). Assessments must be individualized. Understanding how different disorders contribute either distal or proximal risk factors for violence, or both, and how these factors may or may not interact with each other, improves threat assessment and case management strategies. Although we stress that qualified risk assessment clinicians should conduct formal evaluations involving ASD individuals, our intended audience is

all professionals who participate in threat assessment activities.

Relevance of ASD to Threat Assessment Issues and Practice

Threat assessment professionals and threat management teams functioning in organizational settings should be aware of ASD as it relates to violence risk for three primary reasons: (a) Public misperceptions of a direct link between ASD and violence: The occurrence of some sensational mass murders has been accompanied by media reports contributing to the public’s misperception of a clear causal link between autism and violence (Allely et al., 2017; Ghaziuddin, 2013; Im, 2016; Wachtel & Shorter, 2013). The young perpetrators of the mass murders at Sandy Hook Elementary School in 2012, Isla Vista-Santa Barbara in 2014, and at Umpqua Community College in Oregon in 2015, have all been described as either having autism diagnoses or characteristics associated with ASD (Solomon, 2015). (b) The increasing numbers of individuals with ASD in workplaces and on campuses: ASDs are becoming more widely recognized in adults (Bastiaansen et al., 2011). Higher functioning individuals with ASD features are increasingly finding their way onto campuses and into workplaces (Volkmar et al., 2014), and some are coming to the attention of threat assessors who work in these organizational contexts. If an individual with ASD acts in an inappropriate, impulsive, or aggressive manner, it may more readily create concern or confusion among co-workers, colleagues, and managers. This is especially true if observers and bystanders already perceive such an individual as “odd”—a common lay descriptor—due to his or her social awkwardness. Concern is amplified as well by heightened anxiety regarding mass murder in general. (c) Understanding comorbidity issues in risk assessments, and diagnostic complexities in general: Comorbidity is likely a factor when individuals with autism commit violent or criminal acts (Im, 2016; Newman & Ghaziuddin, 2008; Wachtel & Shorter, 2013). However, there is still much to learn. In practice, diagnosis is both complex and critical to case conceptualization and especially to case management, because certain features of ASD combine or interact with other violence risk factors, partic-

ularly psychosis and personality disorders. [Wachtel and Shorter \(2013\)](#) point out that “diagnostic overshadowing” is a challenge: Symptoms of psychiatric illness are incorrectly attributed to a comorbid developmental disorder or simply missed (p. 406). It is especially important to understand how ASD may be mistaken for psychopathy, but also how these two conditions may combine—fortunately very rarely—but with deadly outcomes.

Definitions

Controversy continues regarding an agreed-upon taxonomy for ASD diagnostic criteria. [Volkmar and McPartland \(2014\)](#) point out one reason being, “Autism raises particular problems [in defining a taxonomy] given the broad range of syndrome expression over age and developmental level” (p. 193). In addition, as noted by [Bastiaansen et al. \(2011\)](#), ASD symptoms may not be noticed until adolescence or adulthood due to high intelligence compensating for limitations, good support systems, the presence of more subtle autistic symptoms, and confusion with other disorders.

The 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; [DSM-5; American Psychiatric Association, 2013](#)) included changes to the criteria for ASD, with the intent of improving consistency across diagnosticians. Only one category, autism spectrum disorder, encompasses the four previous separate disorders: autism disorder, Asperger’s disorder, childhood disintegrative disorder or pervasive developmental disorder—not otherwise specified. The 5th edition criteria include two domains of impairment (pp. 50–51):

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):
1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
 2. Deficits in nonverbal communicative behaviors used for social interaction, rang-

ing, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior.

- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
 4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior.

- C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
- D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level (pp. 50–51).

Widely understood is that the cognitive deficits of individuals with ASD create the difficulties they have in understanding what others are thinking or feeling, and cause them significant problems with social interactions. These deficits, and the unusual interests and beliefs of ASD individuals can lead to their being misdiagnosed as schizophrenic, or schizoid, especially those who have an intellectual disability (American Psychiatric Association, 2013; Ghaziuddin, 2013; Im, 2016). The *DSM-5* describes the interpersonal difficulties of even higher functioning adults with ASD: “Adults who have developed compensation strategies for some social challenges still struggle in novel or unsupported situations and suffer from the effort and anxiety of consciously calculating what is socially intuitive for most individuals” (American Psychiatric Association, 2013, p. 53).

ASD and Violence

Researchers have investigated the possible relationship between autism and violence for the past two decades, an interest that has accelerated in the last few years (Im, 2016). Methodological problems are quite apparent in the extant research, and widely acknowledged among investigators. Small or biased samples and case studies, for example, often do not

represent the general population. Methods for how ASD is diagnosed are inconsistent (Allely, Minnis, Thompson, Wilson, & Gillberg, 2014; Im, 2016; King & Murphy, 2014). Such problems with sample selection, measurement, and definitions surrounding independent and dependent variables are not limited to ASD research, of course, but do mean that any research findings need to be carefully and cautiously interpreted.

Research findings may appear contradictory. For example, according to many investigators, there is no conclusive evidence that individuals with ASD are more violent than those without ASD (Bjørkly, 2009; Maras, Mulcahy, & Crane, 2015; Newman & Ghaziuddin, 2008). Most individuals who fall on the spectrum of ASD are neither violent nor criminal. A number of reviews have reconfirmed this finding (Im, 2016; King & Murphy, 2014). Autism advocates, citing studies, assert that “on the whole, there is no evidence that people with autism are more likely to engage in criminal activity than people without autism” (Maras et al., 2015, p. 515). Im (2016), in an extensive review of all studies and research from 1943 to 2014 on autism and violence, concluded that neither descriptive case studies or prevalence studies are persuasive in demonstrating a clear link between autism per se and violence. Mouridsen, Rich, Isager, and Nedergaard (2008) found that individuals with ASD had a lower rate of criminal convictions (9%) than matched controls (18%) in a sample of Danish adults with ASD drawn from a criminal registry. However, disagreement exists as to whether individuals with ASD are over- or underrepresented in the criminal justice system (Lerner, Haque, Northrup, Lawer, & Bursztajn, 2012; Maras et al., 2015).

Other evidence supports the widely held clinical notion that ASD-related social functioning deficits, life events, mood disturbances, impulsivity, and poor emotional regulation and coping skills contribute to offending by individuals with ASD (Allen et al., 2008; Im, 2016).

In his review, Im (2016) also concluded that descriptive case reports suggest the following features of ASD could increase the likelihood of violent acts: impaired theory-of-mind abilities; difficulty appropriately perceiving nonverbal cues; intense, restricted interests; and comorbid psychiatric disorders. The exact nature of such contributions—whether causation, correlation,

mediation, or moderation—is not well understood at present.

Lerner, Haque, Northrup, Lawer, and Bursztajn (2012) present a model that persons with high-functioning ASD (HFASD) have three deficits that may contribute to violent criminal behavior, reflecting similar views widely shared in the literature (Allen et al., 2008; Bjørkly, 2009; Im, 2016):

1. *Theory of mind* refers to one's ability to understand the mental state of others, to interpret social intentions, and understand social nuances (Fonagy, Bateman, & Bateman, 2011). Individuals with ASD may become confused and overwhelmed, especially under duress, by social information they cannot process, and may not recognize the emotional impact of their actions on others.
2. *Emotional regulation* is the ability to quickly and appropriately inhibit the expression of strong emotions. In persons with ASD this may be manifested by poor impulse control, aggression, and negative peer interactions.
3. *Moral reasoning* is a social-cognitive process by which one judges an action to be worthy of praise or blame. Moral reasoning may be viewed as a fundamental and specific capability encompassing normative evaluations of one's own actions and the actions of others in light of their behaviors and mental states. Persons with ASD have more difficulty understanding and predicting the behaviors, beliefs, and intentions of others.

Our first case example illustrates how these basic deficits can lead to further interpersonal issues and consequences, although violence did not occur. It is a fairly common scenario.

Case Number 1: Misperception of a Student With ASD as a "Deranged Stalker"

This case, from the files of author SGW, involved an undergraduate college student, very gifted and intensely focused on his engineering studies, who had shown an interest in a female student in his residence hall. One day, when her door was open, he walked in and spontaneously began talking to her about a recent murder at

another school. He described it in animated nonstop detail. Feeling cornered by him, she anxiously exited the room. As he was already generally perceived as "strange" and had had an angry outburst in the dining hall on a separate occasion, she reported him, concerned that he was a "deranged stalker." His attempt to connect with her totally failed. When formally evaluated it was opined that he posed no risk for predatory (instrumental) violence. There was no evidence for any malicious intent. His interest in murder was thoroughly explored and determined not to be consistent with preattack phenomena on a pathway to predatory violence (Calhoun & Weston, 2003; Meloy & Hoffmann, 2014). However, his developmental deficits were apparent: an inability to perceive and understand social cues and nuances, a capacity taken for granted by others. From the perspective of common social norms, he was "tactless." He didn't realize when he should *not* bring up his interest in murder. He might fall into the category of the "incompetent suitor" in the Stalking Risk Profile assessment guide (MacKenzie et al., 2009): a man who is usually harmless but causing genuine concern and requiring limit setting. Legal consequences could follow if such behaviors persisted. As in this case, when given feedback these individuals may be confused, and feel frustrated or hurt. Some may experience and express genuine remorse, but others may not. Their social naiveté, also genuine, may be apparent to evaluators. In this instance, the student talked intelligently and sadly in the assessment meeting about his isolation. He received ongoing psychoeducation and specific, individualized coaching about proper conduct and identifying nonverbal signs of others' experience in the present (Laugeson & Ellingsen, 2014). The goal was to minimize the risk of impulsive outbursts if he were rebuffed and felt frustrated, as well as to reduce the likelihood of others reacting negatively to him. His progress and conduct continued to be monitored. A comprehensive risk assessment and explanation to campus officials avoided his being misperceived and treated as a potential homicidal stalker.

Further examples of such deficits and their impact are found in forensic contexts. Mahoney (2009), a criminal defense attorney, explains that adolescents with ASD can become obsessively involved with child pornography. They

do not realize the social and legal implications due to their naïveté and uninhibited curiosity. The term for this, “counterfeit deviance” (Hingsburger, Griffiths, & Quinsey, 1991), occurs when an individual engages in behavior that appears on the surface to be a paraphilia, but in fact is not based in psychopathological urges or predatory motives. Advances offensive to others or aggressive behavior may result, but this is due to a lack of understanding of what are appropriate relationships and how they are normally formed. The individual assumes these depictions of sexual behavior and relationships on the Internet are normal. ASD individuals tend to have good technical skills, argues Mahoney (2009), and may be drawn to computers which are logical and syntax-guided, whereas social interactions are confusing, anxiety provoking and guided by semantics (Mahoney, 2009). Absorption in computers increases social isolation and vice versa, which may perpetuate a vicious cycle of maladaptive habits.

Violence Risk Related to ASD Comorbidity With Other Disorders

Comorbidity of ASD with other psychiatric disorders is a significant violence risk and threat assessment issue. Individuals with ASD have an elevated risk for other psychopathologies, such as mood disorders, psychosis, personality disorders, and obsessive disorders. Simonoff et al. (2008) found that 70% of a sample of children aged 10 to 14 with ASD also had a diagnosed psychiatric disorder. Comorbid psychiatric conditions are usually present when individuals with ASD commit serious crimes such as homicide, assault, sexual assault, stalking, and arson (Im, 2016; Newman & Ghaziuddin, 2008; Wachtel & Shorter, 2013). Newman and Ghaziuddin (2008), using online databases, identified 37 criminal cases of individuals with ASD, 30% of whom also had another definite psychiatric disorder, and 54% who had a probable psychiatric disorder at the time they committed the crime. More specifically, a “one-two vulnerability punch” for violence risk may occur in persons with ASD and comorbid psychosis (Wachtel & Shorter, 2013, p. 408). The content of psychotic ideation may include thoughts of lethal violence, but if the individual also has ASD he may be quicker to act on such psychotic thoughts and impulses (Wachtel & Shorter,

2013). Not surprisingly, aversive life events may mediate violence by individuals with ASD. Kawakami et al. (2012) found that a history of neglect or physical abuse in childhood was correlated with later criminal behavior by individuals with high-functioning ASD. A very small proportion of individuals with ASD present with comorbid psychopathy, discussed in the following section.

ASD and Psychopathy

Psychopathy is a severe personality disorder characterized by a lack of conscience, a detached, callous, and manipulative orientation in relationships and a chronic antisocial lifestyle. Psychopaths may be very perceptive, but they lack true empathy for others and remorse for wrongdoing. Although easily irritated and subject to impulsive outbursts, their mode of violence is often planned and predatory, from bullying to homicide. There are two significant issues regarding ASD and psychopathy: misdiagnosing an ASD individual as psychopathic, and the comorbidity of ASD and psychopathy as a serious violence risk combination, however rare. In either forensic or dynamic threat assessment contexts, some individuals with ASD may mistakenly be perceived or judged as self-centered, lacking empathy, or sadistic, but due to presumed characterological callousness—that is, psychopathic—rather than as behaviors resulting from their core cognitive deficits (Bastiaansen et al., 2011; Bjørkly, 2009). This may especially be the case among more intelligent individuals with HFASD (Ghaziuddin, 2013). Case Number 1, above, is an example where the misapplication of psychopathy would have led to an inappropriate and ineffective case management plan.

The opposite can occur as well, ASD being inappropriately offered as a mitigating explanation for criminal behavior, as in the following case.

Case Number 2: False Claim of ASD in a Psychopathic Individual

In a capital case from author KM’s forensic files, the defense attempted to claim that the defendant had an atypical pervasive developmental disorder (a previous term now encom-

passed within *DSM-5*'s definition of ASD) to mitigate his criminal responsibility in a double homicide that appeared financially motivated. However, a review of the fact pattern revealed that the defense attempt to align the defendant as someone akin to media depictions in the film, *Rain Man*, fell short. The defendant's extensive history of exploiting others, skillful interpersonal manipulation, significant prior incarcerations, criminal adaptability and versatility, use of numerous aliases and scams, underscored his severe psychopathy with no characteristics of ASD: in lay terms, a "con man."

Bjørkly (2009), in his review of the empirical basis of a relationship between ASD and violence, included a qualitative analysis of the studies, looking at patterns in the dynamics of violence. He offers a tentative comparison of psychopathy and ASD, suggesting there may be differences between the two disorders in the characteristics of violent behavior:

Even as a determined manipulative style is one of the prominent features of psychopathy, the socially ignorant naïve style of interpersonal communication is typical of AS. However, both response styles may lead to frustration and subsequent violence. Psychopaths are known to have excessive displays of instrumental or proactive violence that are governed by planned and goal-directed search for positive reinforcement. In contrast to this, although people with AS are not incapable of instrumental violence, they mainly appear to be triggered through a three-step process consisting of reactive or affective violence and a negative reinforcement contingency (Bjørkly, 2009, p. 311).

Applying Bjørkly's (2009) approach, with Case Number 1 above as an example, consider the following hypothetical. The young lady becomes increasingly agitated and fearful. When she tries to leave the room the student of concern grabs her tightly and shakes her. She screams and the male student releases her but then remains in the room. In the case of the individual with ASD, he is socially naïve, becomes frustrated with his failure to get the reaction he wants from the girl, and impulsively grabs her as she tries to leave (deficit in emotional regulation). He just wants her to stay; that is his primary reason for grabbing her (deficits in theory of mind). When she screams, he does realize he should just exit—he's not completely clueless that she is upset. By contrast, assume the student was psychopathic and had engaged

the young lady in stories about murder because he enjoyed watching her growing discomfort. She feels trapped in her room. His intent is to dominate and control her—and she senses his "cold" manipulation. He may take pleasure in seeing her squirm, and may already have thought of blocking her from leaving the room. The behaviors are predatory and sadistic. When she screams he quickly puts his hand over her mouth to silence her, but then leaves so he will not get apprehended. He knows he's "bad," that is, deviant—and he enjoys it, as he lacks a conscience. He just has to be careful with his conscious manipulations and not get caught, something he has likely dealt with on numerous previous occasions.

When interviewed, the student with ASD readily admits everything, but doesn't think that what he did was wrong (deficit in moral reasoning). One characteristic of ASD being literal-mindedness, he is totally candid. Ultimately, he feels misunderstood and bad about himself—not an uncommon experience for him—adding to his fear and reluctance to engage socially. The psychopathic student is evasive, minimizes what he did, and outright lies. He may talk about how the young woman got upset "over nothing" and is exaggerating. He retorts "No way I kept her from leaving the room."

Bjørkly's (2009) three-step process in the case example above would be: First, the ASD student wants a relationship but his attempt is provocative; second, when rebuffed, he becomes frustrated; third, his impaired social-problem solving ability, fueled by his frustration, increases the likelihood of aggression or violence. This is qualitatively different from the instrumental violence of the psychopath. Although both hypothetical acts may appear quite similar if analyzed only at the level of the offensive behaviors, the subjects' psychology and intents are very different and must be understood as such.

Bjørkly further compared psychopathy and ASD on five criteria and concluded that "Findings from these comparisons indicated that there may be substantial differences between the two diagnostic disorders . . ." (Bjørkly, 2009, p. 310). The five criteria and how they differ between the psychopathy versus Asperger's syndrome are: sensory reactivity (hypore-

activity vs. hyperreactivity); interpersonal communication (manipulative vs. naïve); typical violence (proactive vs. reactive); reinforcement contingency (positive vs. negative); and relating to violence (denial vs. confession).

With regard to the second issue—comorbidity of ASD and psychopathy—a very small proportion of individuals present with both disorders. This may more fully explain some cases of serious violence and mass shootings—violence that is clearly instrumental or predatory—by individuals who were just presumed to have an ASD. Fitzgerald (2015) proposed that Asperger's original category of autistic psychopathy (Asperger, 1944) be acknowledged in the nomenclature with a new diagnostic term, criminal autistic psychopathy. This would consist of those persons with the dual features of ASD and psychopathy and who engage in criminal behavior. Fitzgerald contends this may describe some school shooters who are mistakenly diagnosed as only having ASD—the distinct differences between ASD and psychopathy having been overlooked in such cases. Rogers, Viding, Blair, Frith, & Happé (2006) measured psychopathic traits in boys with ASD and found that psychopathic tendencies were not related to severity of ASD, and did not seem related to core autistic cognitive deficits. They concluded that callous-psychopathic acts in a small number of individuals with ASD probably reflect a “double hit”—an additional or compounding impairment of empathic response to distress cues, which is not an aspect of ASD itself (p. 1789).

More often than not, individuals with ASD are likely to be the victims of crime rather than the perpetrators (Allely et al., 2017; Beadle-Brown et al., 2014). Their vulnerability can, in certain instances, subject them to other forms of “victimization” with very serious consequences. Some, with other contributing characteristics such as strong dependency needs, may be susceptible to exploitation by calculating, callous individuals. They may wind up as accomplices in crime and violence with psychopathic partners, ultimately just as dangerous as their partner, and through a mistaken notion of guilt by association, may be incorrectly assumed to be psychopathic as well. The following case demonstrates the potential for such an unfortunate circumstance.

Case Number 3: ASD Individual's Accomplice to Homicide With a Manipulative Psychopath

This case was evaluated and testified to by author JRM, and involved the pairing of two young men, George Woldt and Lucas Salmon. Woldt had a diagnosis of sexual sadism and psychopathy, and Salmon a diagnosis of ASD. They were best friends, or so Lucas Salmon believed. They had met in high school when Salmon moved back to Colorado Springs from California, and stayed in close contact over the next 4 years. Unbeknownst to Lucas Salmon, who was later diagnosed at his murder trial with dependent personality disorder (*DSM-IV*) and pervasive developmental disorder NOS (*DSM-IV*), George Woldt had attempted unsuccessfully to recruit other males to commit a rape and a murder with him. Salmon was his third and only successful recruiting attempt.

In February, 1997, Lucas, age 21, moved in with George, age 20. They spent virtually all their time together, angering George's wife; they worked the same jobs and were engrossed by the same entertainment. They were fascinated by the film *Blood In, Blood Out*, which they watched at least 10 times together (repetitive viewing), strongly identifying with the bond between the two Hispanic gang members portrayed in the film. But the movie that aroused George the most was *Clockwork Orange*. First released in 1971 and directed by Stanley Kubrick and starring Malcolm McDowell, this film portrays the sexual violence of a British gang and society's failed attempt to extinguish the psychopathic leader's criminality through aversive conditioning. There are four temporal and proximal pairings of sex and violence in this film: the attempted gang rape of a woman by five men; the rape of a woman; Jesus being whipped and three naked women eating grapes; and a gang rape.

George and Lucas watched this film together at least once in the month preceding their abduction, rape, and murder of a stranger female. They communicated with each other during this period by using the phrase, “the ole in and out,” which in the movie meant rape (scene specificity). George adopted the role of MacDowell and Lucas became his compliant partner. George would tease, humiliate, and urge Lucas onward,

desensitizing him to the idea of a sexualized murder.

On April 29, 1997, after a month of cruising and surveilling local bars for a suitable victim, the two happened upon a 20-year-old blonde woman jogging in the “Garden of the Gods,” a public park in Colorado Springs, Colorado. Exchanging the phrase, “the ole in and out,” George then hit her with their car, knocking her to the ground and bruising her. They feigned surprise and fear at the staged accident, but the woman refused their offers of help to take her to a hospital. Frustrated but excited, they left the park, went home, spent several hours eating and watching TV, and eventually left for the evening to seek another victim. Shortly after midnight, they pulled up next to another young blonde woman, a 22-year-old-female college student alone in a red car. Quickly identifying her as another candidate for “the ole in and out,” they followed her to her boyfriend’s apartment complex. As she approached the door to his apartment, George grabbed her from behind, and with Lucas’ help forced her into the back seat of their car while a half-dozen onlookers yelled at them. They drove to a nearby school parking lot and took turns vaginally raping her on the back seat. After ordering her to back out of the car on her hands and knees, they then stabbed, cut, smothered, and stomped the young woman to death as she lay naked on the pavement. They drove home, cleaned up, turned on the TV, and were arrested within the hour while eating pizza. Lucas Salmon wrote in his confession a few hours later “The roots of this incident date back to approximately 1 month ago. My friend, George and I viewed a film called *Clockwork Orange*. This film depicted graphic scenes of violence, betrayal, and rape. It was then that we first became interested in the act of sexual assault (theme consistency). We had only joked about it first, but as time went by, we both agreed it was something we would like to do” (Handwritten confession, April 30, 1997, *People v. Lucas Salmon*, El Paso County District Court, CR 97–1551-1, JRM files). When Lucas was arrested, he asked the officer “Can you just give me a ticket so I can go home?” Lucas was eventually convicted and sentenced to life in prison; George was sentenced to death (Meloy & Mohandie, 2001).

This case illustrates the unusual pairing of two offenders, one a comorbid psychopath and

sexual sadist, and the other a comorbid case of ASD and dependent personality disorder. The psychopath, focused upon and wishing for the excitement of committing an act of predatory and sexualized homicide, needed a compliant partner who would facilitate the accomplishment of his goal. There are many reasons for such a pairing in general, including the psychopath’s desire for an accomplice to enhance tactical success, and his need for adulation and admiration from another who is prone to idealizations. Meloy (1992) discussed the psychodynamics between psychopaths and those who bond to them, emphasizing certain personality characteristics such as hysteria and masochism. In this case, both the dependent personality as well as the ASD specifically heightened the success of the pairing and its emotional intensity: Lucas Salmon was easily conditioned by George Woldt so that sexual killing became normalized, primarily through the use of repetitive viewing of film, and their mutual identification with the violent characters portrayed in the film (Meloy, Mohandie, Knoll, & Hoffmann, 2015). His deficiencies in his own moral compass, and his suggestibility and dependency on others, made Salmon particularly vulnerable to a dominant psychopath who quickly assessed his loneliness and strong sexual desires as a young man. His lack of empathy for others, relatively benign in other social contexts, was manipulated by Woldt to physically abduct the victim and cajole Salmon into raping the young woman while Woldt watched. In the opinion of JRM, there was no theory of mind on Salmon’s part, allowing for the full expression of Woldt’s predatory acuity (Meloy, 2012), first toward Salmon, and then toward the victim.

Research exploring the nexus of psychopathy and autism remains in its infancy, and is largely behavioral. However, there are interesting preliminary data; for example, in one study comparing psychopathic and autistic boys between the ages of 9 and 16, the psychopathic subjects were good at knowing what other people were thinking, but they did not appreciate the *emotional experience* of others, that is, their affective empathy was impaired, as would be expected (Jones, Happé, Gilbert, Burnett, & Viding, 2010). The autistic subjects, on the other hand, did not appreciate others as *social agents* in their own right, that is, they had difficulty knowing what other people were think-

ing. But the affective empathy of the autistic boys was intact (even though they may have reacted in inappropriate ways).

Although clinical differences abound, further investigation will likely focus upon the neurobiological differences among psychopathic and autistic subjects (Gacono, 2016). For example, are there structural differences apparent in neuroimaging research which can distinguish between the psychopathic and autistic brain, or will the differences only emerge through functional imaging of the dynamics between paraling and prefrontal cortical areas of the brain (Blair, Mitchell, & Blair, 2005; Raine, 2013)?

ASD and Mass Murder

A significant and controversial issue is the role of ASD in mass murders. Allely, Minnis, Thompson, Wilson, and Gillberg (2014) conducted a systematic review of mass and serial killings, searching peer reviewed literature, but mostly journalistic and legal sources. Taking into account the inherent methodological limitations, they concluded:

... probably more than 10% of serial/mass killers have ASD and a similar proportion have had a head injury ... considerably higher than would be found in the general population ... [yet] Neither of these neurodevelopmental factors appears to be sufficient in the etiology of serial/mass killing as the great majority of those with ASD or head injury had also experienced psychosocial risk factors such as parental divorce, physical or sexual abuse, and major surgery during childhood. This leads us to suspect that ... to a certain degree, there is a complex interplay between neurodevelopmental and environmental factors—particularly psychosocial adversity—[that] can potentially result in an individual being predisposed to develop into a serial/mass killer (Allely et al., 2014, pp. 296–297).

In a following review, Allely et al. (2017) examined the presence of ASD in the 73 lone shooter cases from the well-known *Mother Jones* database (Cohen, Azrael, & Miller, 2014). These were “indiscriminate” public shootings with at least four homicide victims that occurred between 1982 and 2014 (Allely et al., 2017, p. 6). The authors found “strong” evidence for ASD in 8% of the cases (six individuals), and “some indication of ASD traits” in 21% of the total sample (16 cases), as compared with the less than 1% prevalence of ASD in the general population (Allely et al., 2017, p. 7). Among the authors’ conclusions was that “Cru-

cially, the findings of this review are not advancing the notion that individuals with ASD are more likely to be mass shooters or commit serious crime. There may, however, be a small subgroup of individuals with ASD who are more likely to become serious offenders . . .” (Allely et al., 2017, p. 10). The authors again note the inherent methodological limitations in this kind of review.

As emphasized by Maras, Mulcahy, and Crane (2015), studies that examine the known or suspected various factors that lead some individuals with ASD to engage in criminal (or violent) behavior would be the most useful research, rather than studies of whether ASD individuals in general are more likely to commit offenses than the general population. We agree. For example, regression analyses could help understand the proportion of variance accounted for by ASD, as well as other risk factors, in a sample of violent individuals.

Faccini (2016) proposes integrating two models, a three-factor clinical theory and the path to intended violence concept to account for the actions of such mass murderers as the Newtown assailant, Adam Lanza. The “pathway to violence” concept, now widely accepted in contemporary threat assessment, was first articulated by Fein and Vossekuil (Fein, Vossekuil, & Holden, 1995) and further articulated by Calhoun and Weston (2003). Faccini’s clinical theory consists of autism-based deficits, psychopathology, and Eriksonian (Erikson, 1950) psychosocial deficits, which Faccini points out have been shown to lead to criminality in a number of case studies.

In his theory of psychosocial development, Erikson proposed that the individual faces eight different “crisis,” distinctly social in nature, from infancy to adulthood. How they are managed leads to positive or negative outcomes (Erikson, 1950). A focus on the failure to negotiate these stages has received little attention in ASD-related violence research. The rippling consequences of unsuccessfully navigating various turning points in life, however, are often referred to in case studies of violence. Viewing the longer trajectory of an individual who eventually moves on the pathway to violence from this perspective adds value. The successful resolution of Eriksonian “normal crises”—for example leading to hope (the crisis of trust vs. mistrust), will (autonomy vs. shame), purpose

(initiative vs. guilt), and competency (industry vs. inferiority)—leads to socially acceptable behaviors and outcomes. Negative resolution of these stages creates insecurity and may lead one to seek self-worth in dark, antisocial ways. This developmental perspective is clearly visible in a number of other cases of young mass murderers such as Seung-Hui Cho at Virginia Tech and Elliot Rodger, the 2014 Isla Vista, California assailant. Rodger's picture is complex. He was essentially an intelligent HFASD who also suffered from "shy" narcissism and severe envy, and with the onset of puberty, was afflicted with great anxiety and feelings of worthlessness. Blaming the world for his virginity, over time he developed a detailed plan for a campus community mass murder which he carried out, culminating in his suicide (White, 2017). Faccini is one of the few authors to specifically incorporate the pathway to violence concept in discussions of ASD and violence. His approach is an attempt to better identify the connection between earlier developmental deficits and related failures and the critical steps that eventuate in acts of catastrophic violence by individuals such as Lanza or Rodger. Ultimately of course, it is the operational, preparatory "red flags" on the pathway to violence that assessors (and others) are looking for, whatever the motives and psycho-history of a potential perpetrator (Meloy & Hoffmann, 2014). The following case, the Newtown mass murder, provides an example of complex pathologies leading to the pathway to violence.

Case Number 4: Likely Predominance of Severe Psychopathy Comorbid With ASD in a Mass Murder

A fourth scenario is the mass murder perpetrated at the Sandy Hook Elementary School by Adam Lanza. A number of investigators have studied this case, attempting to understand the ingredients that led to this event (Allely et al., 2017; Faccini, 2016; Fitzgerald, 2015). As presented in the comprehensive investigative report by the Connecticut Office of the Child Advocate, the subject's long-standing ASD was well documented in his medical and educational records, as well as his history of anxiety and severe obsessive-compulsive disorder (State of Connecticut, Office of the Child Advocate, 2014). Observations varied of Lanza growing

up—he was bullied, he was not; he was social, he was unemotional and withdrawn. He was very uncomfortable with change, noises, any confusion, and physical contact with others, characteristics typically associated with ASD. Lanza had been obsessed with violence since his years in elementary schools, alarming some teachers early on with his gory essays about war. Was this an ASD-related "highly restricted, fixated interest . . . abnormal in intensity or focus" (American Psychiatric Association, 2013, p. 50), or early signs of psychopathy?

An evaluation by the Yale Child Study Center when he was 14 expressed great concern about his increasing withdrawal, and for his future. The report urged extensive treatment, special education, ongoing expert consultation, and medication for his obsessive-compulsive symptoms. Lanza's divorced mother made initial efforts to seek and coordinate appropriate resources, but Lanza resisted medication, and ultimately the Yale recommendations were not put in place. His mother withdrew him from school after the eighth grade. Efforts to gradually return him to school were unsuccessful, and she increasingly had to deal with his demands to be left alone. She did not work because of his condition and worried about what would happen to him if anything happened to her. He refused to see his father or respond to his e-mails the last 2 years of his life. In spite of his great difficulties and consternation with homework, Lanza did eventually complete high school, through a combination of independent study, tutoring, and classes at a local college. He did have a few acquaintances, one who played video games with him, as he was very involved with video games, both violent and nonviolent. He participated in recreational shooting with his parents and brother growing up. His mother purchased all his firearms and continued to allow him access to them as his condition worsened.

Among his activities, Lanza eventually created a meticulous spreadsheet, more than 7 feet long, detailing past mass murders and attempted murders that he wished to surpass in number of victims. He became more and more isolated, in the end only communicating with his mother by e-mail, not allowing her to enter his room. Although he increasingly "deteriorated," the State of Connecticut report states it "does not suggest the presence of psychosis" (State of Connecti-

cut, 2014, p. 8). However, he was also described as suspicious. Was this hypervigilance for fear of being detected, or extreme isolation that led to paranoia, another important risk factor for targeted violence and mass murder (Dutton, White, & Fogarty, 2013; Knoll & Meloy, 2014)? His rigidity and lack of cooperation became more obvious as the years went on. His stories were about killing or hurting children, and with a chilling tone of felt cruelty.

There is no mention of psychopathy in the State of Connecticut report; further stating “no sustained input from any mental health provider is documented” in Lanza’s records in the last six years of his life (State of Connecticut, 2014, p. 8). Was psychopathic callousness and sadism involved as well? It would definitely seem so, and perhaps paranoia. Did an early fixated interest in violence become ominously amplified by psychopathy, with his obsessive–compulsive tendencies further energizing his preparatory actions for violence? Knowing Lanza was on the autism spectrum seems an insufficient and incomplete explanation for his motives and actions. Fortunately, his case is extremely rare, exemplifies how the determinants of violence risk can be very complex, and, not particular to any diagnosis, the ultimate role of an enabling context when red lights are flashing.

Case Number 5: ASD and Comorbidity Issues in a Thwarted Attack

On April 29, 2014, a school murder plot by 17-year-old John LaDue was discovered in Waseca, Minnesota. Police ultimately found an arsenal of bombs, bomb-making materials, guns and ammunition in LaDue’s private storage unit and in his home (Drash, 2015.) LaDue readily confessed the details of his elaborate plot, which included killing his family with a .22 caliber rifle and setting a fire in a remote area as a diversion for first responders (Waseca County Court, 2014). LaDue planned to go to the local junior/senior high school and kill the school resource officer, then kill as many students as possible by detonating bombs and Molotov cocktails, before opening fire on students and teachers. He informed police where to find his journal which chronicled 9 months of planning, his firearms and ammunition acquisition, and his research and experimenting with explosives manufacturing techniques (Waseca County

Court, 2014). LaDue videotaped himself engaged in practice and rehearsal, igniting his homemade explosives at various locations in town including high school athletic fields, an elementary school playground, a skateboard park, a church, and a shooting range. He stated this activity “. . . released pressure. It was very uncommon and illegal. I was happy I’d done it . . . sometimes proud” (State of Minnesota, 2015, p. 9).

These statements and behaviors could be viewed as consistent with ASD-related excessive, ritualistic interest which escalated into his high-risk fixation upon violence. His admissions during his police interviews, appearing in various media accounts (e.g., Drash, 2015; Fesher, 2015), could suggest ASD-related deficient moral reasoning. He explained why he would kill his family: “They did nothing wrong. I just wanted as many victims as possible” (Brumfield, 2014, para 2).

Other evidence, however, raises questions about comorbid narcissistic features and/or psychopathic features that may have been predominant in his overall clinical picture and violent trajectory, or at least contributory. Later evidence indicates the presence of a major depressive episode at the time as well. LaDue studied U.S. mass homicides dating to 1920—which could be interpreted as an ASD “intense interest”—but he “kind of rated them” on the number of victims and other characteristics of the crimes (Waseca County Court, 2014, p. 54). Alternatively, this is consistent with typical narcissistic or psychopathic offenders who identify with prior attackers, without any ASD contribution. In his journal, LaDue expressed both admiration for the two offenders who carried out the Columbine attack, and criticism for how they planned and carried it out. He wanted to differentiate himself from previous mass murderers like Adam Lanza whom he viewed as weak for killing young children. LaDue confessed to the investigator three motives for his planned school massacre: (a) “to get outta here;” (b) for “fun;” and (c) to follow his “#1 Idol,” Eric Harris (Waseca County Court, 2014, p. 29). Contrasting himself to other school violence perpetrators who had been bullied, LaDue stated “I don’t think I’ve ever been bullied in my life. I have good parents. I live in a good town . . . I think I’m just mentally ill. And no one’s noticed and I’ve been trying to hide it”

(Waseca County Court, 2014, pp. 2–3). LaDue harbored ill feelings: He wrote about five specific students he wanted to target, two for talking too much in class and one for calling him “queer” on the bus. He told police “I had fun entertaining the thought of actually, like, injuring and maiming people, and, like, showing people that I am dominant over them” (State of Minnesota, 2015, p. 15). These suggest a felt injustice, entitlement, revenge, and sadism, as well as a desire for power, suggesting narcissistic traits. Seeking notoriety is suggested by his wanting to have at least 40 victims so that he would kill more than previous mass murderers.

At the time of his trial, court-appointed psychologists opined that LaDue had ASD with deterioration in adolescence and comorbid unspecified attentional disorder and mood disorder not otherwise specified (State of Minnesota, 2015). His ASD was manifested by:

... impaired capacity for relational reciprocity; lack of social connectedness and interest; deficient empathic capacity; restricted range of affective response; impaired ability to read social cues and interpersonal reactions; limited capacity to incorporate emotional/relational data into his thinking/problem solving; and a restricted interest pattern fixated upon themes of violence (State of Minnesota, 2015, p. 7).

The Court experts noted that beginning in 2013, he had become fixated on violent images of death, spending about 5 hr a week watching videos of murders, autopsies, war, and gruesome scenes. Such aggression immersion (Meloy & Mohandie, 2001) has been commonly observed among violent offenders who commit mass homicide, in the absence of any known ASD.

But the court experts also stated that he had no remorse for his plot, and showed no concern for the impact on others his actions would have. They in fact concluded that LaDue had grievance-oriented thinking, as he expressed beliefs that killing his family and classmates was necessary to “right the wrongs” (State of Minnesota, 2015, p. 15). He believed he had experienced social rejection by them and a failure to appreciate his specialness and superior intelligence.

Further evidence suggesting narcissistic entitlement or perhaps psychopathy was revealed during LaDue’s participation in a juvenile treatment program. He admitted that he viewed himself as very good at using others or taking

advantage of them, describing himself as a good manipulator and reporting that others only saw his “masks,” not the “regular me.” In contrast to persons with ASD who struggle to recognize the emotions of others, LaDue saw himself as very good at reading his friends’ moods, stating “I can get more information. I get inside their heads, making them feel that I think they are special, but I don’t believe they are” (State of Minnesota, 2015, p. 9). When asked how he would feel if he had been able to carry out the plan to murder family and classmates, LaDue told counselors “I figured it would be very exciting and enjoyable. I certainly like watching it and I figured it would be better doing it” (State of Minnesota, 2015, p. 9). Sensation seeking and high-risk behavior are characteristics often seen in acting-out personality disorders such as antisocial and narcissistic personality, and are not frequently observed in ASD, the latter usually preferring sameness as opposed to novelty.

An evaluation conducted in January, 2016, about a year and a half after the discovery of his plan, concluded that LaDue was not on the autism spectrum, but had instead suffered a major depressive episode (with which LaDue has since stated he agrees) that presumably contributed to his violent plan (Louwagie, 2017). The new diagnosis was narcissistic personality disorder and unspecified personality disorder with obsessive–compulsive traits. The risk for long-term violence and imminent harm were opined as low, but it was recommended that LaDue should remain in treatment with a skilled therapist (Louwagie, 2017).

In April, 2016, LaDue was allowed to return home, with restrictions. According to a media investigative report in July, 2017, that included an interview with LaDue, he was attending a community college, learned welding, had started working full time, and was attempting to improve his relationships. He stated he had no interest in repossessing his journal with his violent plan. His reaction at the time of this interview was that his violent planning and intent were the actions of “. . . a stupid kid . . . It’s basically just a book full of pessimism” (Louwagie, 2017, para 153). LaDue admitted to the interviewer that he would have tried to carry out the massacre, but that he is more mature now and his mind is in a better place (Louwagie, 2017).

While the genesis of his violent trajectory may be debatable, it seems highly likely LaDue would have carried out his attack. He evidenced multiple warning behaviors noted in the scholarly literature (Meloy, Hoffmann, Guldemann, & James, 2012) operationally significant to increased potential for violence: pathway warning behavior, fixation, identification (including aggression immersion), and energy burst warning behavior. These behaviors have all been shown to significantly distinguish between school shooters and other individuals of concern who have no intent to be violent (Meloy, Hoffmann, Roshdi, Glaz-Ocik, & Guldemann, 2014). If one accepts the possibility that he had some degree of ASD, this could be considered contributory to his intense fixated interests and poor moral reasoning. On the other hand, violent and grandiose fantasies, entitlement to implement them, extreme selfishness, and lack of empathy for and concern about others, are well-known to be highly associated with narcissistic individuals who later commit acts of predatory violence. As the data for the analysis in this article are admittedly second-hand, readers are left to appreciate the diagnostic complexities in this case and to draw their own conclusions.

Threat Assessment Guidelines

Given that certain ASD-specific factors as well as non-ASD factors can contribute to an individual's violence risk, complexity will greet threat assessors. Adding to the challenge, ASD degrees of severity are wide-ranging, as is the variety of potential transgressions and their implications—from inappropriate social behavior, intrusions, outbursts that frighten others, to theft, stalking, assault, arson, and homicide. As so many observers emphasize, at the core of ASD individuals' problems is their difficulties with interpersonal reciprocity, and understanding the effects of their actions on others. These deficits and their secondary consequences carry over to the assessment of violence risk.

Researchers and clinicians generally agree on the features of ASD that may increase violence risk: impaired theory-of-mind abilities, difficulty interpreting social and nonverbal cues, emotional dysregulation, and intense restricted interests (Im, 2016; Volkmar et al., 2014). The most relevant non-ASD associated risk factors are comorbid psychiatric disorders—especially

psychopathy—and a history of childhood abuse or neglect (Bjørkly, 2009; Im, 2016; Kawakami et al., 2012). These factors form the basis for an assessment, and are what we attempt to address in these guidelines, as complements to standard practices for assessing risk.

Nonclinicians can note suggestive behaviors, but more granulated analyses and diagnoses should only be rendered by licensed mental health clinicians knowledgeable about violence risk factors. ASD, and thus its implications for violence risk, is commonly missed or misdiagnosed. Diagnostic “overshadowing” is an issue, as mentioned earlier. Complex clinical pictures underscore as well the importance of corroborating information.

Developmental History

Establishing the presence or not of ASD is partly accomplished by taking a comprehensive developmental history. Indicators are early problems relating to peers, early diagnosis of schizophrenia in the absence of hallucinations or delusions, and early ritualized intense interests that are not psychotic in nature (Ghaziuddin (2013). Problematic is the availability and quality of such information. Assess as well for any history of childhood neglect or abuse—a standard in risk assessments—with an eye to its influence as an associated risk factor for later violence.

Social Communication Deficits

Assess for ASD theory-of-mind core characteristics of social communication deficits (linked as well to naïveté). How difficult is it for the individual to understand the mental state of others and social nuances, and to interpret social intentions? Does he show inappropriate social approaches and a failure to engage in reciprocal conversation (as in Case Number 1)? How susceptible is he or she to becoming confused and overwhelmed by social information? What are the behavioral implications and consequences for him or her? Compensatory strategies such as self-isolation to reduce anxiety, high intelligence, and good support may make detection of these characteristics more difficult, especially if the expression of ASD is subtle.

Naïveté Contributing to Risk

Often quite baffling to uninformed assessors (or others), ASD-related naïveté stems from these individuals' literal-mindedness, as in the cases of John La Due and Lucas Salmon. In serious scenarios such as theirs, it may be difficult for assessors to consider that malicious intent is not involved. Salmon was so suggestible—he had no internal “brakes”—that it led to him carrying out the murderous instructions of his psychopathic partner. (Assessors need to be aware of an interviewee's vulnerability to suggestibility as well, and avoid asking leading questions). Sound judgment may be distinctly lacking in spite of normal or above intelligence.

Problematic Intense Interests

The obsessive interests of an ASD individual is often pleasurable for him or her, and an escape from the difficulties of social challenges. The issue is problematic interests. Could fascination with flickering flames lead to arson? An interest can get out of control and create hazards, such as involvement with chemicals. An ASD individual may be fascinated with bomb paraphernalia, and very curious to “see how it works.” He could realize that assembling the components could get him into trouble or even arrested—that such actions are illegal—but he may not understand the moral implications of setting off a bomb at his school. Antisocial characterological attitudes of conscious defiance or contempt are absent, as are the defenses of minimization, rationalization, lying, or denial. A subject who acknowledges (or confesses) his behaviors of concern with a genuine sense of naïveté, and perhaps confusion about the alarm shown by others, is likely one with ASD. Intense but nonbizarre interests of someone with ASD must be distinguished from an intrusive and involuntary psychotic delusion, fixation, or obsession, whether or not they suggest intent and/or hazards associated with the activity, let alone actual operational preparations for violence.

Poor Tolerance for Frustration

Emotional dysregulation is a core ASD characteristic that by definition is central to violence risk assessment. How does the individual re-

spond when he experiences frustration, when he doesn't get his way or is provoked? Poor impulse control and aggressive or violent responses are mediated as well by deficits in moral reasoning, that is, understanding right from wrong.

Stressors and Provocative Contexts

Given ASD-based issues with emotional regulation, assessors must be aware of the special vulnerability of these individuals to outside pressures and provocations, and how, if possible, these external stressors may be managed. Challenges with dating, sexuality, or relationships, and school pressure and bullying feed ASD individuals' vulnerability to frustration and may trigger aggression or violence—either impulsive violence, or by contributing to motives for predatory violence. Being subject to immediate, impulsive aggression does not mean ASD individuals cannot have feelings of revenge. They may know full well that someone will suffer, physically and emotionally, from their acts of violence. On La Due's list were school mates whom he claimed had bullied him. Possible is the mingling of naïveté with malicious intent that may distinguish the ASD “avenger” from the more classic, narcissistic, predatory, and/or psychopathic attacker.

Comorbid Axis I Psychiatric Disorders

The evidence for comorbidity significantly raising the risk of violence by ASD individuals is quite convincing (Allely et al., 2014; Im, 2016; Maras et al., 2015; Newman & Ghaziuddin, 2008). The careful assessment for psychosis and mood disorders and thus their treatment when it can be implemented, is “crucial in helping to mitigate the increased violence that these illnesses confer on individuals with ASD” (Im, 2016, p. 30). Should psychosis be comorbid with ASD, consider the hypothesis of Wachtel and Shorter (2013): If a psychotic individual with violent ideation also has ASD he may be quicker to act on his psychotic thoughts and impulses. As stated previously, psychotic fixations must be distinguished from ASD intense fixations.

Comorbid Psychopathy

Comorbid ASD and psychopathy is potentially a very serious combination, granted at first glance it may be difficult to distinguish between the two. “Lack of empathy” is a characteristic of both disorders, but the underlying reasons are very different. Mistaking ASD-driven behavior for deviant psychopathic behavior is a potential misstep, and can lead to inappropriate and unjust case management strategies. Although psychopathic individuals will typically pose a higher risk for violence than those with an ASD, the potential for an extremely violent outcome is possible for someone with either condition, as the case studies illustrated. Comorbidity is a red flag. ASD intense fixations may add fuel to a psychopathic subject’s preparation for violence. Psychopathic and antisocial traits can further motivate someone with ASD characteristics—whose obsessional interest is violence, assassins, or weapons—to mobilize for violence. Rare but possible is a “triple hit”—ASD, psychosis, and psychopathy.

Pathway to Violence Planning

Assessing for preattack planning is inherent to targeted violence risk assessments. The typical motives have been identified and repeatedly demonstrated: a sense of injustice over felt grievances, a desire for revenge or notoriety, unbearable losses, and/or violent delusions (Fein et al., 1995; Meloy & Hoffmann, 2014). In very rare cases the behaviors stem from a naïve understanding of the implications of one’s actions, and are driven by intense fixations and interests that are inherently dangerous, likely influenced by absorption in social media and video games (a possible marker for ASD). The pathway to targeted violence may have a long trajectory, reflecting developmental failures, the early experience of pain, frustration, and isolation—and the emergence of violent ideation at a fairly young age as compensatory negative coping. Multiple psychiatric conditions may exist in a case, and the motives for violence may even change. Evidence for the existence of proximal targeted violence warning behaviors and preparatory actions (Meloy et al., 2014) shifts the immediate focus of a case to interdiction strategies, whatever diagnostic and clinical complexities may be driving the behavior. The as-

essor’s task is to uncover and understand why violence would solve a problem or serve a goal in the mind of the subject, and to determine, to the extent possible, if evidence exists for any decisions and actions indicating a violent path forward.

Case Management and Treatment

Case management planning for ASD individuals with violence risk issues must be individualized and comprehensive, due to the variety of possible presentations, wide-ranging degrees of impairment, the range of violent and criminal behaviors and their seriousness, and the potential significance of comorbidity. Outcome research addressing the effectiveness of case management and treatment of persons with ASD who have a history of violent behavior is a newer area of inquiry requiring a great deal more scholarly investigation. A thorough review of work in this area is beyond the scope of this article, but general trends and practical considerations are addressed.

The assessment and targeting of comorbid major mental disorders with medication may be of the most immediate help in reducing risk in a case. However, ASD as a developmental disorder is unlikely to change significantly over time. If violence risk is an issue, long-term care and supervision is required.

Scientific studies assessing programs and treatment targeting ASD core difficulties suggest that interventions across various problem areas can lead to improved outcomes (Volkmar et al., 2014). Techniques to address social skills deficits include teaching explicit rules for establishing and maintaining relationships, social stories and scripts, how to recognize facial expressions and emotional states of self and others, rules for giving and withholding eye contact, video modeling, problem solving in group settings, and structured practice with typical peers (Im, 2016; Laugeson & Ellingsen, 2014). Emotion regulation issues may be addressed with cognitive reappraisal strategies for alternative responses to frustration, and stress and anger management practices adapted for ASD individuals (Im, 2016). Laugeson and Ellingsen (2014) state that no evidence-based guidelines are available to address ASD-related problematic intense fixations. They recommend close attention, monitoring and supervision of such

interests, whether apparently associated with violence or not. Such recommendations are common in the literature—to monitor and supervise behaviors that do not respond easily to treatment interventions (and for which there is little empirical guidance), and interrupt problematic behaviors prior to negative consequences.

The management of ASD persons who have been violent or threatening includes incarceration in jail according to the criminal law of the jurisdiction, commitment to psychiatric hospitals using the provision of mental health law or court diversion, and management in the community with access to generic or specialist mental health services. Most persons with ASD who have been violent are managed in a noncorrectional setting. There are few treatment programs designed specifically to care for persons with ASD-related violence issues, and more attention is needed in this area (Brewer & Young, 2015). With limited options, professionals working within these systems are forced to piece together treatment and risk management responses in a “no one size fits all” approach.

In cases involving high risk of future violence, the ASD individual may become involved in civil commitment proceedings or be ordered to participate in treatment by a criminal court. Such ASD individuals may spend significant periods of time in structured psychiatric hospitals or residential facilities that are more equipped to respond to reactive, impulsive violence (Brewer & Young, 2015). ASD individuals who are incarcerated following an act or the threat of violence may experience considerable difficulty coping with a jail environment where they are unable to practice their daily routine, become overwhelmed with jail noise and activity, and face the challenges of relating to other people—in general, as well as the especially difficult types found in jail populations. Inmates with ASD are particularly vulnerable to exploitation and abuse and may do better in protective isolation rather than general population (Brewer & Young, 2015).

A vast safety net is needed to monitor persons with ASD who have been violent, including a multidisciplinary team of mental health professionals, various treatment and social programs, and close supervision by community corrections. The treatment team and/or probation officer may place restrictions on the ASD individual's behaviors that aligns with the type of

violence exhibited (e.g., no contact with children or restrictions of social media access for sexual offenders, compliance with terms of a No Contact Order for stalkers, supervised Internet access for those fixated on violent images or targeted violence). Therapists skilled in working with an ASD population may develop a treatment plan specifically focusing on ASD features that might have contributed to prior violence. When mental health treatment occurs on an outpatient basis for persons with ASD who have been violent or may pose a risk, it is advisable that the treatment be long-term in order to monitor for the reemergence of symptoms or issues that might escalate violence risk.

Final Note

Threat assessment professionals and managers may on occasion encounter strong social and political resistance—particularly among some families with ASD children—to the notion that ASD may contribute to violence risk in some form or another. Objective, evidence-based, and informed professional judgment serve all parties. Being conscious of the potential for stigma associated with any mental health diagnosis is a fundamental principle of ethical practice. A threat assessment tenet is to neither overstate risk, or minimize it. As in Case Number 1 in this article, there are many instances where threat assessors have the opportunity to prevent or dampen overreactions, and to educate their clientele that individuals with ASD are more often to be helped and supported than to be feared.

The vast majority of individuals with ASD do not pose a risk of harm, but some with that diagnosis do. The question is what characteristics of any condition, or any fact in an individual's life or circumstances, may suggest or lead to a risk of harm? As noted earlier by researchers Maras et al. (2015), generalizations should not be made on the basis of individual cases. Studies that examine the known or suspected various factors that lead *some individuals with ASD* to engage in criminal or violent behavior would be the most useful research, rather than studies of whether ASD individuals in general are more likely to commit offenses than the general population. In their review of mass murder cases committed by individuals who had an ASD, Allely et al. (2014) found that the vast majority experienced other risk factors such as

physical or sexual abuse. They concluded that a complex combination of neurodevelopmental and environmental factors, and not ASD alone, may cause someone to commit a serious act of violence. This is consistent with a threat assessment approach—targeted violence is dynamic, contextual, and the result of a “perfect storm” of risk factors. The population of individuals with ASD is not served by blanket statements that their condition either leads to violence, or it does not. People are individuals, not a diagnosis, and there are many reasons why they may do the things they do, for good, or otherwise.

References

- Allely, C. S., Minnis, H., Thompson, L., Wilson, P., & Gillberg, C. (2014). Neurodevelopmental and psychosocial risk factors in serial killers and mass murderers. *Aggression and Violent Behavior, 19*, 288–301. <http://dx.doi.org/10.1016/j.avb.2014.04.004>
- Allely, C. S., Wilson, P., Minnis, H., Thompson, L., Yaksic, E., & Gillberg, C. (2017). Violence is rare in autism: When it does occur, is it sometimes extreme? *The Journal of Psychology, 151*, 49–68. <http://dx.doi.org/10.1080/00223980.2016.1175998>
- Allen, D., Evans, C., Hider, A., Hawkins, S., Peckett, H., & Morgan, H. (2008). Offending behaviour in adults with Asperger syndrome. *Journal of Autism and Developmental Disorders, 38*, 748–758. <http://dx.doi.org/10.1007/s10803-007-0442-9>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Asperger, H. (1944). Die “Autistischen Psychopathen” im Kindesalter [The autistic psychopaths in childhood]. *European Archives of Psychiatry and Clinical Neuroscience, 117*, 76–136.
- Barry-Walsh, J. B., & Mullen, P. E. (2004). Forensic aspects of Asperger’s Syndrome. *Journal of Forensic Psychiatry & Psychology, 15*, 96–107. <http://dx.doi.org/10.1080/14789940310001638628>
- Bastiaansen, J. A., Meffert, H., Hein, S., Huizinga, P., Ketelaars, C., Pijnenborg, M., . . . de Bildt, A. (2011). Diagnosing autism spectrum disorders in adults: The use of Autism Diagnostic Observation Schedule (ADOS) module 4. *Journal of Autism and Developmental Disorders, 41*, 1256–1266. <http://dx.doi.org/10.1007/s10803-010-1157-x>
- Baxter, A. J., Brugha, T. S., Erskine, H. E., Scheurer, R. W., Vos, T., & Scott, J. G. (2015). The epidemiology and global burden of autism spectrum disorders. *Psychological Medicine, 45*, 601–613. <http://dx.doi.org/10.1017/S003329171400172X>
- Beadle-Brown, J., Richardson, L., Guest, C., Malovic, A., Bradshaw, J., & Himmerich, J. (2014). *Living in fear: Better outcomes for people with learning disabilities and autism*. Canterbury, UK: Tizard Centre, University of Kent.
- Björkly, S. (2009). Risk and dynamics of violence in Asperger’s syndrome: A systematic review of the literature. *Aggression and Violent Behavior, 14*, 306–312. <http://dx.doi.org/10.1016/j.avb.2009.04.003>
- Blair, J., Mitchell, D., & Blair, K. (2005). *The psychopath: Emotion and the brain*. London, UK: Wiley-Blackwell.
- Brewer, N., & Young, R. L. (2015). *Crime and autism spectrum disorder: Myths and mechanisms*. London, UK: Jessica Kingsley.
- Brumfield, B. (2014, June 25). Minnesota teen who planned school massacre: “I think I’m really mentally ill.” *CNN*. Retrieved from <http://www.cnn.com/2014/06/25/us/minnesota-attack-teen-interview/index.html>
- Calhoun, F. S., & Weston, S. W. (2003). *Contemporary threat management: A practical guide for identifying, assessing, and managing individuals of violent intent*. San Diego, CA: Specialized Training Services.
- Cohen, A. P., Azrael, D., & Miller, M. (2014, October). Rate of mass shootings has tripled since 2011, Harvard research shows. *Mother Jones*.
- Drash, W. (2015, November 3). The massacre that didn’t happen. *CNN*. Retrieved from <http://www.cnn.com/2015/11/03/us/minnesota-foiled-school-massacre-john-ladue/>
- Dutton, D. G., White, K. R., & Fogarty, D. (2013). Paranoid thinking in mass shooters. *Aggression and Violent Behavior, 18*, 548–553. <http://dx.doi.org/10.1016/j.avb.2013.07.012>
- Erikson, E. H. (1950). *Childhood and society*. New York, NY: Norton.
- Faccini, L. (2016). The application of the models of autism, psychopathology and deficient Eriksonian development and the path of intended violence to understand the Newtown shooting. *Archives of Forensic Psychology, 1*, 1–13.
- Fein, R. A., Vossekuil, B., & Holden, G. A. (1995). *Threat assessment: An approach to prevent targeted violence* (Vol. 2). Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.
- Feshir, R. (2015, August 21). Teen charged in school plot to be tried as an adult. *Minnesota Public Radio News*. Retrieved from <http://www.mprnews.org/story/2015/08/21/ladue>
- Fitzgerald, M. (2015). Autism and school shootings—Overlap of autism (Asperger’s syndrome) and general psychopathy. In M. Fitzgerald (Ed.), *Autism spectrum disorder—Recent advances* (pp. 3–12). In-Tech. Retrieved from <https://www.intechopen.com/books/autism-spectrum-disorder-recent-advances/>

- autism-and-school-shootings-overlap-of-autism-asperger-s-syndrome-and-general-psychopathy
- Fonagy, P., Bateman, A., & Bateman, A. (2011). The widening scope of mentalizing: A discussion. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 98–110. <http://dx.doi.org/10.1111/j.2044-8341.2010.02005.x>
- Gacono, C. B. (Ed.). (2016). *The clinical and forensic handbook of psychopathy*. New York, NY: Routledge.
- Ghaziuddin, M. (2013). Violent behavior in autism spectrum disorder: Is it a fact, or fiction? *Current Psychiatry*, 12, 23.
- Hingsburger, D., Griffiths, D., & Quinsey, V. (1991). Detecting counterfeit deviance: Differentiating sexual deviance from sexual inappropriateness. *The Habilitative Mental Healthcare Newsletter*, 10, 51–54.
- Im, D. S. (2016). Template to perpetrate: An update on violence in autism spectrum disorder. *Harvard Review of Psychiatry*, 24, 14–35. <http://dx.doi.org/10.1097/HRP.0000000000000087>
- Jones, A. P., Happé, F. G., Gilbert, F., Burnett, S., & Viding, E. (2010). Feeling, caring, knowing: Different types of empathy deficit in boys with psychopathic tendencies and autism spectrum disorder. *Journal of Child Psychology and Psychiatry*, 51, 1188–1197. <http://dx.doi.org/10.1111/j.1469-7610.2010.02280.x>
- Kawakami, C., Ohnishi, M., Sugiyama, T., Somekl, F., Nakamura, K., & Tsujii, M. (2012). The risk factors for criminal behavior in high-functioning autism spectrum disorders (HFASDs): A comparison of childhood adversities between individuals with HFASDs who exhibit criminal behaviour and those with HFASD and no criminal histories. *Research in Autism Spectrum Disorders*, 6, 949–957. <http://dx.doi.org/10.1016/j.rasd.2011.12.005>
- King, C., & Murphy, G. H. (2014). A systematic review of people with autism spectrum disorder and the criminal justice system. *Journal of Autism and Developmental Disorders*, 44, 2717–2733. <http://dx.doi.org/10.1007/s10803-014-2046-5>
- Knoll, J. L., IV, & Meloy, J. R. (2014). Mass murder and the violent paranoid spectrum. *Psychiatric Annals*, 44, 236–243. <http://dx.doi.org/10.3928/00485713-20140502-07>
- Laugeson, E. A., & Ellingsen, R. (2014). Social skills training for adolescents and adults with autism spectrum disorder. In F. R. Volkmar, B. Reichow, & J. C. McPartland, (Eds.), *Adolescents and adults with autism spectrum disorders* (pp. 61–85). New York, NY: Springer Science + Business Media. http://dx.doi.org/10.1007/978-1-4939-0506-5_4
- Lerner, M. D., Haque, O. S., Northrup, E. C., Lawer, L., & Bursztajn, H. J. (2012). Emerging perspectives on adolescents and young adults with high-functioning autism spectrum disorders, violence, and criminal law. *The Journal of the American Academy of Psychiatry and the Law*, 40, 177–190.
- Louwagie, P. (2017, May 21). Trying to escape shadow of dread. *StarTribune*. Retrieved from <http://www.startribune.com/john-ladue-works-to-build-a-life-in-a-city-where-he-planned-to-kill/411587345/>
- MacKenzie, R., McEwan, T., Pathe, M., James, D., Ogloff, J., & Mullen, P. (2009). *Stalking risk profile: Guidelines for the assessment and management of stalkers*. Melbourne, Victoria, Australia: Centre for Forensic Behavioural Science, Monash University.
- Mahoney, M. J. (2009). *Asperger's syndrome and the criminal law: The special case of child pornography*. Harrington & Mahoney Law Firm. Retrieved from <http://www.harringtonmahoney.com/content/Publications/AspergersSyndromeandtheCriminalLawv26.pdf>
- Maras, K., Mulcahy, S., & Crane, L. (2015). Is autism linked to criminality? *Autism*, 19, 515–516. <http://dx.doi.org/10.1177/1362361315583411>
- Meloy, J. R. (1992). *Violent Attachments*. Northvale, NJ: Jason Aronson.
- Meloy, J. R. (2012). Predatory violence and psychopathy. In H. Häkkinen-Nyholm & J. Nyholm (Eds.), *Psychopathy and law* (pp. 159–175). London, UK: Wiley <http://dx.doi.org/10.1002/9781119944980.ch8>
- Meloy, J. R., & Hoffmann, J. (Eds.). (2014). *International handbook of threat assessment*. New York, NY: Oxford University Press.
- Meloy, J. R., Hoffmann, J., Guldemann, A., & James, D. (2012). The role of warning behaviors in threat assessment: An exploration and suggested typology. *Behavioral Sciences & the Law*, 30, 256–279. <http://dx.doi.org/10.1002/bsl.999>
- Meloy, J. R., Hoffmann, J., Roshdi, K., Glaz-Ocik, J., & Guldemann, A. (2014). Warning behaviors and their configurations across various domains of targeted violence. In J. R. Meloy & J. Hoffmann (Eds.), *International handbook of threat assessment* (pp. 39–53). New York, NY: Oxford University Press.
- Meloy, J. R., & Mohandie, K. (2001). Investigating the role of screen violence in specific homicide cases. *Journal of Forensic Sciences*, 46, 1113–1118. <http://dx.doi.org/10.1520/JFS15107J>
- Meloy, J. R., Mohandie, K., Knoll, J. L., & Hoffmann, J. (2015). The concept of identification in threat assessment. *Behavioral Sciences & the Law*, 33, 213–237. <http://dx.doi.org/10.1002/bsl.2166>
- Mouridsen, S. E., Rich, B., Isager, T., & Nedergaard, N. J. (2008). Pervasive developmental disorders and criminal behaviour: A case control study. *International Journal of Offender Therapy and Comparative Criminology*, 52, 196–205. <http://dx.doi.org/10.1177/0306624X07302056>

- Newman, S. S., & Ghaziuddin, M. (2008). Violent crime in Asperger syndrome: The role of psychiatric comorbidity. *Journal of Autism and Developmental Disorders*, *38*, 1848–1852. <http://dx.doi.org/10.1007/s10803-008-0580-8>
- Raine, A. (2013). *The anatomy of violence: The biological roots of crime*. New York, NY: Pantheon.
- Rogers, J., Viding, E., Blair, R. J., Frith, U., & Happé, F. (2006). Autism spectrum disorder and psychopathy: Shared cognitive underpinnings or double hit? *Psychological Medicine*, *36*, 1789–1798. <http://dx.doi.org/10.1017/S0033291706008853>
- Schwartz-Watts, D. M. (2005). Asperger's disorder and murder. *The Journal of the American Academy of Psychiatry and the Law*, *33*, 390–393.
- Simonoff, E., Pickles, A., Charman, T., Chandler, S., Loucas, T., & Baird, G. (2008). Psychiatric disorders in children with autism spectrum disorders: Prevalence, comorbidity, and associated factors in a population-derived sample. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*, 921–929. <http://dx.doi.org/10.1097/CHI.0b013e318179964f>
- Solomon, A. (2015). *The myth of the "autistic shooter."* Retrieved from <https://www.nytimes.com/2015/10/12/opinion/the-myth-of-the-autistic-shooter.html>
- State of Connecticut, Office of the Child Advocate. *Shooting at sandy hook elementary school*. Retrieved from <http://www.ct.gov/oca/site>
- State of Minnesota. (2015). *Findings of fact, conclusions of law, and order, in the matter of the welfare of: John David LaDue, child*. Retrieved from <http://ftpcontent6.worldnow.com/kttc/newsdocs/ladufindings.pdf>
- Volkmar, F. R., & McPartland, J. C. (2014). From Kanner to DSM–5: Autism as an evolving diagnostic concept. *Annual Review of Clinical Psychology*, *10*, 193–212. <http://dx.doi.org/10.1146/annurev-clinpsy-032813-153710>
- Volkmar, F. R., Reichow, B., & McPartland, J. C. (Eds.). (2014). *Adolescents and adults with autism spectrum disorders*. New York, NY: Springer Science + Business Media. <http://dx.doi.org/10.1007/978-1-4939-0506-5>
- Wachtel, L. E., & Shorter, E. (2013). Autism plus psychosis: A “one-two punch” risk for tragic violence? *Medical Hypotheses*, *81*, 404–409. <http://dx.doi.org/10.1016/j.mehy.2013.05.032>
- Waseca County Court. (2014). *Interview with John David LaDue*. Retrieved from [http://kstp.com/kstpImages/repository/cs/files/LADUE%20INTERVIEW%20TRANSCRIPT%201\(2\).pdf](http://kstp.com/kstpImages/repository/cs/files/LADUE%20INTERVIEW%20TRANSCRIPT%201(2).pdf)
- White, S. G. (2017). Case study: The Isla Vista campus community mass murder. *Journal of Threat Assessment and Management*, *4*, 20–47. <http://dx.doi.org/10.1037/tam0000078>

Received January 31, 2017

Revision received July 31, 2017

Accepted August 2, 2017 ■

E-Mail Notification of Your Latest Issue Online!

Would you like to know when the next issue of your favorite APA journal will be available online? This service is now available to you. Sign up at <https://my.apa.org/portal/alerts/> and you will be notified by e-mail when issues of interest to you become available!