
A Clinical Study of Those Who Utter Threats to Kill[†]

Lisa J. Warren, M.Psych., Ph.D.^{*}, Paul E. Mullen, M.B.B.S., D.Sc.[‡] and James R.P. Ogloff, M.A., J.D., Ph.D.[‡]

Objective. The current study sought to examine the psychiatric characteristics and rate of subsequent violence among those who uttered explicit threats to kill. **Method.** Data were drawn from 144 referrals of adults to a community-based forensic mental health consultation and treatment service. Each had explicitly threatened to kill a person other than themselves. **Results.** Assaults were made by over 20%, including one homicide, within 12 months of assessment. Two participants committed suicide in the follow-up period. Factors found to contribute to violence risk were substance abuse, prior violence, limited education and untreated mental disorders. Threateners were often habitual in their threatening behaviour and typically targeted those they interacted with on a daily basis. Clinical characteristics showed a psychiatrically complex group who shared many features of other offender groups. **Conclusions.** The type of threat that led to referral for a mental health assessment was not uncommonly followed by violence. Factors enhancing risk resemble findings from other groups of offenders. Those referred for clinical evaluation typically have complex clinical presentations and marked deficits in effectively managing interpersonal conflict. Copyright © 2011 John Wiley & Sons, Ltd.

Statements such as “I could kill him” are a common form of expression. Most are uttered in a context, such as being a participant or spectator of a sporting event, that make it clear the threat is an expression of emotion, or misplaced humour, not carrying any commitment to future action. There is, however, a quite different category of threats characterized by their capacity to evoke apprehension or actual fear in those to whom they are uttered. Surveys in the United States suggest that each year 1.6% of the population receive threats that create fear for their safety or the safety of others (Bureau of Justice Statistics, 2006; van Kesteren, Mayhew, & Nieuwbeerta, 2000). It is this smaller subgroup of the total population of threats that can lead to both criminal prosecutions and referrals to mental health professionals for evaluations of the risk of future violence.

Threats delivered directly to a target have been termed *direct threats* by the FBI (O’Toole, 2000). They differ from statements made to third parties, such as those in the influential *Tarasoff* ruling (*Tarasoff v. Regents of University of California*, 1976), and have been delineated from direct threats using the terminology *leakage*, first coined within the literature on violent acts by adolescents, particularly at schools (O’Toole,

*Correspondence to: Lisa J. Warren, M.Psych., Ph.D., Centre for Forensic Behavioural Science, 505 Hoddle Street, Clifton Hill, Victoria, 3068, Australia. E-mail: lisa.warren@monash.edu

[†]The current research forms part of the first author’s Doctor of Philosophy studies.

[‡]Center for Forensic Behavioural Science, Monash University, Victoria, Australia.

2000). Both have relevance to violence risk assessment, although neither are prerequisites for violent acts.

Violence without threats, representing a false negative for threats, has been measured at between 15 and 20% in the stalking literature (e.g., Harmon, Rosner, & Owens, 1998; Meloy *et al.*, 2000). This suggests a tenuousness between the variables of threats and violence, something highlighted in earlier studies of threats and approaches to public figures, where the false negative rate was huge, as almost all who attacked or assassinated failed to threaten (Dietz *et al.*, 1991; Fein & Vossekuil, 1998, 1999). Based mostly on correlational analyses, the stalking studies have been recently re-examined using composite odds ratios, which revealed that stalking victims who were threatened were three times more likely to be assaulted than those not threatened (Mullen, Pathé, & Purcell, 2009). Taken together, these findings indicate that the association between threats and violence can be seen as only coming into focus.

Direct threats and those *leaked* to third parties impact mental health professionals both when their patients confide intentions to kill third parties and when they make direct threats to kill clinicians. Though such threats are sometimes ignored (Dubin & Lion, 1992; Lamberg, 1996), caution dictates that the risk of subsequent violence be evaluated, particularly when the manner in which the threat was delivered created apprehension.

The threats most commonly assessed by mental health professionals are those of suicide, but being called on to evaluate a patient who has threatened to kill is far from unusual. In the case of suicide threats the clinician can fall back on a substantial body of empirical evidence on the risk factors for future self-harm. In assessing threats to kill others the emergent literature has taken a largely pragmatic approach to examining the behaviours on which managers of threats can focus to curb risk (Calhoun & Weston, 2009). While this has advanced the field of threat management impressively, it has neglected psychological analyses of threateners. This is curious, as the literature on threats uttered by mental health patients, for example, though extensive (Bernstein, 1981; Brown, Dubin, Lion, & Garry, 1996; Coverdale, Gale, Weeks, & Turbott, 2001; Davies, 2001), provides information primarily about the types of patient who threaten, the context in which such threats are uttered, and the emotional impact on professionals. With a few notable exceptions, such as the now venerable article by MacDonald (1963), what the existing clinical literature fails to provide is guidance on the all important factors of the incidence of subsequent violence and the risk factors predicting such violence.

Explicit threats are a behaviour of concern in large part because they may be a harbinger of violence (MacDonald, 1963; Warren, Mullen, Thomas, Ogloff, & Burgess, 2008). Our current knowledge relevant to assessing the risks presented by direct and indirect threats to kill comes largely from studies of non-clinical populations. Threats, for example, in the stalking situation have been shown to be a robust predictor of violence (McEwan, Mullen, & Purcell, 2007; Mullen *et al.*, 2009). Threats to the lives of public figures, while almost exclusively uttered to persons other than the public figure, have also been associated with violence (James *et al.*, 2008). Similarly, offenders convicted of the offence of threat to kill subsequently committed violent acts, often to persons other than the threat victim, in over 44% of cases (Warren *et al.*, 2008). A study of mass homicide offenders found that, particularly among adolescent offenders, prior threats were not infrequent (Meloy *et al.*, 2004). Of more immediate relevance to mental health professionals, is following these highly publicized tragedies there is often a

rash of attention seeking young people referred after threatening to commit similar acts of mass murder (Mullen, 2004).

Breaking down the facets of this risk has heralded the realization that risk of violence following threats is greatest in cases where the threatener and their target are well acquainted. This now commonly accepted notion, known as the *intimacy effect* (Calhoun & Weston, 2003), has established that the more intimate the relationship between the threatener and target the more likely threats will be uttered and the more likely they will be enacted (Meloy & Gothard, 1995; Mullen et al., 2009).

The current study examined the clinical characteristics of individuals referred to a forensic mental health service for assessment following threatening to kill. Data were then gathered for 12 months following the assessment to establish the rate of subsequent physical violence. The information was combined to establish the risk factors for violence in this clinical population.

MATERIALS AND METHODS

One hundred and fifty-two participants were approached between 2002 and 2005, and 144 (95%) agreed to participate (128 males, 16 females). The demographic characteristics of those who declined (six males, two females) did not differ significantly from those of participants.

Participants were recruited from referrals to an outpatient forensic mental health consultation and treatment service. Within this service, a specialist assessment clinic had been created to provide mental health evaluations and violence risk assessments for those who had directly threatened to kill their target or had uttered a death threat to a third party, such as a treating doctor. The rationales and protocols of the specialist assessment clinic have been described elsewhere (Warren, MacKenzie, Mullen, & Ogloff, 2005).

Data were gathered in each case using self-report, collateral data from mental health professionals, and police records. In addition, threateners were asked whether collateral data could be sought from persons they nominated, such as a parent or partner. One hundred and twelve (77.8%) consented. Self-report data were gathered during semi-structured interviews conducted by a consultant psychiatrist and/or clinical/forensic psychologist. Mental health professionals were asked to provide details of current and previous treatment protocols, differential diagnoses, known incidents of violence, including whether criminal charges arose, and interpersonal difficulties. In cases where referrals were made by criminal justice agencies such as courts, every effort was made to source historical data they could ethically release, such as past clinical assessment reports and treating clinicians' reports. In all cases mental health data were obtained, albeit of varying quantity and therefore comprehensiveness. Criminal histories were obtained from Victoria Police records and were sourced from their mainframe database, known as the Law Enforcement Assistance Program (LEAP). This database is a compendium of all contacts the public have with police.

Referrals came from health providers (46.5%, $n = 67$), criminal justice agencies (51.4%, $n = 74$), and three who self-referred (2.1%). Referring clinicians usually requested a risk assessment and management and safety plans. Courts sought advice on sentencing, disposal or treatment for convicted offenders serving a community-based

sentence. Self-referrals came from past patients of the clinic who requested further assistance in the months and years after their initial episode of care.

Data on subsequent violence perpetrated by threateners were gathered 12 months after the assessments were completed. Data were sourced from Victoria Police. When assault offences were discovered they were coded in two ways: (1) severe or not severe, and (2) perpetrated against the threat target or another person.

DATA ANALYSES

Descriptive statistics were used to characterize threateners, with categorical data being reported as frequencies and percentages and continuous data as means, standard deviations and ranges. Univariate analyses were used to compare the characteristics of the threateners who committed acts of violence during the follow-up period and those who did not. In the analyses involving mass homicide threateners, the Fisher exact test was used due to the small sample size.

The associations between the variables were converted into odds ratios to describe the strength of the association between the characteristics and the outcomes. Associations that were univariately significant were modelled using logistic regression to explore whether it was possible to develop a predictive model for subsequent violence.

Multivariate analyses accounted for possible confounding and effect modification between variables. The area under the curve (AUC) of the receiver operating characteristic statistic was also plotted to measure the predictive accuracy of the resultant model (Mossman, 1994), and the ‘‘goodness of fit’’ of the full model was checked using the Hosmer–Lemeshow test (Hosmer & Lemeshow, 2000).

ETHICAL CONSIDERATIONS

Potential participants were provided with a plain language statement explaining the study and a written consent form to sign if they wished to participate. The clinic’s administrative staff presented the forms to reduce the likelihood of perceived coercion. An additional verbal explanation of the study was offered and questions were answered as required. It was emphasized that the decision of whether or not to participate in this study had no effect on the nature or outcome of their assessment, was not documented in their clinical file and was not mentioned in the clinical report generated from the assessment. The participants specifically consented to a criminal records search as part of the overall consent procedure.

Ensuring the privacy of threateners’ information was a paramount consideration, given the sensitive and highly confidential nature of the information gathered. Entering data for the research into a database where threateners were identified by a code and not by their personal details ensured confidentiality. A separate database, available only to the researchers, held the key to the codes. This file was password protected and kept entirely separately. No original data or person identifiable information were removed from the clinic at any time as data entry was done onsite.

Ethical approval for this study was obtained from the Standing Committee on Ethical Research with Humans from Monash University, the Ethics Committee of the

Victorian Department of Human Services, the Research Committee of the Victorian Institute of Forensic Mental Health, and the Victoria Police Human Research Ethics Committee.

RESULTS

Characteristics of the Threats

All threats had reportedly created a fear of future violence in those to whom they had been made. A single threat to kill was uttered by 36 (25%), which contrasted with the 69 (47.9%) who issued multiple threats. In addition to killing, other forms of harm were threatened by 35 (24.3%). Threateners directed their threats at multiple targets in 41 (28.5%) cases.

Criminal prosecutions followed the threats to kill in 57 (39.6%) cases. An additional 10 (6.9%) were convicted of breaching a restraining order as a result of threatening to kill the order's complainant. A further seven were included as their recent offences incorporated threats, an example being telephoning a person and threatening to cut their throat, which resulted in a conviction for using a telephone service to harass.

The relationships between the threateners and their targets are summarized according to motivation (Table 1). In 42 (29.2%) cases threats were directed at a current or past intimate partner. In 56 (38.9%) threats were uttered in the context of conflict at work or with family or friends. Threats to commit a mass homicide were issued by eight (5.6%) threateners. The remainder were attempts to influence either a

Table 1. Motivation for uttering the threat

Motivation	Frequency
	<i>n</i> (%)
Threats in the context of ongoing or establishing a relationship	
While attempting to establish an intimate relationship	6 (4.2)
As part of ongoing domestic violence	11 (7.6)
Attempt to stop threat target ending the intimate relationship	13 (9.0)
Punishment for ending an intimate relationship	5 (3.5)
Threatened new partner of an ex-intimate	7 (4.9)
Threats as a conflict resolution strategy	
Conflict with a family member other than an intimate partner	19 (13.2)
Peer conflict	19 (13.2)
Neighbour conflict	7 (4.9)
Workplace conflict	11 (7.6)
Threats as an attempt to control directions the threatener is required to obey	
Mental health clinician	14 (9.7)
Child protection worker	2 (1.4)
Criminal justice personnel (police, judge)	11 (7.6)
Disclosing an intention to harm a third party	
Threats to carry out a mass homicide	8 (5.6)
Threats to rape and murder a stranger	1 (0.7)
Threats to harm a public figure	1 (0.7)
During the carrying out of another crime	
Armed robbery	5 (3.5)
Loss prevention officer when caught shoplifting	2 (1.4)
During road rage	2 (1.4)

service provider or the target of another offence committed by the threatener. In one case the threats were issued against a well-known Australian politician.

Threats were issued face to face by 74 (51.4%), 14 wrote, 19 used the telephone, 24 told a third party and two were classified as having uttered veiled threats (one mailed a bullet engraved with the target's name and the other persistently mailed funeral home brochures). The remaining 11 (7.6%) used multiple delivery methods. Where threateners wrote to their targets, eight posted letters, one faxed a letter, four emailed and one used a short messaging service (SMS).

This meant that 120 (83.3%) threateners had made *direct* threats. The remaining 24 (16.7%) were issued to a person other than the target and were classified as *leaked* threats. Examples of these indirect leaked threats were the threats to commit mass homicides, where targets were typically unnameable people who would have the misfortune of being at the location designated by the threatener. Others were clinicians having patients tell them of intent to kill family members and work colleagues speaking to one co-worker about the intent to kill another.

Characteristics of the Threateners

Demographic and clinical characteristics of threateners are presented in Table 2. Most were males aged in their 30s, born in Australia. The mean level of educational attainment was Year 10, the last government mandated year of education in Australia. This was found to be significantly lower ($t(143) = -8.1$ (two tailed), $p = .000$) than the state of Victoria's average of Year 12 (Australian Bureau of Statistics, 2006).

Table 2 included data on the large proportion with histories of violence and criminal convictions. Violence history was also categorized as minimal for 42 (29.2%) threateners, moderate for 47 (32.6%), and substantial for 16 (11.1%). An example of a minimal history was a threatener who was cruel to animals as a child and had a prior conviction for property damage. A moderate classification was assigned to a threatener who had several convictions for minor assaults. Finally, a substantial classification was assigned where the threatener had injured his mother by shooting her, had stabbed a stranger, and had assaulted several others. Self-directed violence was found among 69 (47.9%) threateners who had histories of deliberate self-harm or suicide attempts.

Seventeen (11.8%) threateners had a substantial and ongoing interest in weapons, particularly firearms and bladed weapons. A further 49 (34.0%) did not report this interest but had used a weapon while uttering a threat. Thirty-four (23.6%) used a knife, one (0.7%) an axe, eight (5.5%) a syringe reportedly filled with HIV infected blood or a toxic chemical, and six (4.2%) a firearm.

Primary diagnoses are reported in Table 2. Substance abuse, however, incorporates the three (2.1%) threateners whose only Axis I diagnoses related to substances and the 75 (52.1%) with substance comorbidities. Among those with primary substance diagnoses two met criteria for heroin dependence and one for alcohol dependence.

Axis II disorders were considered separately, rather than as comorbid conditions, in order to gain a more complete picture of threateners' clinical presentations. Among the threateners with mental retardation, known as an intellectual disability in Australia, two also suffered a psychotic illness and two an affective disorder. Where a personality disorder was diagnosed, six were also diagnosed with a psychotic illness, five with an affective disorder, two with anxiety, one with a drug and alcohol condition and one with

Table 2. Characteristics of threateners

Characteristics	Frequency
	<i>N</i> (%)
Demographic characteristics	
Males	128 (88.9)
Age (years)	mean = 33.1, SD = 10.4, range 17–77
Country of birth	
Australia	121 (84.0)
New Zealand	4 (2.8)
Europe	12 (8.3)
Middle East	4 (2.8)
Asia	3 (2.1)
Marital status	
Married/de facto	28 (19.4)
Single/separated	116 (80.5)
Education	
Tertiary	23 (15.9)
Secondary	78 (54.1)
Occupation	
Unskilled	101 (70.1)
Tradesperson	19 (13.2)
Professional	11 (8.3)
Frequency of employment	
Never worked	13 (9.0)
Occasionally employed	87 (60.5)
Regularly employed	44 (30.5)
Prior histories of violent and criminal behaviour	
Self-reported history of violence	105 (72.9)
Self-reported history of threatening	90 (62.5)
One or more criminal convictions	94 (65.3)
One or more convictions for violence	42 (29.2)
One or more convictions for threat to kill	19 (13.2)
Clinical characteristics	
DSM-IV-TR Axis I disorder	94 (65.3)
Psychosis	51 (35.4)
Non-psychotic affective disorder	30 (20.8)
Anxiety disorder	7 (4.9)
DSM-IV-TR Axis I substance use disorder	
Polysubstance disorder	29 (20.1)
Single illicit substance disorder	23 (16.0)
Alcohol-related disorder	23 (16.0)
DSM-IV-TR Axis II disorder	
Mental retardation	7 (4.9)
Personality disorder	24 (16.7)

adult Attention Deficit Hyperactivity Disorder. In another 55 cases, personality disorder traits were noted as being problematic both currently and historically. These cases were not included in the data on personality disorder, as diagnostic criteria had not been fully met.

Subsequent Offences and Violent Acts

Within 12 months of being assessed for threatening to kill, 60 (41.7%) threateners had committed subsequent offences, where 33 (22.9%) committed a violent offence (Table 3). Among the violent, 27 (18.7%) committed less severe acts such as common

Table 3. Subsequent offences and violent acts

Offence	Frequency		
	<i>n</i>	% of reoffenders	% of sample
Homicide	1	1.6	0.7
Non-fatal assault			
Assault – not severe	25	41.7	17.4
Assault – severe	6	10.0	4.2
Assault and property damage	5	8.3	3.5
Property damage	3	5.0	2.1
Threats	6	10.0	4.2
Other offences			
Theft offences	8	13.3	5.5
Driving offences	6	10.0	4.2
Illicit drug offences	4	6.7	2.8
Unacceptable public behaviour	2	3.3	1.4
Unlicensed firearms	1	1.7	0.7
Total	60	100	41.7%

law assaults and 6 (4.2%) committed severe violence, including one (0.7%) murder and five (3.5%) assaults that resulted in the target sustaining injuries. In addition, 12 (8.3%) also uttered further threats. Six (4.2%) uttered further threats but were not violent. Subsequent threats were directed at the same target by 29 (20.1%), with 18 (12.5%) going on to assault the initial threat target, one fatally. In 13 (9.0%) cases the person assaulted was not the object of the index threat.

During the 12 months four threateners spent part of that time in custody. No threatener spent the entirety of the 12 months incarcerated. Each of the four had committed an act of serious violence, including one who murdered. The remaining two who had committed a serious assault were granted bail pending criminal trials.

There were two completed suicides during the follow-up period and one known suicide attempt. Both completed suicides were overdoses of illicit drugs. The attempt was taking an overdose of paracetamol consumed with alcohol.

Given that the incarcerated and deceased threateners had lessened opportunity for violence they were considered for removal from subsequent analyses, as not doing this may have had a depressing effect on the rate of subsequent violence. As no case was absent for the entirety of the 12-month follow-up it was decided to include them.

RISK FACTORS FOR SUBSEQUENT VIOLENCE

Four variables were found to significantly increase the risk of subsequent violence. Violence occurred significantly more often among the threateners who had a history of substance misuse (28.7% versus 9.3%, $\chi^2 = 6.4$, $p = .02$; OR = 3.9, 95% CI = 1.3–12.0), the threateners who had a history of violence (27.6% versus .2%, $\chi^2 = 4.8$, $p = .03$; OR = 3.3, 95% CI = 1.1–10.2), the threateners with ten years or less of schooling (30.2% versus 12.1%, $\chi^2 = 6.5$, $p = .01$; OR = 3.2, 95% CI = 1.3–7.9), and those who did not receive any mental health treatment during the follow-up period (29.9% versus 14.9%, $\chi^2 = 4.5$, $p = .05$; OR = 2.4, 95% CI = 1.1–5.6).

The above-mentioned four variables were then included in a multivariate model. Having a history of violence was retained as a variable in this model despite it becoming

Table 4. Multivariate model of characteristics predictive of violence by threateners

	Adjusted OR	95% CI	Model characteristics
History of drug and alcohol abuse	4.192	1.31–13.37	Sensitivity = 48.5%
Not receiving mental health care	2.786	1.16–6.71	Specificity = 87.4%
Poorer education (Year ten or less)	2.744	1.04–7.24	PPV = 53.3%
History of violence	2.334	.713–7.64	NPV = 85.1%
			Total % correct = 78.5% or 113/144
			UC = .76 (SE = .050)
			GoF = $\chi^2 = 7.67, p = .36$

non-significant. This decision was made as violence was such a strong risk marker univariately and including it in the multivariate model improved the AUC (when the model was re-run without the variable the AUC reduced to .74). Characteristics of the model are depicted in Table 4. The combination of having a history of substance abuse, not receiving mental health care, having minimal education and having a history of violent behaviour predicted violence by threateners with a specificity of 87.4%, a sensitivity of 48.5%, positive predictive value of 53.3%, and an AUC of .76 (SE = .05; see Figure 1). The Homer–Lemeshow test suggested no difficulties with the fit of the model ($\chi^2 = 7.7, p = .4$).

The rates of progression to violence following threats were contrasted between cases dealt with primarily by a legal intervention ($n = 84, 58.3%$) and those managed

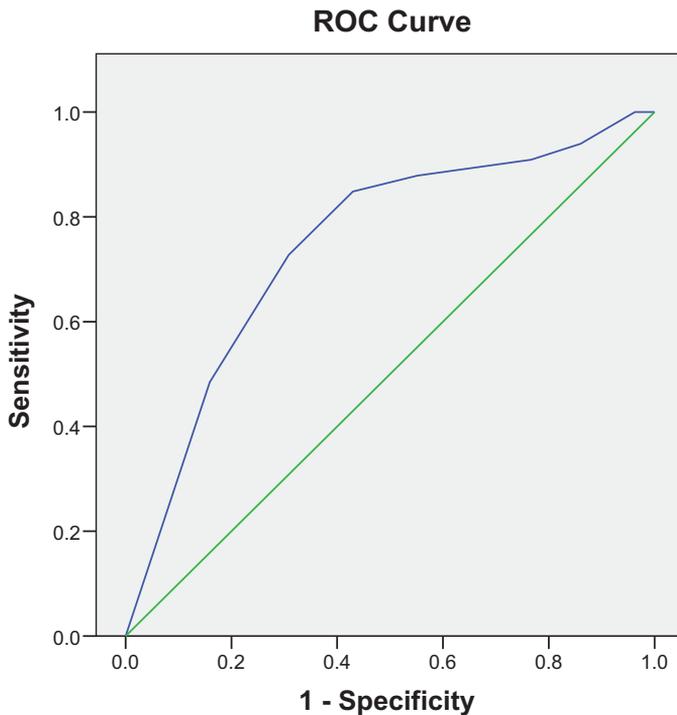


Figure 1. The receiver operating characteristic (ROC) curve for the multivariate logistic regression model predicting subsequent violence by threateners (area under ROC curve = .76). Diagonal segments are produced by ties.

therapeutically ($n = 60$, 41.7%). Violence recidivism occurred at statistically comparable rates (27.4% versus 16.7%, $\chi^2 = 2.3$, $p = .16$).

Characteristics of Mass Homicide Threateners

Eight (5.5%) threateners stated that they intended to kill as many people as possible, rather than kill a named target. In each case the plan for the mass homicide focused on a specific group within society the threatener detested. In one case, for example, the threatener disliked Muslims and stated that he was preparing to detonate a bomb at a popular Halal butcher.

During the follow-up none of the mass homicide threateners enacted, or attempted to enact, their plans. Two of the eight did assault a person not obviously related to the group that aggrieved them, which suggested that they escalated to violence at a comparable rate to the remainder of the group (25% versus 22.8%, $\chi^2 = .2$, $p = 1$).

The rate at which they suffered mental disorders was not elevated comparably to the remainder of the group (87.5% versus 64.0%, $\chi^2 = 1.85$, $p = .26$), but affective disorders were significantly more common (62.5% versus 18.4%, $\chi^2 = 8.92$, $p = .01$).

DISCUSSION

This study revealed a surprisingly high level of subsequent violence among threateners referred for clinical evaluation, which included 33(22.9%) assaults, one of which was fatal. Most assaults were, however, relatively minor in that the target did not sustain injuries. There were in addition two suicides within the 12-month follow-up period. The usual target of the subsequent violence was the individual threatened, though in some 40% of cases someone other than the threat target was attacked.

Factors that contributed to the risk of violence were substance abuse, prior violence, limited education, and untreated mental disorders. Substance abuse emerged as the strongest univariate predictor. Rather than being intoxicated at the time of threatening, risk from substance abuse was in most cases related to the destructive influence on the abuser's lifestyle: influences such as financial problems, conflictual relationships, and poor work performance (Hamilton, King, & Ritter, 2004).

Mental disorder also emerged as having an important role. This was in part the result of symptoms explaining some of the threatening behaviour. For example, one threatener said they intended to kill a neighbour whom they believed was poisoning any person complaining of a headache. Untreated mental disorders also emerged as an important risk factor, as those not receiving such treatment were 2.43 times more likely to escalate to violence. At first glance this result appeared to be at odds with the literature on risk factors for offending by the mentally disordered (Bonta, Law, & Hanson, 1998; Gendreau, Little, & Goggin, 1996). In this literature clinical variables, such as being diagnosed with a mental disorder or having a history of mental health treatment, were found to have the smallest effect sizes (Bonta *et al.*, 1998), with criminal histories and deviant lifestyles being more powerful predictors of recidivism among the mentally disordered (Bonta *et al.*, 1998). Closer consideration of the current results, however, suggested that threateners may bear similarities to the larger population of mentally disordered offenders, as the threateners who refused or dropped out of treatment were frequently those with more extensive criminal careers.

When the risk factors were considered collectively, they were found to effectively discriminate violent from non-violent threateners. As the model bore resemblance to that used with other groups of offenders (Bonta et al., 1998; Hanson & Morton-Bourgon, 2005; Linaker & Busch-Iverson, 1995; Monahan et al., 2001; Quinsey, Harris, Rice, & Cormier, 2006), the use of existing risk management protocols to assess violence risk among threateners is supported. This being said, when clinically assessing the risk of violence an approach modelled on the assessment of suicide risk was also employed. That is, once substance abuse, history of violence, and educational and social background were assessed in each case, then the elements of availability of means, planning, preparation, and the acknowledged commitment to put the words into action irrespective of consequences were discussed with each threatener. Just as with suicide, certain states of mind in combination with the risk assessment were considered to justify immediate admission, voluntary or compulsory. However, unlike the suicide situation, the conditions considered to require immediate admission were the delusional illnesses and morbid jealousy.

In Australia psychiatrists can recommend on mental health grounds the removal of guns and the revocation of a licence to hold firearms, a recommendation the police almost always act upon, and the courts almost always support should an appeal be launched. In three cases the police were involved to remove both licensed and unlicensed firearms from the patient's home. This was concerning as it indicated that at least 2% of the sample had access to firearms. While at first glance this number appears low, it indicated greater prevalence than among the Australian community, which has one of the lowest gun ownership rates in the world at 15 guns per 100 citizens, as compared to the United States at 90 guns per 100 citizens (Graduate Institute of International and Developmental Studies, 2010). While numbers did not support statistical analyses of differences, the rate of subsequent violence did not appear to differ between these three and the remainder as of the sample, as one of the three progressed to violence. That violence was, however, among the most serious incidents, as this threatener, some ten months after being assessed, created a siege situation in a public building that lasted several hours.

Threateners were found to be habitual in their threatening behaviour. More than half had threatened before the threats examined in this study and 12.5% had threatened again within 12 months. Risk, therefore, might usefully be defined as requiring consideration of recidivist threatening as well as risk of escalation to violence. Such notions have begun emerging in the stalking literature, where stalking risk assessments now include risk of violence, recurrence, and persistence (McEwan et al., 2007, 2009; Mullen, MacKenzie, Ogloff, McEwan, & Purcell, 2006). The importance of discouraging repeated use of threats has advantages to both the threatener in adopting more adaptive forms of communication and targets who are spared trauma. Threats, such as those considered in this study, were acts that created fear and distress regardless of whether they culminated in violence. Repeating such acts with regularity, therefore, increases the damage and costs of this behaviour to targets and the community at large.

Several habitual threateners targeted their treating mental health clinician. Mental health clinicians, particularly psychiatrists, can have the unenviable position of forcing their decisions on unwilling patients. In these situations threateners sought any means to gain some control over a situation in which they felt, and often were, powerless. While it was important to empathize with their plight, it was imperative to be unequivocal about the unacceptability of using death threats as a way to communicate distress.

Threats also emerged as an attempt to influence others, particularly among the 70% who threatened the people they interacted with on a daily basis. Threats to family members were typically an attempt to force a resolution to a family conflict, whereas threats to intimates were either a way of trying to force the partner to remain in the relationship or a way to frighten as punishment for rejecting the threatener. Listening to the accounts given by these threateners, their motives seemed akin to those of stalkers who use threats as a instrument of control or influence (Meloy, 1999). When asked about the success of their threats, most admitted that the desired outcome did not eventuate; however, all insisted they had no other means available. Threatening to kill requires very few skills. Mental health clinicians are well placed to encourage appropriate skill development. Willingness to learn such skills seemed to be at its best when the motivation is threatener based, such as avoiding criminal prosecution.

Contrasting this were those who threatened as a way to regulate their own emotions. Meloy termed these threats expressive (Meloy, 1999), as they revealed both the nature and intensity of the emotions experienced by the threateners.

In both instrumental and expressive threats a third distinct motive arose. This related to the “shock value” many of our threateners understood and occasionally enjoyed. In these cases eliciting an emotive response, rather than a course of action, seemed prominent. As an example, one threatener waxed lyrical about enraging court staff by shouting out threats to “kill judges and bomb courts” while being tried for various offences. His narrative was filled with comments such as “. . .should have seen their faces. . . I made it a circus.”

Reflecting on these motives indicated that a three-pronged motivational typology might have utility. The motive of venting could be labelled as *screaming*, eliciting an emotional response as *shocking*, and controlling or influencing as *scheming*. While not mutually exclusive, questioning each threatener about each motive revealed for us a great deal about intentions, attitudes, and psychological defenses.

An exception to those who habitually threatened was the small but interesting group of mass homicide threateners. Those threatening mass murder shared some of the reported characteristics of resentful stalkers, who select targets they believe are representative of their grievance (Mullen *et al.*, 2009). This group of resentful stalkers has been found to threaten frequently and escalate to violence rarely (Mullen *et al.*, 2009). In this study, none acted in any way to further their mass homicide threat. They did, however, escalate to violence at the same rate as the remainder of the sample, supporting the emerging view that the risk posed by threateners extended far beyond the specifics of the threat and to whom it was directed (Warren *et al.*, 2008).

Threateners in the current study displayed clinical similarities to the threateners studied by MacDonald (1963), who were assessed at a psychiatric hospital in the aftermath of threatening to kill. Psychosis was highly prevalent (23% for MacDonald’s sample, 35% for the current sample), as were personality disorders (67% for MacDonald, 17% diagnosed in the current study plus 38% with notably disordered personality traits), which suggested that at least some of the characteristics of those who warrant clinical attention may not have changed greatly.

The greatest limitation of this study was its methodology, where two issues emerged. One was the generalizability of the findings. All threateners in this study had piqued the concerns of referrers, suggesting that, at least at an intuitive level, they were thought to be a risk to others. This is unlikely to represent the broader population of threateners where many were simply making inelegant expressions that served a function similar to swearing.

The other limitation of the study was the appropriateness of labelling the follow-up period 12 months, as the lag between the threat being uttered and assessed varied, and was, in some cases, difficult to determine. A general medical practitioner, for example, referred a patient who had spoken of killing family members several times. The doctor had not kept records of the dates of each threat and had chosen to refer when the frequency of the threats increased. The effect of labelling the follow-up period 12 months is a possible distortion in the rate of violence, as the actual amount of time that had elapsed between threatening and escalating to violence was *at least* 12 months. This point is being addressed in a future study, where longitudinal police and mental records of threateners are being sought (Warren & Mullen, 2010).

This research demonstrated that threats tend to be a habitual behaviour indulged in by those with limited skills in managing their own frustrations and/or persuading others to attend to their needs. Threats that were issued in a manner that created fear and distress were predictors of significant increased risk of violence, though not always to the individual or individuals threatened. In addition to treating existing mental illnesses, clinical interventions aimed at changing and improving the patient's ability to manage anger, and equally importantly manage other people as it thought this, may decrease the rates of both violence and further threatening. Threateners referred for mental health evaluation are likely to have complex mental health needs and equally complicated personal lives.

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DECLARATION OF INTEREST

Nil.

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