

ASSESSING CHILDREN'S AND ADOLESCENTS'
DANGEROUSNESS IN SCHOOL SETTINGS

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Educators increasingly request that child mental health clinicians in outpatient and school settings provide guidance about how to assess children who may carry weapons to school or who may pose a potential threat to the school community. They may also request help in determining if a student's aggression is exacerbated by an untreated psychiatric disorder. Many schools have to make critical judgments while relying on an inexact assessment despite the fact that there is an emerging descriptive knowledge base about students involved in school shootings (Twemlow et al., 2002). As Verlinden, Hersen, and Thomas (2000) point out in their comprehensive review, there are limits in the ability of clinicians to predict the potential for violence and there are no reliable screening instruments that identify students at risk for violent behavior and who will need intensive interventions. Assessments are extremely time sensitive and lack specificity (Verlinden et al., 2000).

The focus of this chapter is to provide clinicians with relevant descriptive data about violence in schools, thorough examinations of case evaluations, and pertinent assessment guiding principles developed by the Federal Bureau of Investigation (FBI) to educate schools about conducting threat assessments. Here, I present the relevant descriptive data about violence in schools. I then highlight a case evaluation model for violent students, using pertinent guiding principles that the FBI developed based on its analysis of students who killed multiple people (planned school attacks).

The author wishes to especially acknowledge Milly Krakow and Alexa Geovanos for their assistance with this manuscript.

Although psychiatrists may be asked to assist with analyzing potential targeted school violence, it is more likely that psychiatrists as school consultants are in a unique position to offer a comprehensive diagnostic evaluation and formulation that takes into account the situational factors for less-lethal but more-pervasive types of school violence. I provide three case studies of intensive evaluations that two other child and adolescent psychiatrists and I conducted for two district offices of special education, outlining the evaluation process and components. The evaluation, assessment, and intervention process used in the case studies differs from the FBI orientation in two ways. First, the population is different. The FBI intervenes with an extremely volatile group of young people who seem capable of imminent violence (e.g., tomorrow), whereas the cases presented in this paper are with a less-violent group. Second, the method is different: the goal of the FBI assessment and intervention, or both, is to prevent violence in a potentially explosive group of young people, whereas the focus of the assessment and intervention for the cases in this chapter is to galvanize resources and provide advocacy to support the highest functioning of the students.

BACKGROUND DATA ON SCHOOL VIOLENCE

Types of Violence in Schools

Although there is heightened public concern about the potential for students to harm each other or teachers, the first step in developing effective assessment approaches is to understand the data that describe the problem of violence in schools. Despite the rhetoric that schools are dangerous places, in actuality, schools are relatively safe havens compared to the often aggressive atmosphere of the streets or home. In fact, children and adolescents are three times as likely to be victims of serious violent crime away from school than they are on school grounds (U.S. Department of Education and U.S. Department of Justice, 2002). Epidemiological data collected by multiple sources such as the Centers for Disease Control, the U.S. Office of Juvenile Justice, and the National School Safety Center, beginning in the late 1980s, showed convergent trends about the type of violence in schools (Flaherty, 2001).

The most common type of violence is interpersonal disputes and assaults without weapons that usually occur as fistfights between male

students. School-associated deaths are rare and account for less than 1% of the homicides among school-aged children 15 to 19 years old (Reddy et al., 2001). From 1996 to 2000, an average of five multiple-victim events occurred per year from school shooting attacks. The annual incidence of school-associated deaths is .068 per 100,000 students, and studies demonstrate that the odds that a child or adolescent will die in school are no greater than 1 in 1,000,000 (Reddy et al., 2001). CDC data show that between 1993 and 1997, there was a national decline in the number of students carrying weapons in school, from 12% in 1993 to 8% in 1997. Additionally, the percentage of students engaging in fights on campus decreased from 16% to 15% (Reddy et al., 2001; U.S. Dept. of Education, 2002).

School characteristics that are associated with higher rates of school violence are large school size, problematic leadership, and the presence of gangs in the school. The optimal number of students for a school to have in order to avoid violence is between 400 and 600 students, yet 30% of schools in the United States have more than 800 students (Galletti, 1998). Smaller schools allow students to have more positive connections with teachers and closer supervision (Warner, Weist, and Krulak, 1999). School-associated violence is more likely to occur before and after school, during transitions between classes, during lunch, in the locker room, and at dismissal time (Flaherty, 2001). These are times when students are often unsupervised, and casual insults or slight provocations can escalate into violent altercations.

Teachers are increasingly concerned for their own safety, and from 1994 to 1998, 83 incidents of violence per 1,000 teachers were reported in the school setting (Kaufman et al., 2000). The U.S. Department of Education broadly defines an incident as a criminal offense involving one or more victims and one or more offenders. However, there is wide variability in threats to teachers. Threats can range from a student pushing past a teacher to exit a classroom, to a teacher being injured when interrupting a fight, to students threatening a teacher, to an outright physical attack by students. During this same time period (1994–1998), an average of 16,000 serious violent crimes (rape, sexual assault, robbery, or aggravated assault) per year: or, roughly 4 reported serious violent crimes per 1,000 teachers (Kaufman et al., 2000). Male teachers are more likely to be attacked than female teachers. The changing tendency for increased aggression to teachers is captured by Bloch's (1976) description of the battered teacher syndrome. The battered teacher is characterized by a combination of symptoms, including de-

pression, elevated blood pressure, interrupted sleep, and headaches. Despite the difficult predicaments that teachers confront with more challenging behavior from their students, the prevailing aggression in school is between students and not directed at teachers.

Currently the majority of public schools adopt a zero-tolerance stance for any kind of violent behavior—including that of an immature boy who brags that he is making a bomb using blueprints from the internet, to that of a young second-grader who accidentally brings a water gun to school, to that of an explosive girl who makes unsubstantiated threats—with no research to demonstrate the efficacy of these policies (Skiba and Knesting, 2001; Rappaport, 2002). As a result, educators sometimes respond to trivial potential threats or minor transgressions of school rules with mandatory expulsion. This suggests that although zero-tolerance should, in theory, increase school safety by setting firm limits in which no violence is tolerated, a zero-tolerance policy makes no distinction between various types, forms, and levels of violence or social context, and treats all offenders the same.

Characteristics of Students Who Exhibit Violent Behavior

There are differences between the classroom avengers, who are involved with shooting multiple students, and typical students who are prone to aggression. Compared to the more typical aggression-prone students, the premeditated assailant (rare despite extensive publicity) often comes from rural or suburban areas and has a stable family and average academic achievement, with little prior involvement with the juvenile justice system (Twemlow et al., 2002). In contrast, students who may more commonly face suspensions and detentions for aggressive behavior are often from families in turmoil with a history of abuse and neglect, are failing academically, and are struggling with impulsive behavior, poor frustration tolerance, and limited concentration.

Special Education Students

Minority students and students with special needs are disproportionately suspended and expelled (Morrison and D’Incau, 1997; Skiba and Peterson, 1999). A qualitative examination of characteristics of students recommended for expulsion from schools illustrates that the punishment

is not always tailored to the offense and that many of these students do not represent a danger to other students or staff (Morrison and D'Incau, 1997).

Consistently, special education students are subjected to higher levels of discipline for incidents of serious misconduct than their classmates in regular education—15 serious misconduct cases per 1,000 regular students as opposed to 50 cases per 1,000 students for special education students (1.5% versus 5%; Skiba and Peterson, 1999).

This trend is more alarming in the context of data from the National Longitudinal Transition Study of Special Education students (Wagner, 1991). These data show that many special education students categorized with severe emotional/behavioral disturbances (SEBD) are more vulnerable to provocative behavior that could lead to expulsion. Many schools cannot provide students with ready access to mental health services that could potentially prevent severe disciplinary actions or placement in more restrictive educational settings. Only 11% of students with SEBD had behavioral programs in place in their regular education classes. Furthermore, only 33% of students with SEBD reported that they received counseling. A survey of 60 school districts revealed that 58% of districts did not have the capacity to provide counseling or other mental health services (Wagner, 1991). Often there were waiting lists, program gaps, and uneven service delivery.

Mattison provides descriptive research on the relatively new role of the child psychiatrist in the special education setting (Mattison, 2001). He also documents the undertreatment of SEBD students, leading to a chronic subgroup of students in SEBD programming who are seriously dysfunctional students. He examined 169 standard consultations based on reviewing school records and student interviews. He found that 56% of the teachers' questions were about diagnosis, and that 79% of the students had ADHD. In a three-year longitudinal study of 89 students with SEBD, he showed that there was a subgroup of SEBD students who were seriously dysfunctional and did not receive any treatment (41%; Mattison, 1999).

Mental health professionals who work with adolescents need to understand the legal rights of special education students who display disruptive behaviors. Federal mandates (that is, Section 504 of the Rehabilitation Act of 1973 and the Individuals with Disabilities Educational Act, or IDEA) are designed to protect students with disabilities. These mandates provide legal protection for students with disabilities so that they can stay in the least restrictive environment. They can also

prevent severe disciplinary actions. These legal statutes require schools to determine if students' misconduct is connected to their disability. If a student with special needs is suspended for more than 10 cumulative days in a school year, or if more than 10 nonconsecutive days constitutes a pattern, then a manifestation hearing (a review to determine whether the student's problematic behavior is linked to his or her disability) is required. The educational team (usually consisting of a school psychologist, administrator, and teacher) determines if the disability impaired the student's judgment and made the student more susceptible to the problematic behavior. This determination has far-reaching consequences. If there is no link between the student's disability and behavior, then the discipline can be the same as for a regular education student. If the team agrees that there is a link between the student's disability and behavior, then the student may get a shorter punishment or, if the punishment is expulsion, the school district is required to provide an alternative school placement (Browne, Losen, and Wald, 2001).

A student with disability-linked misconduct may be expelled and transferred to an alternative placement under two circumstances: (1) if the student possesses a weapon in school or has unlawful possession of drugs, or (2) if maintaining the current placement is likely to cause serious injury to another person (Walter, 2003).

Three sobering common scenarios are outlined by Morrison and D'Incau's (1997) examination of the trajectory of 158 special education students faced with the possibility of expulsion, usually for threats or aggressive behavior. First, 10 students were decertified and found ineligible for special education services. Even if the possibility of comorbidity for other psychiatric disorders existed (and many clinicians and researchers struggle to differentiate between conduct disorder and serious emotional disturbances), the school system determined that these students only had conduct disorder. Therefore, because of the definitional exclusion criteria, the students were no longer eligible for special education legal protection. Thus, it was easier for school administrators to expel the students (Loeber et al., 2000). The second situation occurred when initially students with special needs were suspended, and a manifestation hearing was then held to determine the relationship between each student's disability and his or her offense. If the misconduct was related to the disability and the placement was judged appropriate, the student was maintained in the same school environment with special education services. The last situation occurred when the student had ongoing difficulties with school adjustment but

received no special education services prior to the incident potentially leading to expulsion. Active parents or educational advocates argued that the incident needed to be assessed in the context of eligibility for services for emotional disturbances, because there was a pattern of troubling behavior. If the student was found eligible for special education services, the student could then be transferred to a school or class that ostensibly provided therapeutic services and support.

ASSESSMENT OF THREATS

Our knowledge of how to assess threats and the potential for violence is at a fairly rudimentary level. However, the FBI developed important guiding principles after a team of experts carefully analyzed school events in which students killed multiple people (Browne et al., 2001). They offered a perspective on conducting behavioral threat assessments for youth who make threats. The evaluators seek to determine, in their best judgment, the extent to which the student appears to have the resources, intent, and motivation to carry out the threat. Threats are defined as spoken, written, or symbolic (e.g., a school composition or video) and can be direct, indirect, veiled, or conditional (e.g., “If I don’t graduate, then . . .”). High-risk behavior includes direct, specific threats when the student has concrete plans to execute his or her threats. Medium-level threats can be concrete, with descriptive detail, but there are no discernable preparation plans. Low-level threats seem exaggerated, and the student has inconsistent details of the plan (Twemlow et al., 2002).

The information is usually collected from multiple sources—personal interviews, materials created or possessed by the student, and behavioral data about the subject’s motives, interventions, and conduct. The emphasis is on recognizing that violence is often highly dependent on context and specific circumstances, that most children and adolescents are rarely violent all the time, and that these violent episodes have low incident rates with long latency periods between events. When trying to determine if a youngster poses a threat, it is useful to think of the tendency for violence as occurring along a continuum of probability (Tolan and Gorman-Smith, 2000). Violent acts are usually a culmination of long-developing, identifiable problems, conflicts, disputes, and a pervasive sense of failure. The likelihood of violence is not static; that

is, probability changes—either increasing or decreasing—over time. The threat assessment is time limited insofar as there needs to be a mechanism in place to conduct another assessment if there are changing circumstances. Evaluators also need to ensure that the student understands that the assessments are not confidential, that evidence may be used against the student, and that there may be a duty to warn the potential victims.

The FBI investigators emphasize that in the assessment report, it is crucial to prioritize information, not just to report descriptive facts. Sharing the process of how the evaluator judges the combination of risks is more valuable than listing general risk factors; although not the same as case formulation in psychiatry, there are some shared features. It is useful to analyze information in four domains:

1. *Individual traits* describe a wide range of behaviors such as low frustration tolerance, poor coping skills, recent rejection, and signs of depression.
2. *Family dynamics* highlight difficult parent–child relationships, including parents denying their child’s troubled behavior and providing minimal supervision (Twemlow et al., 2002).
3. *School problems* include teasing and a school climate that encourages a code of silence and reinforces bullying behavior.
4. *Community factors* may inhibit or stimulate aggression depending on the availability of guns, immersion in deviant peer groups, and easy access to drugs and alcohol.

In exploring a student’s capacity for targeted violence, the FBI team outlined pertinent questions to clarify the student’s motives and goals (Browne et al., 2001).

- Has there been any communication that suggests ideas or intent to attack?
- Has the student shown deviant fantasies of revenge?
- Has the student engaged in attack-related behaviors?
- How organized is the student’s thinking and behavior?
- Is the student experiencing hopelessness, desperation, or despair?
- Does the student have a trusting relationship with at least one responsible adult?

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- Does the student see violence as an acceptable—or desirable—way to solve problems?
- Is the student’s conversation and story consistent with his or her actions?
- Are other people concerned about the student’s potential for violence?
- What circumstances might affect the likelihood of an attack?

Components of the Case Evaluation Psychiatric Consultation Model

In one of the urban, moderate-sized Northeastern city schools where I currently provide school consultation, a director of special education and superintendent reframe the threat of expulsion for special education students from a negative to a positive experience, as an opportunity for intensive assessment and treatment planning. In this system, the consultant child-and-adolescent psychiatrist conducts from 10 to 20 hours of evaluation and treatment planning per student, including a home visit, interviews with school personnel and mental health service providers, an interview with the student, and presence at the manifestation hearing. This evaluation is delivered in a timely way so as to provide assistance to the special educational team in determining if the student has an emotional disability that contributed to the disciplinary offense. The psychiatrist also provides information about the context of the aggressive episode and offers suggestions for providing extra support to the student. The opportunity for engaging a student and family in treatment is enhanced, as they are often motivated to maintain access to regular education. Although many districts may not be able to afford the financial investment in a psychiatrist’s extensive evaluations, this process provides a unique opportunity to field-test this approach in settings where the school district is significantly committed.

The case-evaluation psychiatric consultation model consists of the following sequential steps:

1. *Informed consent:* The office of special education obtains informed consent from the guardian for the psychiatrist to proceed with the student evaluation. It is critical to clarify who has the authority to initiate the consultation request or referral to the psychiatrist and how the information will be used.

2. *Referral information:* The consultant psychiatrist reviews relevant referral information; for example, report(s) of the incident, the academic transcript and psychological/neuropsychological results, if available.
3. *Contact with school and other professionals:* The psychiatrist talks with the school psychologist, guidance counselor, and other relevant school personnel, probation officers, and therapists, either in person or by telephone.
4. *Student and parent interviews:* Student and parent interviews are conducted at the youngster's house if that is deemed appropriate and safe; otherwise, interviews are conducted at the school-based clinic. The students are usually suspended for the aggressive offense, so it is generally not possible to observe them in their classes. Most students have been very responsive to home visits, and the outreach helps to validate the parents' authority at a time when they may feel disempowered, ashamed, or defensive about their child's behavior.
5. *Report and feedback:* If possible (schedule permitting), the consultant attends the manifestation hearing. The psychiatric consultant also provides a 6- to 10-page written report for the manifestation hearing, with recommendations about treatment and type of educational setting in which the student will perform optimally. The report is not kept in the student's academic file, but rather is stored at the central office of special education, and a report is provided to the school psychologist, who is usually chairing the manifestation determination. A parent can request a copy of the report.

Conditions of the Case Consultation

Usually, the office of special education requests an extensive evaluation for a student when the case is particularly complicated from a diagnostic standpoint, or when the school staff have sufficient anxiety or apprehension about how to proceed. The psychiatrists conducting the evaluations have extensive experience in consulting to the school system (Mattison, 1993). They follow the standard rules of clarifying with who they are consulting and the questions to be addressed. Frequently, the administrators and school psychologists recognize that the psychiatrist is an independent evaluator who is both collaborating with the school to

provide the best treatment and also has the responsibility of identifying areas in which the resources of the school are inadequate to meet the needs of the student. This balance can be challenging and needs to be handled delicately, because the clinician is not providing the evaluation for the student and his or her family but is hired by the school district's office of special education. Therefore, it is critical to inform the parents and the student up front that the consultant will be generating a report that may be used in the manifestation hearing and may impact the eligibility for special education service. Also, it is imperative that the student knows that the evaluation is not confidential and that the psychiatrist may make recommendations about treatment and access to care.

CASE STUDIES

In this section, I present three case consultations and demonstrate the case evaluation process. During the evaluation process, I examine multiple sources of information and interview relevant key informants to illuminate the complex diagnostic and treatment concerns related to potentially violent, aggressive students in school settings. I evaluate the causes and meaning of the students' aggression while taking into consideration the complex factors that contribute to the hostile behavior. I then show how to develop clinical formulations based on the diagnosis and understanding of a student's behavior, and define the need for responsive tailored services.

Throughout the process, I highlight the interface of the consultant with the school personnel, as well as the collaboration and follow-through with the community hospital to optimize access to care and critical transfer of information. Clinicians and educators can be encouraged to increase their level of monitoring and engagement while also designing optimal strategies to enhance at-risk students' functioning and reduce the possibility of disruptive events.

These cases also demonstrate how a psychiatrist can sometimes diffuse an adversarial relationship that may exist between the school and family while still offering pertinent feedback. Often the consulting psychiatrist is in a position to examine the system response to these vulnerable youth and to tactfully encourage subsequent improvements while also recognizing the enormous sustained effort that these students

demand. Recommendations need to be extremely practical and concrete to gain credibility with school personnel, who often need to respond to students' behavior in an immediate way.

Case 1: Jay

Background. Jay was a 13-year-old male with sporadic school attendance in eighth grade. The consultation was initiated because he had displayed increasingly disturbing behavior over the previous several months, with escalating oppositional or intimidating behavior and truancy. Several troubling incidents occurred in which he was allegedly sexually inappropriate. There was a dramatic decline in his hygiene, and he was often seen circulating around the school grounds in a menacing way, even though he was barely attending school.

Individual factors. Jay did not have an early history of violence or aggression and had no known pattern of substance abuse. According to his mother, when Jay was in fourth grade, she began receiving frequent phone calls from his teachers because Jay was "not focusing, was poking other kids, and was not keeping his hands to himself." In sixth grade, Jay stopped liking school and characterized it as "such a struggle." Neuropsychological testing from one year before showed a Full-Scale IQ in the average range. He demonstrated problems with nonverbal reasoning that were consistent with a nonverbal learning disorder. In projective testing, there was no evidence of major disturbance of thinking or reality testing. Jay had started to have nocturnal enuresis in fifth grade, and by seventh grade he would randomly urinate in corners of the house.

Family factors. Jay's behavior declined dramatically when a close uncle died suddenly when he was in fourth grade; following this loss, he stopped doing homework and participating in class. In the five months prior to the evaluation, he had difficulty sleeping, sometimes staying up until 6:00 in the morning playing on the computer, watching TV, and being restless. His mother said that if she set a limit, he would bang on the bedroom doors.

School and peer factors. Jay had multiple aggressive episodes at school. The school psychologist reported that he once approached a

smaller student and cornered him, pulling the boy's hood over his head when no one was around. He punched another student. He had several sexualized episodes in which he grabbed female peers' breasts. Jay seemed oblivious to consequences; for example, he appeared nonchalant when the principal had to call the police because he had wandered off the school campus. Finally, his increasingly frequent absences and deteriorating behavior induced the school to arrange for him to be assessed in the psychiatric emergency room to determine if more intensive interventions would be appropriate. He was assessed as not at risk of harm to himself or others and was discharged.

Treatment history. Jay's family was seen by a social worker during the six months prior to the evaluation. Jay would not agree to see a therapist individually. The social worker focused on helping the mother to stop minimizing Jay's behavior. Jay frequently missed appointments with a child psychiatrist, who prescribed a medication for his agitation and difficulty concentrating.

Case psychiatric consultation. I saw Jay for psychiatric evaluation at the request of the school one week after his emergency room assessment. After reviewing the data and interviewing the school personnel and the parent and student, I agreed with the school personnel regarding the precariousness of this situation. Jay's situation was complex in terms of the differential diagnosis, and he needed additional, comprehensive diagnostic workup. I contacted the psychopharmacologist who was treating him to provide an update about Jay's level of acuity. We agreed that if Jay did not make it to his next appointment (scheduled for the following day), it would be necessary to initiate hospitalization, because he could not be evaluated as an outpatient—and another missed appointment would be indicative that his situation was so chaotic. Because of his bizarre behavior and enuresis, it was also suggested to the psychopharmacologist that it was critical to rule out a brain tumor. Some of Jay's presentation was consistent with bipolar disorder, with the additional information that I had collected—sexualized behavior, agitation during the night, and grandiosity, so I recommended that a mood stabilizer might improve his behavior. I also recommended that Jay not return to his elementary school at this time, because he needed a therapeutic setting where he could be closely monitored.

After a brief hospitalization, Jay was discharged and appeared at his school. He declared that he did not like the way a seventh-grade boy attending his school was looking at his sister, and he made a veiled threat that the next time he returned to the school he would come back with something more than just his hands to settle his vendetta. The principal was concerned that Jay appeared irrational and agitated.

This youngster was caught in an all-too-familiar treatment system gap. He had been discharged from psychiatric hospitalization, yet there was a gap between the hospitalization and the point at which the school could realistically secure an appropriate therapeutic placement. The hospital evaluators noted that although Jay was a potential threat to the community, he did not warrant hospital-level care. The school psychiatrist responded to this quandary by developing an emergency plan with the principal, outlining what to do if Jay came to school with a weapon and also alerting the emergency room and police about the potential danger. When Jay returned to the school campus, the police were called, a knife was found, and he was hospitalized and subsequently placed in a therapeutic residential school.

Case 2: Vic

Background. Vic was a 15-year-old boy who, at the time of the assessment, had been on house arrest for the previous five months, monitored by a tracking device, while awaiting trial for being an accomplice to an assault. The school requested assistance in assessing how safe it would be for Vic to return to school.

According to Vic, he was in the wrong place at the wrong time. He had gone to the park and his friend was involved with a fight. He tried to break up the fight but didn't realize that his friend had beaten another adolescent. Vic returned home, changed his clothes, and then the police arrived at his home. Vic was awaiting trial for being an accomplice to an assault.

Individual factors. According to his therapist, whom Vic had been seeing for about a year, Vic had made a poor decision in leaving the fight, because doing so implied that he was guilty. The therapy focused on helping Vic to identify when he was a follower rather than a leader and also helped him to invest in school. The therapist said that he had not seen Vic act impulsively.

Family factors. Vic lived in a chaotic family situation. He had an older brother with intractable seizures and confined to a wheelchair; Vic was partially responsible for his care. Vic's father was reported to have "drunk himself to death" when Vic was eight. Sometimes his mother had overwhelming anxiety and, according to Vic, "screamed a lot."

School and peer factors. Vic had never repeated a grade. He found math difficult. His mother reported that he had sloppy handwriting that looked like that of a kindergarten child and that he had trouble reading. He spent time with peers who were on probation and, before being placed on house arrest, had often stayed out of the house as late as 2:00 A.M. He had no prior history of aggression at school.

Psychiatric consultation. The consultant was asked to help the school make an informed decision about Vic's potential for assaultive behavior that could harm others—a clinical prediction of risk. The consultant recommended that Vic be allowed to return to school rather than continue to receive home tutoring. Vic knew that, because he was awaiting trial, any threat to another student would most likely lead to his being incarcerated in a juvenile justice facility, something he wished to avoid. He had no prior history of aggression or impulsivity. The fact that he had remained at home, despite a stressful environment, during the five months prior to the evaluation showed that he would abide by rules to avoid an undesirable consequence. The consultant also suggested to the team that Vic needed several changes in school: a more careful assessment of his learning difficulty, access to a vocational curriculum to capitalize on his desire to become a mechanic, and improved school attendance through the assignment of a case manager to monitor his progress. By explicitly supporting Vic's dream to become an auto mechanic like his deceased father, the consultant hoped to reinforce identification with the father's positive aspects rather than the negative substance-abusing pattern.

Case 3: Lana

Background. This case involved a psychiatric consultation concerning a difficult political situation that escalated due to a teacher's inappropri-

ate comments. According to the teacher, three students were having an animated conversation in the hallway, and the teacher admonished them not to use the word whore. One of the students, Lana, thought the teacher had called her a whore, so she put her hands on the chest of the teacher and asked, "What did you say?" When the student proceeded into the classroom, the teacher angrily said to the student, "If you don't stay out of the class, I am so angry that if I had a gun I could shoot someone." In this school, the incident was managed as an assault on a teacher, which meant an automatic 10-day suspension for the student. Lana's mother was informed enough to know that requesting an emergency evaluation to see if her child qualified for special education services could delay the suspension.

Individual factors. Lana had no psychiatric hospitalizations or current symptoms of depression or ADHD. She had no probation officer and had not been arrested. She was involved with multiple after-school activities. Teachers reported that sometimes Lana had trouble listening, but this difficulty always improved if she had an alliance with her teachers.

Family factors. Lana's mother was angry that there seemed to be zero tolerance for her daughter and also felt lied to by school administrators, as if they were trying to cover up the teacher's misbehavior. She recognized that her daughter needed to follow rules and that she shouldn't hit someone first, but she had instructed her daughter to stand up for herself.

School and peer factors. This school was in a process of needed transition, because the principal had difficulty imposing accountability on his staff. Additionally, the teacher had relatively few students in his class because of his difficulty with classroom management. The student was seen as "liking to mind other people's business, but able to be redirected."

Psychiatric consultation. The formulation of this situation was that the consultation request was a request, not so much for a diagnostic evaluation to identify if Lana had an emotional behavioral disorder as for an unbiased assessment of the systemic difficulties that had created a standoff between the school and the parent. Schools can be an arena

where cultural differences are amplified, particularly when there is tension concerning school discipline and codes of conduct. Teachers and administrators can be puzzled by the anger that parents and students may express (Lightfoot, 1978). For example, parents may feel judged or may feel that their child's experience is evocative of their own frustration and struggles in school. Perhaps they transmitted the cultural value that might be right to their child or feel that teachers have unfairly misinterpreted their child and not provided the necessary structure (Anderson, 1994; Delpit, 1995). It is helpful in this type of complication, for the psychiatrist to be familiar with these dissonant perspectives and that he or she find a way to enhance communication between the parents and the school.

Lana could be belligerent, but she responded to structure, accountability, and firmness. Her mother had a keen sense of justice, and her authority would be undermined if the suspension was applied to her daughter and a different standard was administered to the teacher. The emphasis in this evaluation was to create an opportunity to align with the mother in conveying to the daughter that appropriate behavior was expected, but also to acknowledge that the teacher's behavior was not to be condoned, therefore requiring a modification of the standard discipline code. Schools need a graduated system of discipline that communicates the expectation that students are capable of better. The problem with detentions and suspensions are that these consequences do not seem to change the behavior—rather, students return to school usually more defiant and defeated (Mattison, 2000; Atkins et al., 2002; Rhodes, Rappaport, and Reddy, 2003).

Discussion

The three case examples all point to issues that are important to consider and processes that are critical to follow as we develop effective threat assessment models. Jay's bizarre and intimidating behavior and truancy illustrates gaps in the treatment system and the importance of having access to a range of services, Vic's house arrest raises the question of what clinical issues best predict risk, and Lana's interaction with school personnel indicates the difficulties of school system interventions.

Key components of the consultant's role. The consultant has a critical role in each assessment. Some of the key components include the following:

Comprehensive evaluation: A comprehensive evaluation detailing the student's deteriorating behavior will expedite accessing necessary interventions. School information is vital in detailing the student's deteriorating functioning.

Providing support to the school: Demonstrating an appreciation of the educational staff's concerns and helping to mobilize a crisis response provide support to school staff. This support is a critical piece of the assessment process.

Clear expectations: Although a pervasive goal is to maintain a student in the school setting, it is unrealistic to assume that the regular educational setting can always maintain a student safely. It is important to have clear and realistic expectations throughout the evaluation.

Addressing treatment system gaps and accessing services: The consultant can help a principal and treatment team identify and address treatment system gaps. Whereas the need to provide comprehensive and flexible services for a particular type of student is frequently recognized, there are often practical limitations to doing so. Helping to facilitate and access treatment is time-consuming but also a critical response to students who decompensate. Ideally, it is useful to have access to a range of well-coordinated services; however, often the reality is a range of services that are not well coordinated. In Case 1, the consultation about Jay took place with access to a psychiatric emergency room, an inpatient unit, and outpatient services. Such support makes the task less daunting and also allows the clinician to share responsibility with other relevant parties involved in the case. Frequently these complicated patients are in school settings, and accessing a comprehensive, readily available continuum of care can be difficult.

The myth of the teenage werewolf. The first case (Jay) illustrates how reality differs from the myth of the teenage werewolf: the idea that popular media often insinuate of there being minimal warning signs for violent teenagers. In contrast, violent students often have histories of low frustration tolerance, impulsivity, and angry outbursts and do not emerge out of the blue. Adolescents who are at risk often externalize their anger and are less subtle about their agitation. A system examina-

tion about how to monitor these students and provide them with intensive services is critical.

A Therapeutic Intervention: Multisystemic Therapy

Multisystemic therapy employs many different treatment techniques, with an emphasis on flexibility and building on the patient's strengths and interests. It is used with the most difficult-to-treat population and is effective for adolescents with conduct problems (Henggeler, Melton, and Smith, 1992; Mattison and Spirito, 1993). Some school systems are able to access these types of flexible services with some of their most psychiatrically volatile students, if the students have qualifying Department of Mental Health diagnoses and have been hospitalized. But it is still a difficult and anxiety-producing situation when schools are asked to respond to students such as Jay (McMahon and Wells, 1998).

Clinical prediction of risk. Clinically predicting risk, as was the request regarding Vic in Case 2, is difficult. Whereas forensic psychiatrists frequently provide this type of direction in delinquency evaluations, there is very little research on the accuracy of clinical prediction of violence with adolescents (Grisso, 1998). The limits of clinical prediction should be recognized when conducting an evaluation—a clinician should collect information on risk factors, resilience factors, and potential triggers. It is critical that the clinician be able to demonstrate his or her reasoning for assessing the degree of risk that the case poses relative to some population. As Grisso (1998) describes, the approach is similar to forensic evaluations: “I do not know whether this youth will engage in violent behavior, but the risk that it may happen is (greater than, similar to, less than) the risk posed by youths in general in (the relevant setting)” (p. 130).

By emphasizing risk estimates, there needs to be a theoretical understanding of risk factors. Several authors have developed models of risk assessment that can be useful when interpreting information (Borum, 2000; Loeber et al., 2000; Verlinden et al., 2000; Borum, Bartel, and Forth, 2002; Connor, 2002). Grisso (1998) outlines nine critical factors, including past behavior, substance use, peers and community, family conflict and aggression, social stressors and support, personality traits (including anger, impulsivity, and lack of empathy), mental disorders,

opportunity and access to weapons, and future residence (where the student will be attending school). This type of information was utilized in assessing Vic's potential risk and in making the decision that it was relatively safe for Vic to return to school.

School and curriculum modifications. Curriculum and class modifications are often important in developing effective interventions. Connor (2002) promotes a transactional case formulation in which the clinician analyzes how domains influence each other reciprocally to either maintain conduct problems in the identified student (circular causality) or realign to encourage more constructive engagement. Goodness of fit, as defined by the responsive interactions of two systems, suggests that there is an opportunity for growth when there is a good match between the student's capabilities and the expectations of the environment. Students who have difficulty with reading and writing in elementary school often do not receive adequate services in the transition to high school and subsequently demonstrate less motivation because of their chronic struggle in school (Mattison, 1993). Also, students who have not acquired sufficient class credits frequently do not get access to the vocational curriculum, thereby becoming increasingly disengaged. The positive correlation between school engagement and decreased school violence indicates that it is crucial to modify schedules to enhance positive school experiences (Connor, 2002). In Case 2, Vic's move toward technical and mechanical classes supports this theory.

Analysis of school climate. Twemlow, Fonagy, and Sacco (2001) encourage school consultants to expand the diagnostic assessment of a troubled youth to include a thoughtful analysis of the school climate. The school community can tolerate or endorse "a covert power dynamic" (p. 377) or seek to structure dialogue about how a "child, teacher, or other staff member of the school abusively coerces others repeatedly through humiliation and mockery" (p. 377). The most overlooked dynamic in bullying is the role staff members may have in escalating a conflict (Mattison, 2001; Rappaport, 2002). Often administrators, in the interest of being fair, hand out cookbook discipline that does not give students (or staff) an opportunity to be reflective about their actions. The psychiatric consultant cannot only help both administrators and teachers to attend to the valid programmatic approaches to bullying, but can also support administrators and staff in analyzing and

confronting the pathological roles of some teachers who may escalate conflict and alienate students (Olweus, 1993; Walker, Colvin, and Ramsey, 1995). Because classrooms are relatively insulated from observations, only the most vulnerable students may herald the covert power dynamic. In the school that Lana attended, an ineffective principal had provided poor documentation of this teacher's interactions.

CONCLUSION

The three case studies highlight the processes that evaluators must use when assessing violence potential among students. In conducting a comprehensive assessment, it is critical to gather information and evaluate the impact of individual, family school, peer, situational and systemic factors on the presenting situation. Clinicians can then use this information to present an analysis of the potential for violence, identify treatment system gaps and service needs, coordinate care across health and social services systems, and develop recommendations for school and curriculum modifications, as well as recommendations for systemic changes.

This framework is extremely helpful when consulting with teachers and administrators about how to work with troubled students. In a time of increased vigilance about ensuring school safety, psychiatrists at a minimum can provide schools with a differential diagnosis underlying a student's disruptive, aggressive behavior; demonstrate a familiarity with the student's legal rights; and advocate for a measured school discipline response (Mattison, 2000). With a thoughtful, comprehensive, and individualized approach, potentially violent students can be redirected and their environment optimized to support the highest functioning possible. At the same time, it is equally important to advocate for the systemic preventive interventions that make children more resourceful by addressing parent involvement, providing nonstigmatized support, and advocating for students to have structured extracurricular activities and mentoring.

It is an honored position to be allowed to provide school systems with comprehensive evaluations (Goldstein, Harootunian, and Conoley, 1994). The psychiatric consultant can provide a sanctuary for staff—providing clarity and supporting their thinking through difficult, high-stakes decisions. Ultimately, it represents the opportunity to transform

a loosely knit patchwork of school and community-based services into a quilted fabric of comprehensive, coordinated, and integrated services for the benefit of individual students, their families, and the larger school community.

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