

Law and Psychiatry

Personality Disorders and Violence Potential

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Violence associated with personality disorders is usually best viewed separately from psychiatric diagnosis, as a syndrome of violence rather than a syndrome of diagnosis. The authors describe eight categories of violence associated with personality disorders that may help clinicians choose treatment or management techniques: purposeful, instrumental violence; purposeful, non-instrumental violence; purposeful, targeted, defensive violence; targeted, impulsive violence; nontargeted, impulsive violence incidental to emotional escape; random but purposeful violence; violence related to perceived or feared loss or abandonment; and violence related to chronic paranoia or related misconceptions. The categories are not completely mutually exclusive, nor do they represent a “decision tree.” We also point out three important principles about the relationship between personality disorders and violence: 1) Personality disorders are rarely ego dystonic; 2) Most patients and violent situations that come to clinical attention involve comorbid conditions. 3) Violence and violence risk are often associated with intoxication. (*Journal of Psychiatric Practice* 2007;13:XXX-XXX)

KEY WORDS: violence, risk assessment, personality disorders

This month, Dr. Thorne and I will summarize some of our experience with the many forms violence may take in people with personality disorders. We'll examine the assessment and management of violence potential in those with substantial characterologic deficits. We hope these principles and examples are relevant to clinicians who must assess risk or work with violent persons with personality disorders.

Personality disorders are routinely associated with a guarded prognosis. Nevertheless, the common practice of viewing them as stereotypically similar is clinically inappropriate. It is more accurate, and more productive, to view personality disorders as heterogeneous, with symptoms and behaviors best viewed on a continuum within each diagnosis. Many people with personality disorders live relatively normal lives. Others, whose syndromes are more severe, who have significant comorbid disorders, or who experience substantial periods of internal or external stress, often function at much lower levels.

VIOLENCE AND PERSONALITY DISORDERS

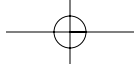
Any association between large groups of patients and the many forms of violence must be parsed, as feasible, into specific diagnoses, kinds and levels of symptoms, kinds and levels of violence, and social context. Although recent MacArthur Foundation data¹ do some

of this, there are few methodologically sound studies that focus on the relationship between personality disorders per se and violent behavior. Otto² noted that the paucity of research about possible relationships between personality disorders and risk of violence may reflect, among other things, limitations in the general diagnostic nomenclature and the fact that assessment of antisocial personality disorder is better refined than assessment of other personality disorders.

The point at which the diagnosis is created is another factor that significantly affects research findings and limits generalization. Violence itself may serve as a basis for making a personality disorder diagnosis.³ Further, clinicians must distinguish between violent behavior and hostile/aggressive behavior (while the latter is easier to examine experimentally, it is not equivalent to violence itself).

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LAW AND PSYCHIATRY

It is also important to use multiple sources of data. Steadman et al.⁴ observed 1-year violence rates of 4.5% in agency records of discharged mental patients in the MacArthur Foundation study, but the same subjects showed six times higher rates of violence when three separate sources of information were queried (records, patient interviews, and collateral interviews). These methodological issues limit the extent to which such studies can be viewed with confidence, compared with other research, or generalized to larger populations.

DIFFERENCES IN BEHAVIOR WITHIN DIAGNOSES

No single personality disorder implies that all people with that diagnosis have the same risk of violence. There may be broad similarities, but the variety, consistency, and intensity of symptoms vary greatly. In addition, despite the definition of personality disorders as characterized by enduring, inflexible patterns of inner experience and behavior, common observation suggests that neither the experiences nor the behaviors are always stable.⁵

Even very specific forms of violence can have a variety of causes, and each person's risk varies with the degree to which his or her personality characteristics and dimensions are exposed to various environmental variables.⁶ That which portends or explains violent behavior in one person does not necessarily suggest similar risk in others with the same diagnosis.

THREE KEY PRINCIPLES

- **Personality disorders are rarely ego dystonic.** With some exceptions, those with personality disorders or aberrant character traits usually do not seek psychiatric help. When they do, it is often to alleviate symptoms rather than to address characterologic issues.
- **Most patients and violent situations associated with clinical issues involve comorbid conditions.** Treating or managing co-existing conditions (which may include comorbid illness, substance abuse, or environmental factors) may alleviate some violence potential.
- **Violence and violence risk are often associated with intoxication.** Treatment of substance abuse may reduce violence risk, but the presence of a personality disorder usually worsens the rehabilitation prognosis.

Non-psychiatric, non-mental-health approaches are often more important than interventions by mental health professionals in preventing or managing violence

by those with personality disorders and in protecting potential victims.

TYPES OF VIOLENCE ASSOCIATED WITH PERSONALITY DISORDERS

The examples below apply to “real-world” situations. The common thread is the violence, not the diagnosis. Understanding similarities among kinds of violence is more useful and relevant to situations that commonly present to clinicians than separating behaviors and psychological issues by diagnosis (although the DSM-IV “clusters” are sometimes helpful). The categories we have developed are practical and based on experience. Note that they are not mutually exclusive and do not create a “decision tree.”

Purposeful, Instrumental Violence

Disorders which decrease or eliminate a sense of empathy or otherwise diminish the potential perpetrator's thoughtful consideration of other people increase the risk of violence for personal gain. Antisocial and narcissistic disorders are common examples. Such violence is *targeted* rather than random. It includes acts in which violence is a means to a conscious, gainful end (such as a robbery or fleeing arrest) as well as violence designed to manipulate or mislead another into some wanted behavior (such as some manipulative behavior seen in those with antisocial, narcissistic, or borderline personality disorders). Violence for revenge and violence for hire should be considered here, provided there is a characterologic deficit in the perpetrator which allows it to take place.

An injured worker suing his employer for millions of dollars lost his lawsuit because of a somewhat technical judicial decision. His attorney noted that the worker was very upset over the loss and referred him to a psychologist. During a brief course of treatment, the therapist uncovered longstanding signs of paranoia, but no frankly delusional material. Believing the sessions to be completely confidential, the patient/plaintiff eventually admitted that, since losing the lawsuit, he had rehearsed sabotaging the defense attorney's car; had actually entered the lawyer's property and examined the engine and brake lines, and had a plan to murder the judge.

A patient with borderline personality disorder was distraught about the possibility of losing custody of her children during a divorce. She told her psychia-

trist that her estranged husband had beaten her in front of the children, and that she was afraid he would harm the children as well. She offered bruises on her neck and arms as evidence. The psychiatrist helped her to contact police and obtain a restraining order prohibiting her husband from visiting her or the children. However, as the police and the state child protective agency investigated the matter, attention began to shift to the patient herself. It eventually became clear that she had inflicted her own bruises and then invited her husband to her house, started an argument in front of the children, and begun hitting him. When he did not hit back and began to leave, she dramatically fell screaming to the floor and loudly proclaimed "Daddy hit me! Daddy's hurting me! Run, or he'll hurt you, too!"

Risk assessment. An experienced evaluator of persons with antisocial, paranoid, or borderline personality disorders should recognize some risk, but the level of risk and the probability of violence may be difficult to ascertain. Those with histories of violent behavior, paranoid or mildly psychotic thinking in a context of possible gain, and/or marked lack of empathy warrant additional concern.

Purposeful, Non-Instrumental Violence

This is purposeful but outwardly unnecessary violence, such as violence for the sake of excitement or stimulation. It may add parenthetically to the pleasure of a stimulating or antisocial activity, but actually injuring others is not integral to the activity's purpose. Bystanders may refer to the violent part of the overall behavior as "senseless" or "random," but it has an emotional purpose (such as stimulation). The target(s) may be random, but the behavior, and placing others in danger, is intentional.

This concept should not be confused with violence in which the danger to others is not intentional, such as that which is incidental to impulsively overreacting to an affective state associated with threatened emotional survival (such as intolerable anxiety, stifling entrapment, acute abandonment, or marked humiliation) (see *Violence Incidental to Emotional Escape*, below).

A man who met diagnostic criteria for antisocial personality disorder but no Axis I disorder broke into a home and stole several items while the occupants were asleep. He then set fire to the house in order to hide his crime, deflect blame from himself, and

destroy evidence that might have incriminated him. The occupants were awakened by a smoke alarm and escaped, but could easily have been injured or killed.

After his arrest several days later, the robber described setting the fire as necessary to avoid being caught. He denied wanting to harm the occupants, describing the fire as simply a means of avoiding arrest. It was "nothing personal," just "something I had to do whether they (the occupants) were there or not." Warning or awakening them so that they could escape had not crossed his mind.

A young man with a long history of relatively minor antisocial acts engaged in a drag race on a city street. As he neared the end of the race, he realized he was about to run a red light. Nevertheless, he continued to accelerate, ran the red light, and struck another car. The driver of the other car was killed. When testifying about his reckless behavior, he described it entirely in terms of taking a thrilling chance with his own life and seemed oblivious to any responsibility for others' safety. He understood the chance of an accident, and the chance that someone might be hurt or killed, but described the danger of racing purely in terms of a focus on himself, saying "I can live with those odds."

Risk assessment. This form of violence is overrepresented in those with substantial antisocial and asocial character traits. In addition to lack of empathy or recognition of other's needs and feelings (a common thread in many kinds of violence), the risk of purposeful but non-instrumental violence may be heralded by a potential perpetrator's wish for pleasure or need for stimulation which overshadows his judgment, impulse control, and appreciation of future consequences.

Purposeful, Targeted, Defensive Violence

This kind of violence is generally a maladaptive attempt to stop some intolerable affect, often associated with humiliation or abandonment. The violent reaction to such a condition, which threatens the integrity of the person's ego, may be rapid (see also *Targeted, Impulsive Violence* and *Violence Incidental to Emotional Escape*, below), or may be carefully planned. The target may seem illogical to an observer (e.g., related to paranoid ideation or some other idiosyncratic source). The level of violence is often baffling until one realizes its internal meaning. Examples include the sometimes extreme behavior of paranoid stalkers, who may create near-delusional scenarios of competition or abandonment, and paranoid

LAW AND PSYCHIATRY

“defenders,” who believe they must defend themselves from imagined or exaggerated slights or threats. Dependent, avoidant, and schizoid traits occasionally increase risk. When such thinking becomes more than mildly delusional and/or other aspects of the person’s functioning are significantly compromised, an Axis I disorder should be considered.

Frequent arguments between a middle-aged man and his wife, often involving intoxication with alcohol, routinely led to his threatening or assaulting her, her threatening or briefly leaving him, and then his successfully begging her to stay. Eventually, the wife resolved to ignore his entreaties and promises and filed for divorce. He did not believe she would go through with the divorce but when he tried to return to the home, she had locked him out. He stayed with a friend for a few days, calling her often and thinking she would change her mind.

After several days, he was served with the divorce papers. He drove to her place of work and once again pled with her to reconsider. She refused, adding (in front of her coworkers) that he had never been much of a husband and had never satisfied her sexually. He returned to his car, took a shotgun out of the trunk, went back into the building, killed her, then waited for police to arrive.

Risk assessment. Characterologic paranoia is among the most dangerous personality traits, and is associated with both domestic and general violence. Many people with paranoid personality disorder routinely imagine and rehearse (mentally or literally) violent “solutions” to paranoia-created scenarios. Truly delusional persons, with Axis I disorders, are much more likely to be seen by a mental health professional than those with paranoid personality disorder alone. Passive, dependent or avoidant people do not anticipate violence but may become dangerous when trapped or restrained and unable to escape emotional pressure; however, they usually can adjust their environments to decrease their anxiety (and concomitantly lower their risk of violence). Threatened breach of narcissistic character defenses carries risk as well.

Targeted, Impulsive Violence

This is a striking out, without planning, at a perceived or psychological threat which others would not consider worthy of the same quality or quantity of violence. The victim is specifically targeted, often in a desperate effort

to eliminate (literally or symbolically) the source of an acute psychic threat. Examples of this kind of violence, which erupts in order to escape an intractable situation by eliminating the source, include enraged reactions to acutely perceived humiliation or abandonment. People who are characterologically paranoid, narcissistic, or suffer the exquisite sensitivity to loss found in borderline personality disorder are often predisposed to such triggering stimuli. Dependent, obsessive-compulsive, and avoidant persons are at less risk, but may decompensate into violent behavior under remarkable circumstances (cf., Coid 2002⁷ and other studies of prison populations⁸).

Note that we are not referring here to violence whose victims are incidental to uncontrolled rage or escape behavior by, for example, “being in the wrong place at the wrong time” (see *Incidental Violence*, below).

An otherwise competent abdominal surgeon was known for both his skill and his irritable, narcissistic manner. He led a regimented life, with little warmth for family or friends, the barest superficial acknowledgement for the role of others in his cases and other achievements, and no tolerance for criticism. The latest of many operating room incidents involved his berating a nurse when she pointed out unacceptable oozing from the omentum as he began to close a laparotomy. Nevertheless, he stopped and dealt with the bleeding before proceeding with the closing. Another nurse commented under her breath, “Saved by a nurse.”

The surgeon finished the closing, then calmly asked, “What did you say?”

The nurse who had made the comment said something like “I didn’t mean anything disrespectful. I wanted to compliment J__ (the nurse who noted the bleeding) for making a good catch; she probably saved the patient from reopening.”

The surgeon replied hotly, “J__ works for me. She did her job. Every damned one of you works for me. I’ll let you know when you make a good catch and I’ll be damned if I’ll tolerate anybody in this hospital criticizing my surgery until you’ve been through medical school and residency yourself.”

J__ came to her colleague’s defense. “No problem, Dr. X. We’ll just get the patient out of here and awake.”

Dr. X then raised his voice and continued to rant in spite of verbal efforts to calm him. Finally, one of the nurses, concerned about the situation and the patient’s safety, announced that she was calling for the chief nurse of the surgery suite. Dr. X responded by

tossing a tray of bloody sponges in the nurse's direction and storming out of the operating room.

Dr. X was disciplined by the medical staff. He protested their verdict and retained a lawyer to sue for libel and expunge his record. The lawsuit was later dismissed. The medical staff matter was eventually reported to the state medical licensing board, which added its own censure.

Mr. S was known as a nice, quiet fellow, the adult son of a very aggressive father whose bullying controlled most people close to him. Mr. S behaved in an almost opposite manner, demonstrating passivity and appearing dependent on his father for income and a place to live. In over a decade of adulthood, he had traveled and interacted socially with others, but had never held a meaningful job for more than a few weeks, married, or lived away from his father. Privately, Mr. S dreaded the thought of being like his father, who had abused him during childhood and as an adult.

One night while both were intoxicated, his father began once again to bully and humiliate Mr. S. At some point, the combination of physical and emotional humiliation reached an intolerable level and Mr. S grabbed his father's arms to restrain them. The father laughed derisively, breaking the son's hold, slapped him repeatedly in the face, and called him "my little bitch." Mr. S exploded, pummeling his father to the ground and finally shooting him in the chest with a shotgun kept nearby in case of intruders.

When his father lay obviously dead, Mr. S wrapped him in a bedsheet and bound the body with adhesive tape, then retreated to his bedroom, locked the door, and went to bed. The next day, he called an attorney and gave himself up to police. Asked later about what he did to the body, Mr. S replied that although he knew his father was dead, he could not feel truly secure until he had wrapped and bound him and locked the bedroom door.

Risk assessment. Many violent acts of this type occur when an external event threatens poorly defended fears of inadequacy or abandonment. Some people with severely dependent, paranoid, narcissistic, schizotypal, borderline, or obsessive-compulsive traits—characteristics that decrease one's ability to marshal and rely upon internal defenses when trapped in emotionally intractable situations from which one cannot escape—can be very dangerous. Such conditions, particularly inability to escape an intolerable and anxiety-producing situation, increase the

likelihood of a violent reaction designed to stop the pain and escape the threat. When conditions are extremely stressful, even schizoid and avoidant persons may revert to primitive, violent actions to defend their egos. Intoxication is a substantial risk factor, as are some kinds of emotional attacks and idiosyncratic emotional triggers (e.g., repeated, inescapable demeaning or "in your face" challenges during arguments with a spouse or competitor).

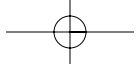
Nontargeted, Impulsive Violence Incidental to Emotional Escape

This kind of violence is generally non-targeted, although the person who triggers the intractable emotional state may bear the brunt of the violence if he or she is in the path of egress. The purpose of the behavior is rapid escape from a situation that has created an acute, intolerable internal situation for which the personality disordered person has inadequate emotional defenses and behavioral alternatives. It is different from the "targeted, impulsive" type of violence we just discussed, in that the anxious or humiliated person does not seek to mitigate or destroy the source of the pain, only to escape from it.

Ms. T was a 43-year-old woman with borderline personality disorder and very primitive attachment needs. She and her 24-year-old daughter had an extraordinarily hostile-dependent relationship which was often characterized by rather obvious manipulations designed to keep the daughter physically and emotionally bound to her mother. The daughter had tried to move away on several occasions, but each time changed her plans to meet her mother's needs and continued to live on her mother's property. At one point, the daughter approached her mother once again, by telephone in order to avoid a personal confrontation, to tell her she was moving in with a boyfriend who lived some distance away. She called from her place of work.

The telephone conversation soon deteriorated into a volatile event. The mother alternated among superficially rational "suggestions" that the daughter reconsider and have her boyfriend move into the daughter's trailer on the mother's property, pleas that the daughter consider the mother's health conditions (which were not particularly serious), sarcastic comments that the boyfriend would probably leave her and, eventually, angry threats to rent the daughter's house to someone else so that she could never "come home."

The daughter would not budge, repeatedly telling her mother that she was indeed going to move away



LAW AND PSYCHIATRY

and parrying each of the manipulative comments and threats with sarcasm and threats of her own (such as "You'll never see your grandchildren" and "You've been sick for years; let me know when it gets really serious"). The daughter finally hung up in the middle of her mother's tirade.

The mother got into her car to drive to the daughter's workplace, shaking with anger and anxiety. On the way, she drove very recklessly, failed to yield at an intersection, and hit another car, injuring several people.

A woman with severe borderline and paranoid traits was being told that she had lost custody of her children. A social worker and a trainee were trying to treat her as gently as possible while making it clear that she would only be allowed to see her children, who had been removed from the home, in a supervised setting. The woman listened for a moment, then began screaming that none of the things they were saying about her was true, that she was a good mother, and that she refused to listen to their lies.

The social work trainee raised her voice and somewhat assertively tried to confront the woman, recounting her past abusive acts in order to make her understand why her parental rights were being terminated. The woman only became more agitated, screamed louder, and bolted from the room, pushing the senior social worker away from the door and into an aquarium, which fell and broke. The social worker fell into the broken glass, cutting her arm and neck.

Risk assessment. This level of fragility and potential for decompensation is not typical of most people with personality disorders, and may suggest an Axis I disorder. Those prone to such reactions have marginal egos which are inadequately protected by (sometimes superficially resilient, but inwardly brittle) defenses. Their personalities may have substantial, poorly integrated borderline, schizotypal, dependent, obsessive-compulsive, and/or avoidant features. They often seem outwardly stable, but have inner worlds kept artificially free of mental controversy that might threaten their emotional lives. They may exhibit stilted, even ritualistic behaviors in order to control the impact of the external environment upon those inner lives, or may simply choose isolation and other defenses as means of avoiding stressors.

Careful examination of such persons' lives may reveal reaction formation, an extraordinary need to defend desperately against discovering in oneself some frightening-

ly destructive core emotion or self-reviled dependency. For some, that veneer can become dangerously weak under stressful (often idiosyncratic) circumstances such as intoxication, loss, or inescapable humiliation.

Random but Purposeful Violence

These people derive pleasurable stimulation from violence itself, often to instill a feeling of power. It is neither a means to some profitable end nor merely an adjunct to some other exciting activity (omitting primarily sexual sadism, which we view as an Axis I disorder even though its roots are often characterological). A particular, repetitive style of violence, such as sniping with a rifle or setting others on fire, is commonly found in these individuals, but careful review usually reveals other violent or sadistic behavior.

The victim may be stalked or the situation carefully planned in order to set up the violent act (and, often, to plan one's escape); however, the victim usually has no direct relationship to the perpetrator, nor is the particular victim associated with revenge or personal gain. He or she is a target of convenience.

Randomness of victim choice does not imply random, impulsive, or uncontrolled action. The violence is not a result of neurological dyscontrol, a psychogenic impulse control or explosive disorder, or a thought disorder (better discussed as Axis I or Axis III conditions). Rather, it is self-absorbed, antisocial, and uncaring, without empathy or sympathy. A wish to exert or establish power over others, and over the passive portion of one's own psyche, is commonly an important component of the violent purpose.

Two men decided to play an "urban war game" in which they played the role of assassins. They outfitted a small van in such a way that one of them could drive to an "assassination" location and park the truck while the other sat in the back with a high-powered rifle. The rifle was equipped with a telescopic sight so that shots could be taken from some distance. The driver would spot a faraway victim, chosen at random according to opportunity, and give the shooter a signal. The shooter would then open a side window, fire, and quickly close the window, after which the van would drive away.

The pair were caught after killing several people. Upon evaluation, neither met criteria for any specific psychiatric diagnosis except personality disorder not otherwise specified with antisocial and (in one) paranoid traits.

Risk assessment. As in the case of several other conditions above, a history of this kind of violence, in reality or in substantial fantasy (e.g., with “rehearsing” behavior) increases risk of future violence. Those with disorders whose hallmark is a lack of empathy, responsibility, and/or impulse control, such as antisocial, narcissistic, or paranoid personality disorders, are of most concern.

Violence Related to Perceived or Feared Loss or Abandonment

This is a special case of targeted, usually purposeful and instrumental violence which may be either impulsive or calculated.

A man and woman had had a dating relationship for 4 months that had fluctuated between superficial intimacy and loud arguments. The man, who treated the relationship primarily as one of sexual convenience, grew tired of the woman’s volatile emotions and demands for proof of his love. The woman clung to the hope that the relationship would lead to a fairy-tale marriage. Finally, he stopped calling and began dating someone else.

The woman was hurt and angry at being abandoned and at losing what she viewed as a lasting future of love and security. Over time, the loss became less and less tolerable and her anger grew. She saw no life for herself without (her fantasy of) the ex-boyfriend, and convinced herself that their relationship would have a chance if his new girlfriend were gone.

One night, when driving by her ex-boyfriend’s house, she noticed the girlfriend’s car in the driveway. She stopped and smashed the windshield with a hammer, then drove away. The ex-boyfriend suspected she had broken the windshield and called to confront her. She denied everything, but took the call as an opportunity to rekindle the relationship and as evidence that she was still in his thoughts. He told her the police had been called and hung up. He continued to date the new girlfriend.

Two weeks later, the woman saw the ex-boyfriend and his new girlfriend in a bar. When they noticed her, they began to leave. She yelled at them to stop and began to berate the girlfriend. The couple continued to leave, and the woman, who was somewhat intoxicated, attacked the girlfriend. She was restrained and later arrested.

Psychiatric evaluation of the woman revealed the above facts as well as a history of significant abuse

by a stepfather, very unstable adult relationships, and episodes of depression and self-injury associated with relatively minor losses. No frankly delusional material was evident.

Risk assessment. People with flagrant manifestations of borderline coping should be viewed with concern. Those with paranoid personality disorder are relatively common perpetrators as well. Severely dependent character traits in the absence of borderline features should raise consideration for violence in some settings and contexts, albeit to a lesser extent. Children with markedly borderline or paranoid parents, especially, are at risk of either direct abuse or exposure to violent moods and unstable parenting.

Violence Related to Chronic Paranoia or Related Misconceptions

Although we are not addressing chronically delusional or otherwise psychotic states here, paranoid and severely narcissistic character features are often associated with episodic violence and enduring levels of tension or threat to others. Many stalkers are paranoid, often acting out of a sense of fear or defense against threat rather than erotomania or other signs of an Axis I delusional disorder. Narcissistic individuals may erroneously view others as attempting to undermine their positions (and, more accurately, their highly defended sense of competence), reacting with irritability or outbursts when assailed by reality. Schizotypal persons, usually well defended with self-absorbed isolation when in stable settings, nevertheless often misperceive the nature and purpose of those around them.

Mr. H was a Vietnam veteran who had a stable but childless marriage to a Vietnamese woman whom he had brought to the United States. He was generally domineering, expecting her to be a submissive wife. Once in the United States, she pursued an education, getting a graduate degree and becoming a college teacher, while he remained relatively uneducated and generally unsuccessful in his small business. At home, his wife tried to tolerate his dominating style, dislike for socializing, and noticeable paranoid traits.

One of Mr. H’s few hobbies was working with his several dogs, pit bulls who required a large pen and considerable care. He was quite gentle with them and, although seclusive and suspicious, with a history of severe childhood beatings from his father,

LAW AND PSYCHIATRY

there was no evidence that he had ever physically abused his wife.

As his business failed, Mr. H spent more and more time working on an elaborate backyard structure, the walls of which were created from thick metal plates salvaged from a construction site. He described the structure as a shelter for his dogs. Police would later describe it as a "bunker" (see below), but there was no other evidence that he was preparing for some fantasized attack and he had no known association with anti-government or "survivalist" groups.

Mr. H legally owned several weapons, some of which he kept at his place of business (which was in an unsavory part of town and vulnerable to robbery). A year before the events described below, he was caught driving with a loaded handgun without a permit. The weapon was confiscated and never returned, in spite of his frequent requests. He told several people that the confiscation was illegal and, although he had excellent relations with the local police through his business, the confiscation remained a sticking point in his interactions with them.

Mr. H's wife finally left him, ostensibly because of the way he treated her and widening divergence of their interests. He was very upset about her leaving, and became noticeably depressed. A family physician prescribed an antidepressant, which he took only sporadically.

Late one night soon thereafter, he was stopped for speeding. The officer noticed a shotgun on the passenger side of the vehicle. He drew his service weapon and retreated to the patrol car. Reports differ at this point, but it appears from patrol car video that soon after he called for a second officer, the first officer fired at the truck, starting an intensive exchange of gunfire. When the second officer arrived, more shots were fired.

No officer was wounded, in spite of the police cars being hit dozens of times by Mr. H's shots. Mr. H was wounded in several places. When he was finally extracted from his truck, several other weapons and a drum of gasoline were found behind the seat.

Mr. H was arrested for attempted murder of a police officer. His defense was that he was trying to commit "suicide by cop," and had been on his way to a police station for that purpose. He had planned, he said, to fire the weapons into the air, then die at the hands of the police whom he respected so much, one of whom would become a "hero" for ending the incident. Criminologic and psychiatric evaluations suggested that the "suicide-by-cop" plan might have been real, but the overall impression was one of paranoid per-

sonality disorder with schizotypal features and episodes of depression. The violent behavior may have been related more to his paranoia and misperception, triggered by the immediate situation, than to depressive suicidal intent. The first officer's behavior was probably part of the final triggering event, although what might have happened had Mr. H not been stopped for speeding is not clear.

Risk assessment. Those with paranoid personality disorder, especially, deserve concern and monitoring, particularly when there is a history of violence or threat. Children in the family are at risk of both direct abuse and exposure to violent moods and cold or unstable parenting. Severe narcissistic and schizotypal traits suggest increased risk as well.

THE LAST WORD

The case examples in this month's column highlight characterologic vulnerability for violence, but also illustrate how environmental factors can increase risk. Clinicians who understand the importance of setting and context, and their relationship to the internal vulnerability associated with different personality traits, will find it easier to recognize and assess risk and will be in a better position to help manage it.

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