

# Cognitive-affective drivers of fixation in threat assessment

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## Abstract

Pathological fixation – preoccupation with a person or a cause that is accompanied by deterioration in social and occupational functioning – has been found to precede most cases of targeted violence. It is clinically observed and theorized to have three different cognitive-affective drivers: delusion, obsession, or extreme overvalued belief. Each driver is explained, and case examples are provided in the context of threat assessment. Extreme overvalued belief as a new concept is discussed in detail, both its historical provenance and its demarcation from delusions and obsessions. Threat management for each separate cognitive-affective driver is briefly summarized, based upon current clinical findings and research. Emphasis is placed upon understanding both the categorical and dimensional nature (intensity) of these cognitive-affective drivers, and suggested guidelines are offered for the assessment of such in a clinical examination by a forensic psychiatrist or psychologist.

## 1 | INTRODUCTION

Pathological fixation – preoccupation with a particular person or cause that is accompanied by deterioration in social and occupational functioning (Barry-Walsh, James, & Mullen, 2020; Mullen et al., 2008; Meloy, Hoffmann, Guldimmann & James, 2012) – has emerged as a very frequent proximal warning behavior in targeted attacks: violence that is planned, purposeful, and predatory (Meloy, 2006). Although fixation is not a *predictor* of such attacks, its frequency across a variety of domains of targeted attackers prior to their actions provides support for its use as a *correlate* of such behavior (Monahan & Steadman, 1994). Table 1 illustrates the frequency of pathological fixation as a proximal warning behavior across 377 subjects in an aggregated dataset of various targeted attackers studied over the past 15 years (range: 41%–100%,  $M = 81\%$ ). Its association with other characteristics of

TABLE 1 Frequency of pathological fixation in targeting attackers

Public figure attackers in the United States ( $n = 18$ ; Meloy, Hoffmann, Roshdi, Glaz-Ocik & Guldemann, 2014a)	78%
Western European attackers of politicians ( $n = 24$ ; James et al., 2007)	54%
German public figure attackers ( $n = 14$ ; Hoffmann, Meloy, Guldemann & Ermer, 2011)	100%
German school shooters ( $n = 9$ ; Meloy, Hoffmann, Roshdi & Guldemann, 2014b)	100%
European individual terrorists ( $n = 22$ ; Meloy, Roshdi, Glaz-Ocik & Hoffmann, 2015c)	100%
British Royal family attackers, 1778–1994 ( $n = 19$ ; James et al., 2008)	63%
US and European lone actor terrorists ( $n = 111$ ; Meloy & Gill, 2016)	77%
German intimate partner homicide offenders ( $n = 70$ ; Glaz-Ocik and Hoffmann, 2011)	93%
North American lone actor terrorists ( $n = 33$ ; Meloy et al., 2019)	85%
US mass attackers in 2018 ( $n = 27$ ; National Threat Assessment Center, 2019)	41%
German mass murderers, psychotic ( $n = 11$ ; Alwinn, Hoffmann & Meloy, 2019)	100%
German mass murderers, non-psychotic ( $n = 19$ ; Alwinn et al., 2019)	84%
Total $N = 377$	Average 81%

an attack and attackers is also notable. In one study of attackers of western European politicians, fixation was strongly associated with death or serious injury, delusion, psychosis, loner status, and other warning behaviors (James et al., 2007). In a study of attackers of the British Royal Family from 1778 to 1994, fixation was found in a majority of the cases (63%,  $N = 19$ ; James et al., 2008). Alwinn et al. (2019), in a contemporary study of mass murderers in Germany, found no significant difference in fixation frequency (84% vs. 100%) when the nonpsychotic and psychotic subjects were compared. In another study of a large sample of North American and European lone actor terrorists, fixation discriminated between successful and thwarted attackers with a large effect size (Meloy & Gill, 2016). However, it did not discriminate between terrorist attackers and other persons of national security concern who did not attack – and were risk-managed instead – in a North American comparative study (Meloy et al., 2019); fixation was present in a majority of subjects in both samples. In a study of mass attacks in public spaces during the year 2018 conducted by the US Secret Service, fixation was evident in 41% of the cases (National Threat Assessment Center, 2019).

Pathological fixation appears to be a chronic and devolving state of mind, manifested in a behaviorally evident preoccupation that damages adaptive social and occupational engagement. Yet the internal dynamics that sustain fixation, what we term cognitive-affective drivers, and their possible etiologies, have not been elaborated upon from a clinical and theoretical perspective. We will emphasize three observed cognitive-affective drivers for fixations: delusion, obsession, and extreme overvalued belief. These three internal drivers which evoke and sustain a pathological fixation can often appear strikingly similar when first assessed, and thus create confusion for clinical as well as forensic examiners. We will describe each of these in greater detail, which will allow for more specific threat assessment and management. These definitions emphasize the etiology of the fixation, and bring further nuance to the threat assessment task by suggesting different treatment interventions in the course of a threat posed by these cognitive-affective drivers. We will begin by discussing delusion (a fixed, false and idiosyncratic belief), which is pertinent to threat assessment depending on the content of the delusion(s). Second, we will discuss overvalued idea, which has a strong provenance in British scholarship and led to the refined definition and study of extreme overvalued belief (Rahman, 2018; Rahman et al., 2020; Rahman, Harry & Resnick, 2016; Rahman, Meloy, & Bauer, 2019). It is a belief shared by others in their culture or subculture and is amplified, relished and defended by the possessor of the belief. We think that extreme overvalued beliefs are the most pertinent and common cognitive driver of lone actor violence as well as group terrorism, and is also the least studied. The content of these beliefs,

particularly in an online world, can easily be mistaken for a delusion due to its odd or bizarre content. Finally, we will discuss obsession, which is experienced as an ego-dystonic, intrusive, and unwanted thought which the possessor of the belief tries to resist. It is generally of lower risk for violence since the possessors of the beliefs are usually fearful of their intrusive thoughts and want them to stop, often through rituals.

There has been much attention paid to whether or not terrorism is associated with mental illness (Corner, Gill, & Mason, 2016; Gill, 2015). We think the model presented here can improve operational definitions to allow for a more calibrated lexicon and study. These definitions provide a framework based on what is currently available and are suggestions for further research, as well as to bolster currently validated data regarding threat assessment and management. Addressing pathological fixation utilizing these three clinical definitions in psychiatry also provides a novel step toward specific recommendations to help mitigate the potential targeted violence risk posed by each type of cognitive-affective driver. Finally, the definitions also provide a framework for future comparison of data and to promote communication between various research investigators.

## 2 | DELUSION

A delusion is a nonfactual certainty which is fixed, false and idiosyncratic. It is based on grossly incorrect inferences about external reality that are firmly held despite what almost everyone else believes, and in the face of incontrovertible and obvious proof or evidence to the contrary. The belief is not ordinarily accepted by other members of the person's culture or subculture, such as an article of religious faith. Delusions have been described as existing on a continuum or spectrum, and sometimes occurring in an isolated fashion. Obsessions, delusions, and extreme overvalued beliefs can usually be distinguished on clinical grounds (Rahman et al., 2020). Delusions are usually accompanied by other psychotic symptoms, such as visual or auditory hallucinations, grossly disorganized speech (formal thought disorder) and disorganized behavior. Isolated delusions without other cardinal symptoms of schizophrenia or a mood disorder do exist as delusional disorder (American Psychiatric Association [APA], 2013), but should alert the examiner to the possibility that the individual has obsessions or, more commonly, extreme overvalued beliefs. Negative symptoms may include social withdrawal that leads to further impaired social functioning; however, in the context of targeted violence, surreptitiously planning for an attack should not be confused with social withdrawal, and should be eliminated as a sign of psychosis in such cases (e.g., Meloy, Habermeyer, & Guldemann, 2015a).

### 2.1 | Case 1 – Delusion as cognitive-affective driver

A man living alone in a studio apartment in Ohio developed an erotomanic delusion that drove his fixation concerning the actress Gwyneth Paltrow: the chronic psychotic belief that she was in love with him. He had seen her in the movie, *Shakespeare in Love*, and that same day, he saw her photo on the cover of a Hollywood magazine in a grocery line, knowing for sure that these were not coincidences and these events were meant especially for him, a psychotic symptom called a delusion of reference. At night, when he would pick up his ringing phone and be confronted with silence, he knew that it was her on the other end – he believed she could not talk because of her mother's disapproval of their relationship, but with her silence was letting him know that she loved him. Fueled by these psychotic symptoms, and over the next several months, he sent her numerous sexualized letters, gifts, and packages, and then traveled on two occasions to visit her at her parents' home in Santa Monica – despite an FBI agent telling him to cease his behavior between the first and second trips. On the second visit, he was arrested and charged with stalking (California PC 646.9). The man was evaluated by Meloy on two occasions: during his trial and after 8 years of confinement in various California forensic hospitals. Schizophrenia was ruled out as a diagnosis given the absence of formal thought disorder, hallucinations, and any other negative symptoms; and he was instead

diagnosed with delusional disorder, erotomanic subtype (APA, 2013). He had been found not guilty by reason of insanity (NGRI) in his original trial, and subsequently was determined not to pose a risk of violence toward Ms Paltrow. After several years of release into the community under the care of his brother, he resumed his attempts to contact her and consummate their relationship. His erotomanic delusion persisted. Although he had received various psychotropic medications, such as olanzapine, and psychotherapeutic interventions through his years in the hospital – and would intentionally disavow his continued fixation upon Paltrow in psychiatric interviews – his active suppression to act on his delusion following his release could not be sustained and he contacted her, although he never posed a physical risk of harm.

## 2.2 | Case 2 – Delusion as cognitive-affective driver

Andrea Yates was a devoutly religious and loving mother of five children in Texas. She was valedictorian of her high school class of 600 students and later became a respected nurse. She suffered from a severe major depressive disorder with psychotic symptoms, requiring four hospitalizations and treatment. She was generally a responsible person and did not use drugs. She sequentially drowned her five children (aged 7, 5, 4, 2, and 6 months) by holding them face down in the bathtub at home. After her arrest, forensic psychiatric examinations by Dr. Phillip Resnick revealed that she held delusions of being possessed by a demon (cacodemonomania). She believed that Satan was actually within her and that if she did not take her children's lives before the age of accountability, her children would be condemned to hell where their souls would remain for eternity. She believed that after their murders, she would be executed for killing her children, and Satan would die from within her and bring about Armageddon. She expected to die as a righteous individual, and that her children would be better off in heaven than on Earth (Resnick, 2007).

## 2.3 | Treatment and risk management

Delusions in the context of a major mental disorder are amenable to treatment with psychotropic medications, and most such patients will benefit from antipsychotic drugs. Current guidelines (Gabbard, 2013; Lehman et al., 2004) support the use of antipsychotic drugs in the management of schizophrenia or in mood disorders with psychotic features (e.g., bipolar or unipolar mood disorders). Substance-induced psychotic disorders (e.g., amphetamine) can also appear with quite elaborate hallucinations and delusions. Such individuals may commit acts of serious violence towards others, including law enforcement officers, due to the physiologically arousing and paranoia-inducing properties of the stimulants. Antipsychotic drugs can be beneficial in such cases and may require several weeks or months of treatment in a drug-free environment to clear their psychotic symptoms (Chiang et al., 2019; McPherson, Hall, & Yudko, 2009). Delirious patients can also exhibit hallucinations and delusions (intensive care units often utilize restraints and antipsychotics in such patients to protect them from self-harm, such as pulling out intravenous lines which are perceived as “snakes” by the patient) (Latronico, 2018). Electroconvulsive therapy is useful in psychotically depressed individuals, such as those with postpartum depression (Lisanby, 2007).

Subjects with persecutory and atypical psychotic disorders such as Capgras syndrome are considered to be a threat to others if the individual is fearful of being harmed (Manschreck, 1995; Silva, Leong, Weinstock, & Boyer, 1989). Capgras delusions are ones in which the person believes others such as loved ones are replaced by an imposter (“I know that is not my real mother because she does not walk like that”). Such encapsulated delusions in the absence of other symptoms are more difficult to treat. Clinicians who treat floridly psychotic patients on inpatient units understand that remaining neutral to delusional content (i.e., not challenging their veracity) establishes a better trust and rapport; the quality of the interpersonal engagement is vital to treatment

adherence and decreases the risk for agitation and subsequent restraint or seclusion. However, forcible treatment can also become necessary in patients with poor insight. Long-acting injectable drugs are often more effective and/or make it more convenient for caregivers to administer the medication (Freudenreich, 2008; Gabbard, 2013).

### 3 | EXTREME OVERVALUED BELIEF

This construct, which we recently refined and began to validate from earlier work by Wernicke (1892, 1906) and McHugh (McHugh, 2006; McHugh & Slavney, 1998), is a second cognitive driver for pathological fixation (Rahman, 2018; Rahman et al., 2019, 2020):

“An extreme overvalued belief is one that is shared by others in a person's cultural, religious, or subcultural group. The belief is often relished, amplified, and defended by the possessor of the belief and should be differentiated from an obsession or a delusion. The belief grows more dominant over time, more refined and more resistant to challenge. The individual has an intense emotional commitment to the belief and may carry out violent behavior in its service” (Rahman, 2018, p. 10).

Just as the content of a delusion, such as persecutory delusion can lead to violence, the content of an extreme overvalued belief can also lead to violence. It is often simplistic and binary, but, unlike a delusion, cannot be disproven. It is the content and its affective intensity that changes the belief from normal to “extreme overvalued,” given the definition above. For example, one of the recruitment elements that became the ideology of the Islamic State was, “the West is at war with Islam” (Warrick, 2015) – a simple, binary, and difficult to disprove, belief. Similarly, a potential mass shooter may have a moral grievance in which he identifies with previous mass shooters and believes, with a passionately held attitude, that his grievance mandates violent action (Hempel, Meloy, & Richards, 1999; Langman, 2009).

Emotions, in particular, play an important role in extreme overvalued belief, and often paradoxically include both positive and negative affect states. For example, lone actor terrorists and some group-based terrorists will often feel moral outrage toward a perceived victimized group, and vicariously identify with that group, feeling anger and humiliation, and other dysphoric states (Meloy & Gill, 2016; Rahmani, Hemmati, Cohen, & Meloy, 2019). As they move on a pathway toward violence, the identification with the victimized group becomes an identification as a warrior or soldier to defend the victimized group, accompanied by feelings of exhilaration and excitement, and other euphoric states (Meloy, 2017). Such paradoxical emotional states, attitudes and assumptions energize the extreme overvalued belief and are nurtured by the extremist group, often through social media (Berger, 2018). Such beliefs can, in turn, drive the impulse to a blood sacrifice of the self and/or others in a cause or for a purpose that is bereft of any critical analysis or judgment (Gibson, 1994; Meloy, 2018; Strozier, Terman & Jones, 2010). The neurobiology of such a cognitive-affective driver may be similar to that found in stalking (Fisher & Meloy, 2005; Meloy, 1989), but needs empirical investigation.

Similar to eating disorders (EDs) – at first glance a very different issue than lone actor terrorism – individuals with extreme overvalued beliefs do not generally walk in to a clinic or emergency room wanting help. Family and others who are close to the individual may be concerned, but often dismiss their ideology as “normal” because it is shared by others in their subculture (Rahman, 2018). For instance, an individual with anti-semitic, anti-Islamic, anti-government, or anti-abortionist views may appear to have beliefs that are no different than others around them. In fact, such individuals, like patients with anorexia, do not have cardinal psychotic symptoms, making them difficult to detect and assess. Often the first sign of their “psychopathology” are late stage markers on the pathway to violence, or a mass attack which appears – but is not – quite spontaneous.

The neuropsychiatrist Carl Wernicke (1892) was the first to describe “overvalued idea.” He argued that it was possible for any belief to become overvalued, and that the individual usually has an affect-laden experience that starts or reinforces the belief. For instance, a depressed or grieving individual, feeling slighted by the government or society, might convert to a new religion or begin exploring new ideologies. Such behavior might help decrease his anxiety and soothe uncomfortable feelings as the new ideology becomes a source of inspiration. He may feel he is fighting for his identity and truest self (the term *jihad*, in a violent context, is an example of Wernicke's concept that there is an “inner struggle” for which a person may fight). Anders Breivik, relishing the 12th-century Knights Templar order, wore US Marine military regalia and designed his own sleeve insignia, thus becoming a “warrior” in his own mind (Meloy et al., 2015a; Rahman, Harry & Resnick, 2016). Such *identification* warning signs are readily noted in some targeted attackers (Meloy, Mohandie, Hoffmann & Knoll, 2015b), and the majority of lone actor terrorists (Meloy et al., 2019). In summary, extreme overvalued belief is an important cognitive-affective driver in many lone actor terrorism cases and requires a careful examination (often through collateral sources) of the content and intensity of beliefs, often including a primary grievance which justifies violence – at the same time ruling out that the fixation is instead driven by a delusion or an obsession (Cunningham, 2018).

### 3.1 | Case 3 – Extreme overvalued belief as cognitive-affective driver

Timothy McVeigh detonated a 500-pound ammonium nitrate and fertilizer bomb on 19 April 1995 in front of the Alfred P. Murrah Federal Building in Oklahoma City, killing 168 men, women, and children. McVeigh was subsequently arrested, charged, tried, and convicted. He was executed by lethal injection exactly 2 months before 9/11, ending the criminal litigation concerning what remains the worst act of domestic terrorism in the history of the United States.

Meloy was retained by the US Attorney General to assess McVeigh and his co-conspirator, Terry Nichols (Acklin, 2018; Meloy, 2004). Neither defendant entered a mental disability defense, and therefore Meloy was unable to clinically evaluate them. Voluminous evidence presented at trial, however, indicated that McVeigh held a personal grievance toward the US Government for his failure to qualify for the selection process for the US Army Special Forces conducted at Fort Bragg, North Carolina. His subsequent immersion in the Patriot Movement, an extreme right wing subcultural militia which was an ideological blend of anti-government, anti-abortion, anti-semitic, pro-Second Amendment, racist and White ethnic nationalist beliefs, culminated in his outrage at the federal interventions against the Branch Davidians in Waco, Texas. He believed that federal agents deliberately murdered men, women, and children in the fires that engulfed the Davidian compound on 19 April 1993.

The blaming of the US Government for the conflagration at Waco, and other untoward events at the time, were shared subcultural beliefs among the members of the Patriot Movement. The anger was deeply felt and magnified through earlier popular books such as *The Turner Diaries*, a novel by William Pierce, the head of the National Alliance at the time and a neo-Nazi, which became McVeigh's template for the bombing of the Murrah Building. But why did McVeigh, among the many who harbored such anger and belief, choose to commit an act of terrorism? McVeigh held two central and unique extreme overvalued beliefs that drove his fixation: he would become the “ultimate warrior;” and his bombing would begin a violent overthrow of the US government, culminating in his rebirth as the “first hero of the second American Revolution.” These beliefs – also examples of identification as a warning behavior (Meloy et al., 2015a) – were expressed through word and pen to several individuals, including his younger sister, Jennifer, and were relished, amplified, and defended for at least 2 years prior to the bombing. They became more resistant to change and dominant in the months prior to the bombing (Meloy case files; Michel & Herbeck, 2002; Serrano, 1998). These extreme overvalued beliefs were inextricably tied to his narcissistic personality traits (Meloy case files; Gabbard, 1989).

### 3.2 | Case 4 – Extreme overvalued belief as cognitive-affective driver

In one forensic evaluation conducted by Meloy, a paranoid and schizoid man went to a neighborhood grocery store armed with an AK-47 to buy a pack of cigarettes. A police officer drove up as he entered the store, and the man shot and killed the officer, who was still sitting in his car, with multiple rounds from his automatic rifle. He told the examiner that he kept the AK-47 because he believed he would be left behind during the Rapture, and would need to defend himself during the seven years of tribulation in the battle of Armageddon before Jesus returned and ushered in the millennium, 1,000 years of peace – a belief dependent on a misreading of the Christian Book of Revelation. There are different theories within Christian theology as to the timing of the Rapture in relationship to the second coming of Christ, and whether or not they are separate events. This subject articulated a “pretribulational premillennialist” theory popular in contemporary evangelical Christianity; but note the necessity of “defensive” violence in his statement, which actually resulted in the offensive and predatory ambush of a police officer. When he was asked if he had actually joined a paramilitary group, he said, “No, I prefer to be my own fringe group” (Meloy, 2018, p. 14).

### 3.3 | Case 5 – Extreme overvalued belief as cognitive-affective driver

Malik Hasan, a US Army Major and psychiatrist, committed a mass murder at Fort Hood, Texas, in November 2009, killing 13 soldiers and injuring 32 others at the time his unit was being medically processed for deployment to Afghanistan. Hasan had become radicalized over the previous few years, evidencing his fixation through presentations during his residency program and his public health fellowship, which increasingly focused on convincing others that the West was at war with Islam – with little reference to psychiatry (Meloy & Genzman, 2016). According to one formal legislative report after the massacre,

Hasan's draft presentation consisted almost entirely of Koranic verses and references, without a single mention of a medical or psychiatric term. Hasan's draft also presented extremist interpretations of the Koran, such as supporting grave physical harm and killing of non-Muslims. He even suggested that revenge might be a defense for the terrorist attacks of 11 September 2001. Hasan's superiors warned him that he needed to revise the presentation if he wanted to graduate and concluded it was “not scientific,” “not scholarly,” and a mere “recitation of the Koran” that “might be perceived as proselytizing” (U.S. Senate Committee on Homeland Security and Governmental Affairs, 2011).

Was his fixation driven by delusion, obsession, or extreme overvalued belief? Following the massacre, he was examined by several military forensic psychiatrists who determined he did not have a mental disorder (Meloy & Genzman, 2016; K. Joshi, forensic psychiatrist and examiner, personal communication, July 2016) and therefore did not qualify for an insanity defense. Some of his comments during his psychiatric examination inferred his extreme overvalued belief: “I was focused ... I had a mission to accomplish ... I got the job done ... I wanted to take out as many soldiers as I could before I got stopped ... I don't think what I did was wrong because it was for the greater cause of helping my Muslim brothers ... I regret being paralyzed... (the soldiers he killed) were going against the Islamic Empire” (Full Report of Sanity Board, *US vs. MAJ Nidal M Hasan*, 13 January 2011). Hasan believed that the United States was waging an unjust war against Islam (Poppe, 2018), and that “fighting for God was a noble deed” (Report of Sanity Board, p. 26). He attempted to enter a “defense of others” defense at trial on the basis that the victims were a part of the US Military. Hasan's belief was that “the others” were the leaders of the Taliban with whom he identified – although he had never met such a leader or visited Afghanistan – and his massacre should be considered a form of self-defense (Meloy & Genzman, 2016). “Defense of others” requires that the person was

compelled to use force against an aggressor to protect a person or group from being harmed or killed by that aggressor. The persons being protected must be victims of unlawful force and face an immediate threat or danger. The judge rejected this defense as a matter of law a week later (<https://www.nytimes.com/2013/06/05/us/fort-hood-suspect-says-he-was-defending-taliban-leaders.html>, accessed 14 May 2020; see also Miller, 2017). Hasan did not present any subsequent defense, preferring to receive the death penalty and become a martyr (Poppe, 2018). Central to his radicalization and motivation for his attack was his theology, which contained within it extreme overvalued beliefs that obligated him to attack. Poppe (2018) elaborated,

Two factors of Hasan's ideology that are critical to understanding his worldview are his conventions of hell and obedience to God. An overarching fear of hell plays an enormous role in determining how Hasan thinks and acts, and he has repeatedly written and said that he believed hell to be a real, physical place and his primary motivation in committing violence was to avoid hell. A fundamental way he thought he could do this was through complete submission to God and His will. Hasan felt that a pious Muslim must obey God's commands without question, and to fail to do so would cause him to lose his "rank" in heaven. As he came to believe that God was commanding him to fight in His name against the enemies of Islam, Hasan, according to his worldview, was left with no other option but to comply or risk condemnation to hell. In both the Sanity Board report and his writings, Hasan said that he did not want to kill soldiers, but felt compelled to do so because God commanded it. Without understanding Hasan's interpretations of hell and obedience to God, it is impossible to understand why he committed the attack (Poppe, 2018, pp. 21–22).

#### 3.4 | Treatment and risk management

There is no known evidence-based mental health treatment for a lone offender with extreme overvalued beliefs. The best current data come from the treatment of other disorders with extreme overvalued beliefs, such as EDs, parasitophobia (Ekblom's syndrome) and other paranoid states. Inpatients with EDs have a high incidence of comorbidities. In one study, 69% met criteria for at least one personality disorder diagnosis and up to 93% also had psychiatric comorbidities of substance abuse, anxiety, and depression. Such comorbidities worsen the prognosis and behavioral events in EDs (Braun, Sunday, & Halmi, 1994). There have been similar findings of mental disorders in lone actor terrorism database studies (Corner & Gill, 2015). Therefore, individuals presenting with extreme overvalued beliefs in threat management should be screened and treated for similar comorbidities (Wilson & Shafran, 2005). Medications and behavioral management, however, may reduce the intensity and preoccupation with overvalued ideas. There are case reports of treatment utilizing medications for such rigidly held beliefs, such as being overweight (Frank, 2016) or infested with parasites (Hinkle, 2010); on the other hand, in randomized controlled trials, antipsychotic drugs do not appear to help these beliefs, further contrasting these disorders from delusion (Attia et al., 2019). Behavioral interventions, such as individual cognitive-behavioral therapy, as well as family and group psychotherapy, are considered primary treatment modalities by experts in EDs, but the strength of the evidence base varies by diagnosis (Marcus & Wildes, 2014).

There have been innovative psychotherapeutic and behavioral attempts to alter or modulate such overvalued beliefs, including counterbalancing efforts and purposeful cognitive dissonance approaches, which may be promising for future development in counterterrorism. One successful approach to reducing EDs in adolescent girls is the "Body Project," an intervention based on the social psychological principle of cognitive dissonance: the contemporaneous experience of conflicting attitudes, beliefs, or behaviors in a person. The main intervention is encouraging females to take an active stance by arguing against the culturally mandated thin ideal. Participants experience cognitive dissonance and actually shift their belief systems to align with a healthier anti-thin ideal stance. This project revealed a 60% reduction in the number of expected cases of EDs that would have



theoretically emerged without this cognitive based intervention (Shaw, Stice, & Becker, 2009). This may provide a valuable template for reducing extreme overvalued beliefs when coupled with public health approaches in which the illogic of certain extreme political, religious or other narratives is challenged. Mental health clinicians are trained to stay neutral when confronting delusions in psychotic patients; however, this tradition may be counterproductive when dealing with overvalued beliefs, as the Body Project data have demonstrated. Therefore, in a prevention model a subject with extreme overvalued beliefs may benefit from a more direct approach by showing the subject other types of overvalued beliefs that help create dissonance in his own thinking. Lone actor violent behavior is similar to ED in that both are motivated by a set of assumptions, beliefs and passionate attitudes. Utilizing a train-the-trainer approach, while protecting first amendment rights, the Body Project has been demonstrably successful in numerous high schools, over 140 college campuses, and over 3.5 million girls and young women in 25 countries (<https://www.bodyprojectcollaborative.com/>). However, there has been criticism of this project despite the recognition that it is the most empirically supported prevention approach to EDs. Testing has been limited to groups that have a relatively low likelihood of developing an ED (i.e., college students) and focuses primarily on the thin ideal as the causative factor, while ignoring genetic, personality, and biological vulnerabilities. Research indicates that energy intake and body weight regulation involve both metabolic and hormonal control mechanisms and neurocognitive processes (Davidson, Jones, Roy, & Stevenson, 2019).

The concept of extreme overvalued beliefs can be applied to targeted violence and lone actor terrorism threat assessment. Individuals with normal beliefs develop a refinement from normal to extreme overvalued beliefs through the use of cognitive shortcuts, or heuristics (Kahneman, 2011), such as availability bias (when personal and emotional meaning overrides knowledge of actual importance of an event) and confirmation bias (when facts are not allowed to interfere with beliefs); when applied to threat assessment, external reality becomes untethered from beliefs. The affect accompanying the beliefs may intensify, especially in the face of confrontation, as the belief becomes more extreme and overvalued. Conspiracy theories, religious fervor, or political ideology can grow rapidly, as the user sees more content without counterbalancing information, a partial result in contemporary times of social media algorithms deciding what the viewer should see next according to his or her interests or “likes.” This process of fixating on ideas may later coalesce into a self-identity or identification. Recent research suggests that such evolution from fixation to identification may be an indicator of mobilization for violence among lone actor terrorists (Challacombe & Lucas, 2018; Goodwill & Meloy, 2019; Meloy et al., 2019). Likewise, over time, individuals with an ED change their diets so radically that cognitive shortcuts allow them to act without thinking each time they encounter food. The fixation, “Food will make me fat,” becomes the identification, “I am fat.” For the lone actor terrorist, the fixation, “I believe in the authority of the Aryan and White nationalist websites,” becomes the identification, “I am a Nazi.”

#### 4 | OBSESSION

The third cognitive-affective driver of fixation is obsession. Obsessions are recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and in most individuals cause marked anxiety or distress (APA, 2013). The individual attempts to ignore or suppress such thoughts, urges or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion). They are ego-dystonic (not compatible with the conscious image of the self), rather than ego-syntonic (compatible with the self, and often an element of one's identity) in psychoanalytic terms. Several clinical scales have been developed for obsessive-compulsive disorder (OCD) screening and tracking. The Yale–Brown Obsessive Compulsive Scale (Goodman et al., 1989a, 1989b) is a clinically useful instrument for measuring OCD severity in adults, and has been used to evaluate efficacy for most of the available pharmacological treatments. However, there are still questions concerning the demarcation between obsessions as a symptom and schizophrenia-spectrum psychopathology (Rasmussen, Nordgaard, & Parnas, 2019; Tolin, Abramowitz, Kozak, & Foa, 2001), particularly

given the longitudinal relationship between a diagnosis of OCD and subsequent risk for schizophrenia (Meier et al., 2014).

Advances in neuroimaging have identified brain structures involved in OCD, including the prefrontal cortex, the dorsal striatum (caudate), and associated neurocircuits modulating emotional, cognitive, and motor control (Fineberg et al., 2017).

In a forensic or threat assessment context, fixations driven by obsessional thoughts are very infrequent and generally do not pose a risk (Booth, Friedman, Curry, Ward, & Stewart, 2014). However, there is a limited body of research reaching back to the early 20th century wherein such violent behaviors were called cathartic homicides (Maier, 1923; Wertham, 1937). The term itself means “in accordance with emotions,” and in a forensic context usually occurs in an acute or chronic form (Meloy, 1992). The acute form is manifest in a sudden murder without any apparent motive, and often has a transference-based explanation: the individual attacks a stranger with sudden, explosive violence, and in the aftermath is consumed with guilt and no understanding of why he did it. Forensic evaluation often uncovers the transfer of intense emotion from an early relationship onto the current victim (Blackman, Weiss, & Lambert, 1963; Weiss, Lambert, & Blackman, 1960).

The chronic form is amenable to threat assessment. In such cases, there are three stages: during the first incubation stage, the individual is obsessed with the unwanted thought of murdering someone, and despite all conscious efforts, cannot rid his mind of these preoccupied thoughts; the second stage is a sudden, homicidal act usually in the absence of any history of violence; and in the third stage, the individual experiences profound relief following the killing and memory is fully preserved (Meloy, 1992; Schlesinger, 2004).

#### 4.1 | Case 6 – Obsession as cognitive-affective driver

The subject was a 37-year-old man, married with three sons, who had been clinically depressed since adolescence. The maternal side of his family indicated that his mother had been depressed since the subject was 6 years old, and eventually divorced her husband and abandoned the family. Both of his maternal grandparents committed suicide. The subject was also diagnosed with a dependent personality disorder and OCD. He was disabled from work as a bricklayer, and confined to his home. He was taking his prescribed medication of olanzapine, bupropion, venlafaxine and lorazepam, and seeing his psychiatrist once a month. He was not in psychotherapy, and no one was asking him about urges to harm others.

His first homicidal thoughts had begun 8 years earlier, captured in a psychiatric note during one of his four psychiatric hospitalizations: “worries whether he will kill anybody or not.” The specificity of his plan did not crystallize until the morning of the murder when it focused on his youngest, a 13-month-old son. He drowned him in the bathtub, left a note for his wife, and called the police. His most plausible explanation was that by killing one of his children, he would be free of all the pressures in his life, and his state of mind, which included feelings of desperation, humiliation for failing as a father and breadwinner, guilt, and social and occupational paralysis, would be gone. After the homicide he reported, “I was relieved at the time. It felt like a burden was lifted off of me. It was there for a couple of hours. Then at the jail I asked God to forgive me for killing me. I realized what I did. Not a lot of emotion. A little guilt. I felt God has forgiven me. I know by faith and his Word he will forgive us our sins and cleanse us from all unrighteousness. I slept that evening” (Meloy, 2010, p. 3). The note he left for his wife said, “I’m sorry I killed John. I couldn’t do anything else. I’m not a man. I am a coward. John is lying on the bed. Here is the key to the mower. Don’t let the boys have it” (p. 2).

The subject had no history of violence or criminality. A court-appointed psychiatrist who evaluated him 6 weeks after the murder wrote in his report, “I have done forensic evaluations for nearly 30 years... I have never seen a case quite like this... His reasoning does not explain an act that was totally out of character for him” (p. 3). Meloy evaluated the subject and testified at his murder trial; the subject addressed the court prior to his sentencing

to life imprisonment. He turned to everyone assembled in the courtroom of this rural town in the Midwest, and tearfully apologized for what he had done.

## 4.2 | Case 7 – Obsession as cognitive-affective driver

A 28-year-old man was seen in a public outpatient mental health clinic for recurrent thoughts of killing people. When he would walk down the street with others passing him, he was hounded with visual images and a desire to behead these individuals. He was anxious that he would follow through, and terrified of these recurrent images and desires. Over the course of weekly psychotherapy with Meloy, he began to learn that these unwanted thoughts, or obsessions, did not contribute to his risk of being violent, as his impulse control was exemplary; and he greatly benefited from talking about the anger and fear that he felt toward his parents in particular, and the violence he had witnessed toward his mother by his father while growing up. He began to understand that his obsessional thoughts were functioning as defenses against these intense childhood emotions that he had never expressed or even talked about. He contacted his psychotherapist 20 years later to report that life was “going OK,” he had never been violent, and had benefited from psychotherapy and psychoanalysis over the course of several decades.

## 4.3 | Treatment and risk management

Selective serotonin reuptake inhibitors and cognitive-behavioral therapy (CBT) are recommended as safe and effective first-line treatments for OCD. Evidence supports using CBT that focuses on techniques such as exposure and response prevention. Dynamic psychotherapy or psychoanalysis has not been shown to be effective. In assessing the presence and history of co-occurring conditions, the psychiatrist should pay particular attention to mood disorders and suicidal ideation and behaviors, since depressive disorders are commonly occurring co-morbid disorders (Gabbard, 2013; Koran & Simpson, 2013).

The cognitive-affective drivers are illustrated in Figure 1, a four-square that emphasizes both the categorical nature of these drivers (the boxes) and the fact that they can each vary in affective intensity (the arrows). As the conscious affect surrounding the fixation intensifies, there is usually a concordant increase in the rigidity and simplicity of the content of the fixation, theoretically represented by the directionality of the arrows. The hybrid nature of combining both categorical and dimensional measures in the figure is consistent with progressive diagnostic endeavors, such as the alternative personality formulations in DSM-5 (APA, 2013). The fourth box, normal, represents the fact that fixations that are not pathological are quite common, such as preoccupation with a hobby, a career, a sports team, a musical group, a musician, an actor, the early stages of romantic love, and arguably the prototype: a mother with her newborn. What is absent in normal fixations is an accompanying deterioration in social and occupational life, which is the dominant corollary in pathological fixation. Deterioration is dynamically related to the pathological fixation and may be both a cause and an effect of the fixation.

## 5 | DISCUSSION

We have set forth the cognitive-affective drivers for fixation, a very frequent proximal warning behavior in targeted violence (Table 1). There are three pathological categories of such drivers, including delusions, extreme overvalued beliefs, and obsessions. A normal category of fixation commonly exists, and all four are illustrated in Figure 1. Although readership familiarity with delusions and obsessions is likely, extreme overvalued beliefs are a refined formulation, and we think it warrants a further detailed discussion, focusing on its historical provenance and its further demarcation from delusions.

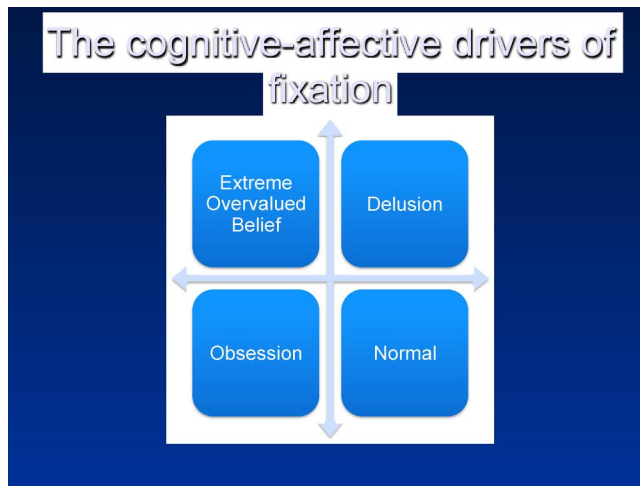


FIGURE 1 The cognitive-affective drivers of fixation. Arrows represent the affective intensity of the drivers; boxes represent theoretical demarcations of the categories

## 5.1 | Overvalued idea

Wernicke (1892) wrote extensively of what he called the *überwertige Idee*, the “overvalued idea,” drawing from the French *idée fixe*. The concept of overvalued idea has a 19th-century historic lexicon in psychiatry, particularly in British scholarship (Oyebode, 2008). It holds a prominent place in the discussion of phenomenology in British texts, yet it is not emphasized in US psychiatry. Overvalued idea, however, does appear in the DSM-5 glossary, which states that it is “An unreasonable and sustained belief that is maintained with less than delusional intensity. The belief is *not* one that is ordinarily accepted by other members of the person’s culture or subculture” (APA, 2013, p. 826) (our emphasis added). This differs from key tenets of the original Wernicke definition which explicitly states that it is a belief *shared* by others – a position we adopt (Rahman, 2018; Rahman, Grellner, Harry, Beck, & Lauriello, 2013). We have argued elsewhere that the absence of such a defined and clear category of rigidly held, non-delusional beliefs in American psychiatry and psychology creates in the forensic context an unreasonable burden for the expert at trial in presenting an alternative to delusion for the trier of fact to consider in “state of mind” or insanity litigation (Rahman et al., 2019; Rahman, Resnick, & Harry, 2016).

## 5.2 | *Idée fixe*

Wernicke further referred to the *idée fixe* (fixed idea) in his subsequent 1906 *Grundriss der Psychiatrie*, “As in the case described ... a stable and fairly unchanging disease picture can be seen in a series of similar cases, that deserves, because of its partiality, the ‘old school’ name *Idee Fixe* (‘Fixed idea’)” (second revised ed., Wernicke, 1906, p. 145). The French had been actively considering this construct throughout the 19th century in medicine, literature, music, and psychology.

The French composer Hector Berlioz used *idée fixe* to describe the principal theme in his 1830 *Symphonie Fantastique*, which expressed the artist’s preoccupation with his beloved (Holoman, 1989). The novelist Honoré de Balzac, a contemporary of Berlioz, used *idée fixe* in his short novel *Gobseck* (de Balzac, 1830) to describe the greed that ruled the life of his protagonist. It drove many of his fictional narratives, including the storyline of *Eugénie Grandet* (de Balzac, 1833) – a father’s quest for wealth – and the plot of *Le Père Goriot* (de Balzac, 1835), – a father’s excessive and lethal affection for his daughters. In a general sense, these artists used the term to describe a

persistent preoccupation that dominated the person's mind, and drew no distinction between the syntonetic or dystonic nature of the overvalued belief. Molière also repeatedly used it to describe his celebrated comic characters who were never cured of their preoccupations (Gaines, 2002).

In medicine and psychology, Pierre Janet used the term in the late 19th century to describe its clinical use. He understood an *idée fixe* as a rigid and often irrational belief, such as a phobia linked to a traumatic memory which unconsciously dominated a person's mental life. For example, he used anorexia nervosa as an outward expression of such an *idée fixe*. To treat the illness, Janet argued, psychologists must address not only the patient's aversion to eating, but also the *idée fixe* and the related traumatic experience that he believed was at the root of the conflict (Ellenberger, 1970).

However, the intellectual historian Goldstein (2002) wrote, "*Idée fixe* was ... probably coined by the phrenologists Gall and Spurzheim in connection with Esquirol's delineation of monomania" (p. 155), and attributed the origin of the term to their 1812 phrenology textbook, *Anatomie et physiologie du système nerveux en général et du cerveau en particulier*, vol. 2 (Greenblatt, 1995). Monomania included *idée fixe*, but was a broader term encompassing a wider range of pathologies of the mind that did not directly spring from a single, intense preoccupation. Both Franz Gall and his student, Johann Spurzheim, are remembered chiefly for their advocacy of the false belief in phrenology in the early 19th century, their tours and lectures together throughout Europe, and their lasting and real contributions to understanding the anatomy of the brain. Both British and American writers have, on occasion, continued the use of the term *idée fixe* despite its anachronistic feel. Arthur Conan Doyle wrote in *The Return of Sherlock Holmes* (Doyle, 2019), "There is the condition which the modern French psychologists have called the '*idée fixe*', which may be trifling in character, and accompanied by complete sanity in every other way. A man might form such an *idée fixe*... and under its influence be capable of any fantastic outrage."

### 5.3 | Delusional disorder or disorders with overvalued ideas?

Winokur (1977) described a clinical definition he called "delusional disorder" in 29 out of 21,000 (0.4%) patients seen at the University of Iowa Hospitals from 1920 to 1975. This definition bears striking resemblance to British descriptions of "disorders due to overvalued ideas" (Oyebode, 2008). Winokur, heavily influenced by Kraepelin, cited previous work as synonymous with his definition of delusional disorder including a paranoid state, delusional monomania, delusional insanity and conjugal paranoia, as well as the French term *deliries chroniques paranoïaques*. What he failed to recognize is that European and British scholars had previously labeled such passionately held shared beliefs as *overvalued ideas*, as we noted were first described by Wernicke (1892, 1906). Veale (2002) later argued that this definition is almost completely ignored by American psychiatrists, who call them delusions, often utilizing poor insight as the distinguishing feature. Winokur, prior to becoming the chairman of the University of Iowa Department of Psychiatry, belonged to a group of psychiatrists at the Washington University in St Louis. This group developed criteria for psychiatric research called the Feighner criteria, which substantially influenced the introduction of multiaxial diagnoses in DSM-III (Feighner et al., 1972) – subsequently removed in DSM-5. Winokur's (1977) research on delusional disorder was adopted by the DSM-III committee, a diagnosis which endures in the DSM-5 (APA, 2013). Manshreck (1995) has been critical of the limited scientific data surrounding delusional disorder and shared psychotic disorders as a category, and instead has argued that, "there is some question as to whether such patients are truly delusional rather than highly impressionable. Frequently there is merely passive acceptance of the delusional beliefs of the dominant person until they are separated, at which point the unusual belief may remit spontaneously" (p. 1044). Rahman et al. (2013) argued that "it is critically important that forensic psychiatrists properly identify a defendant's belief as either a fixed false conviction (a delusion) or as an intense emotional commitment to a commonly held belief shared by other members of his or her cultural group (an overvalued idea)" (p. 1112).

Cloninger (2004) observed that a high percentage of patients with delusional disorder manifest narcissistic traits which may be provoked by feelings of insecurity. They also have a high level of novelty-seeking characteristics. We think that delusional disorder represents a potential misclassification of phenomenology, recognized internationally as overvalued ideas which are shared and held with an intense emotional commitment. Clinically the distinction between a delusion, an obsession and an extreme overvalued belief may seem arbitrary for treatment in patients presenting to hospital acute care. However, violent offenders often have maladaptive personality traits which can bear resemblance to psychotic disorders (e.g., the term “borderline personality disorder” originally meant “borderline schizophrenia” and has been reassigned as a personality disorder, not a psychotic illness; and many clinicians use the term “hypomanic character” – an old psychoanalytic concept – to describe a stable mood abnormality). Similarly, we think that our definition of extreme overvalued belief better clarifies this phenomenology, and brings a particularly helpful lexicon to forensic psychiatry and psychology and the cognitive-affective driver model presented here for threat assessment and management.

## 5.4 | Refinement of extreme overvalued beliefs

The best example of refinement comes from models of addiction and reward-seeking behavior. Most people can identify with refinement of their food choices (a favorite wine or steak). These occur over time and are shaped through trial and error to some degree. In alcoholics, it is common to see a restriction of repertoire of alcohol use to one or two favorite brands of liquor or beer. Individuals with EDs also restrict their repertoire of foods when bingeing/purging. They often pick certain brands of cereal or ice cream to binge and habitually return to them. Lone actor violent behavior is also shaped by a set of assumptions, attitudes or beliefs that are shared with others (McHugh & Slavney, 1998; Rahman, 2018). Similar to the behaviors in EDs and substance use, the ideology or violent solution to a perceived moral grievance is refined and shaped as the addictive models of behavior described earlier have demonstrated, suggesting possible reward-mediated pathways in which to relish (immensely enjoy) these passionate emotions.

A related area of neurobiological research is the exploration of sacred values and the “willingness to fight and die” utilizing functional magnetic resonance imaging, a functional neuroimaging measure of blood flow in various areas of the brain. Sacred values are based upon deontic (related to duty or obligation) rules for which any cost-benefit analysis is irrelevant as the value is a deeply held religious, political, or secular belief. Through a series of preliminary experimental studies with members of various fundamentalist, extremist, and terrorist groups – note the sample selection bias and the lack of any control group – data suggest that such sacred values, very similar to our concept of extreme overvalued belief, activate certain neurobiological pathways (ventromedial prefrontal cortex) that are distinct from those engaged (dorsolateral prefrontal cortex) when a more utilitarian cost-benefit analysis is undertaken to determine a course of action (Hamid et al., 2019). Such research, however, should not be read as supporting the belief that such sacred values *per se* are a risk factor for targeted violence. The neurobiology of human behavior is always mediated by social and psychological factors, clearly evident in time-sequencing studies of lone actor terrorists (Corner, Bouhana, & Gill, 2019; Corner & Gill, 2019).

## 5.5 | Limitations

This study is limited in many ways. First, it is a clinical and theoretical attempt to construct a schematic to help clinicians tease apart the cognitive-affective drivers of fixation, and appropriately treat and manage them, with an eye toward the prevention of targeted violence. It is not an empirical study of the efficacy of this approach in the reduction of targeted violence risk, or the degree to which clinicians can apply this schematic, although this has recently been tested for interrater reliability among a large sample of forensic psychiatrists with excellent results

(Rahman et al., 2020). As with all clinical and theoretical articles, cognitive biases are apparent, including our own confirmation bias to select and align the research studies that are most supportive of our thinking, and minimize those that are not. Through awareness of confirmation bias, we have attempted to minimize it by staying close to extant empirical findings. There are also likely selection effects in the cases we have chosen to illustrate delusions, obsessions, and extreme overvalued beliefs, and likely some availability and anchoring bias given the direct relationship of all the cases in this study to those who have contributed to the understanding and advancement of the concept of “extreme overvalued beliefs”. The strength of the study is its clinical clarity, the primary source material of the cases, and recommendations for all mental health professionals encountering such risk for targeted violence among their patients to help determine the best course of action for treatment or risk management.

## 5.6 | Threat assessment and management

The application of this work to threat assessment and management is threefold: to clinically identify whether a pathological fixation is present – with central attention paid to its detrimental effect on love and work; to determine the cognitive-affective driver (delusion, extreme overvalued belief, or obsession); and to manage with appropriate treatments or non-mental health interventions, if feasible and demonstrably useful. Such clinically nuanced determinations would need to be done by a forensic psychiatrist or psychologist, and would likely require a direct evaluation. However, indirect assessment of the presence of a fixation, as a proximal warning behavior, and its form, are achievable.

The following screening questions developed through our clinical experience – and not yet empirically validated through a formalized structured interview – may serve as a guide in threat assessment when an extreme overvalued belief is the hypothesized cognitive driver:

Does the individual:

1. Relish extreme beliefs? (Enjoys discussion of radical views.)
2. Have extreme beliefs that dominate his or her mind? (Won't easily change the subject.)
3. Bring up extreme overvalued belief in professional, social, school or intimate settings when judged grossly inappropriate by others, resulting in anger, rejection, or confusion by others?
4. Have extreme beliefs that are growing more refined and resistant to challenge? (Cannot see it from another perspective.)
5. Use the Internet to look up radical views that align with his?
6. Know or view videos of charismatic figures that hold similar extreme views?
7. Quickly dismiss, argue or avoid engagement with others who do not hold the beliefs?
8. Often fill in missing and logical cognitive gaps to create a grand, albeit distorted narrative?
9. Have a confirmatory bias which is clearly evident and pervasive in his refusal to let contrary facts challenge or alter his beliefs?
10. Have beliefs that others feel are accompanied by a strong and constant emotional push or press in the subject?
11. Have plans, or is mobilizing and identifying with violence to express his extreme overvalued belief?
12. Is there a different cognitive-affective driver for his fixation (e.g., delusion and obsession) that has been ruled out?

After careful examination, if a delusion is determined to be the cognitive-affective driver, and not an extreme overvalued belief, the examiner should generally be thinking about what mental *disease* the person might have (Guze, 1992). In the delusion quadrant of Figure 1, a checklist approach is likely going to be more fruitful because DSM-5 categories are operationally designed to work for clinical problems that are often treatable with medications and rehabilitative psychotherapy (McHugh & Slavney, 1998).

We think that extreme overvalued belief allows for a paradigm shift in risk management models for higher functioning patients that do not meet the threshold for a diagnosis of mental disorder seen in delusions and obsessions. This is because extreme overvalued belief requires a completely different logic and approach than the disease approach described earlier. For example, with extreme overvalued beliefs, the examiner should look beyond signs and symptoms, and instead probe the person's biographical narrative (Griffith, Stankovic, & Baranoski, 2010) or "life story" (McHugh & Slavney, 1998). Clinical "checklists" for depression and bipolar disorder, often used by mental health providers, will often fail to uncover individuals who are demoralized, grief-stricken or angry (McHugh, 2012). As the DSM-5 does not currently contain a structured road map for life-story narratives, the examiner should begin by taking a comprehensive history in chronological fashion to arrive at a conclusion based on temperament, cognitive capacity, and motivation (McHugh & Slavney, 2012). Careful attention must also be paid to the context in which the interview is being conducted, and the degree to which counter-transference reactions on the part of the interviewer may distort the inferences drawn from the interview (Ackley, Mack, Beyer, & Erdberg, 2011; Clarkin, Fonagy, & Gabbard, 2010). Such detailed examinations are often time-consuming and not reimbursed by health insurance, thus creating serious limitations in many professional clinical settings. Nevertheless, a structured approach beginning at the bottom ("Where were you born and raised?") and ("Have you ever felt unsafe with a caregiver?") and moving up chronologically to the present day ("Are you still with your girlfriend?") will produce a much more valid and nuanced evaluation compared with questions that only focus on present state of mind ("Are you depressed?"). In concert with the threat assessment and management discipline, schools, religious organizations, community centers and workplaces – along with the mental health profession – can create treatment and risk management paths that are dedicated to both the prevention and treatment of persons of concern who may be mobilizing for targeted or criminal violence (Herman, Marriott & Walker, 2018; Meloy et al., 2019; Meloy & Gill, 2016; Meloy & Hoffmann, 2021).

It may be that violence risk is not the sole reason for such interventions, but that individuals who pose such risks are also needing supportive care from which society will ultimately benefit. We think that this model is a step forward in creating risk prevention, mitigation and treatment strategies with regard to the proximal warning behavior of pathological fixation. But we also must be careful. As E. Weiss (2016, p. 39) wrote: "Overvalued beliefs, whereas containing psychodynamic nuggets, have always had a home within freedom of speech. Let us not conflate them with exculpatory mental illness or permit defendants to exploit untidy areas of our system of classification."

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