Missing the Mark: School consultation-assessing students' potential for violence

By Nancy Rappaport, M.D.

In response to the alarming incidence of school shootings across the nation, administrators and teachers are increasingly more fearful of students' capacity to harm. Most school staff attempt to be more sensitive to threats and more cautious in their responses to students who seem angry or depressed. They search for guidelines to navigate between under or overreacting. Multiple checklists have attempted to fill that need, focusing on a variety of student traits indicating higher risk (e.g. child feels tortured, has above average intelligence, has access to high powered weapons, is obsessed by violence, or overindulges in fantasy through media or video games). Although helpful as general guidelines informing educators about risk factors, these checklists can also convey a false sense of security. According to Mary Ellen O'Toole (special supervisory agent to the Federal Bureau of Investigation), the danger of checklists is that we simply don't have an accurate "checklist profile" of who is at risk of lethal acts of violence until **after** these acts occur.

Many school systems are looking to share their concerns, and the responsibility for identifying potentially dangerous students, with a psychiatrist. Psychiatric consultants are increasingly relied upon not only to educate and support staff, but also to assess students for potential violent acts. In addition, consultants are asked to help make schools safe places for both students and staff.

A clinical vignette may help clarify dilemmas that face school personnel and clinicians.

A student allegedly made a threat to harm specific other students. The school guidance counselor called me and wanted to know whether the security staff should interrupt the principal (who was speaking at a high school assembly). Since the student was in a safe place in an administrator's office, it seemed prudent to first assess the student, and not to overreact by pulling the principal away from the assembly.

A tall stylishly dressed Asian boy, who appeared sullen and awkward, sat slouched in the chair, listening to a Walkman. I pulled up a chair next to him and told him that he was on the hot seat and that I needed him to tell me his story so we could figure out how to make things a little easier. The security person interjected that last year the student made comments about a girl that the student liked which were perceived as suggesting that he could/would rape a girl, which staff took literally but the student dismissed as a "joke" and no action was taken. The student explained to me that the night before while at a sports event, this girl's new boyfriend had threatened him, saying "You touch my girlfriend and you'll be history." On returning to school, the student felt ashamed and concerned that this new boyfriend (who was popular and a star basketball player) might beat him up. He was vulnerable and frightened of this new boyfriend but he did not appear psychotic or at danger to hurt the other students or himself.

After my assessment, I contacted the student's Department of Social Services worker, the court liaison to the school, the student's parent, the school administrator and his outside therapist to arrange a meeting. Although there was momentum from the school to hospitalize him because of staff anxiety, I felt the student was safe to return to school the next day. I encouraged mediation between the two boys and increased visits with his therapist to provide closer monitoring of the student (and more reassurance to school staff).

He is still a student at risk for feeling marginalized and for exhibiting inappropriate behavior, but he has done moderately well in school and continues in therapy. He has had no further school altercations.

Some caveats from this case are:

1 Share responsibility. That is, it helps to share your concerns. The worst situation is a psychiatrist alone; it is best to make these kinds of decisions in collaboration.
2 Be cautious of the myth of the "Teenage Werewolf." Violent students often have histories of low frustration tolerance; impulsivity and angry outbursts and so do not emerge out of the blue. These adolescents are students at risk who externalize their anger and are less subtle about their agitation. More concerning are adolescents who do not necessarily appear obviously distressed and yet may be capable of lethal violence, but this is a much smaller proportion of violent youth.
3 There is a dual message. It is important that school staff neither underestimate students' capacity to harm nor cavalierly assume the students are safe. This can be particularly important with a student athlete, where staff may be optimistic

because school personnel are invested in the student's school contributions and overlook aggressive behaviors. The opposite extreme response occurs when staff become hyper-alert to adolescent verbalizations of anger, which interferes with communication and impairs useful adolescent-staff relationships.

4 With students who require an assessment it is helpful to have everyone's perspective as it is with any high- risk patient. However, students should be given the opportunity to share their perception of events. It is helpful to openly seek to understand the student so that the interview does not feel like an interrogation to the student. Often administrators and teachers are perplexed by the student's behavior. As a school consultant, sharing information with the student's permission and helping school staff to be able to see the student's perspective, can be a very useful step toward collaborative planning with school personnel.

5 A key role as a consultant in these situations is to provide the staff sanctuary, through an opportunity for them to be thoughtful and reflective, while the consultant supports their thinking through difficult decisions (preferably aloud). Frequently these situations are inordinately convoluted and complex, and clarity is critical because the stakes are high.

In talking with teachers and administrators, it is often helpful to provide a framework and validation for how significant their efforts can be with troubled students. With a thoughtful, comprehensive and sustained approach (which can be extremely demanding and time-consuming), potentially violent students can be redirected. James Garbarino in Lost Boys: Why Our Sons Turn Violent and How We Can Save them (1999) provides one of the more helpful narratives of his work with students who "pulled the trigger" and murdered classmates. He outlines how many of these violent boys are neglected, ashamed and depressed. He describes how early vulnerability becomes bad behavior and further how fiercely boys will protect their "code of honor." Too often a sense of injustice escalates to a lethal fight. In consulting to schools, besides providing scientific and psychological understanding about aggressive, violent children, we can also advocate for systemic interventions that make children more resourceful, by addressing parent education, providing non-stigmatized support, "bully-proofing" schools and providing students with structured extracurricular activities and mentoring. As collaborative consultants, we can assist in creating a safe learning space for students and staff and share the responsibility and contain the affect so that educators can make good decisions. ■

Dr. Rappaport is Director of Mental Health Service, Teen Health Center, Cambridge Rindge and Latin High School, and Clinical Instructor in Psychiatry at the Cambridge Hospital, Harvard Medical School.

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by Bernard Hudson, M.D. (Vanderbilt). Addressing the question of the adequacy of the training exposure to psychotherapy, Catherine Fuchs M.D. (Vanderbilt) presented initial data that compare the patterns of practice in the private sector with the patterns of practice in the training program. The goal of the database presentation was to consider the following questions: 1. How does the balance of psychotherapy to medication management in the different practices compare? 2. How do trainees' definitions of psychotherapy vs. medication management differ from the private practitioners'? 3. How do the trends in training, presumably in part due to managed care, affect exposure to a range of disorders? The data, to be presented more fully in the future, suggested that there are differences between the clinic practice of the trainees vs the clinical practice in the private sector; training programs need to address these differences in order to prepare residents for potential opportunities in private practice.

The second half of the day consisted of a discussion of the ongoing work to develop Practice Parameters for Psychotherapy in Children and Adolescents (O'Brien) followed by a discussion of Psychotherapy Outcome Studies by Thomas Catron, PhD (Vanderbilt). Dr. Catron spoke on his psychotherapy outcome research and ways to adapt the mental health center model to explore psychotherapy options. We completed the symposium with a panel discussion titled "The Future of Treatment in Child and Adolescent Psychiatry." The panel consisted of the speakers and the Training Directors from the programs in attendance. The culmination of the weekend was a Mock Board examination. This allowed the faculty to assess the focus of the trainees in their evaluations of the patient. Through that process we could once again affirm the importance of considering the child from a biopsychosocial perspective.

The Consortium offered an opportunity for discussion between faculty and trainees. It was exciting to hear the level of interest in psychotherapy training expressed by all involved. There was discussion among the various programs regarding the constraints of managed care as well as the financial constraints that are affecting training programs nationwide. The trainees made a clear bid for ensuring the integrity of training in psychotherapy. The dialogue offered the opportunity for the training programs to exchange creative ideas regarding ways to integrate the training of psychotherapy into very complex schedules. For example, at Vanderbilt, we are beginning a new program within the Mental Health Center for training of residents in psychotherapy. The decision to enhance the psychotherapy role of the residents is a result of ongoing dialogue with Dr. Catron and myself.

The topic will be continued next year when the Consortium will be hosted by the University of Alabama at Birmingham. It will be held in conjunction with a meeting of the AACAP Psychotherapy Committee, allowing us to expand upon a topic that clearly is of great importance in the future of Child and Adolescent Psychiatry. It is hoped that continued dialogue among these regional training programs can offer support as well as opportunity for creative solutions to problems facing the process of training in the 21st century. ■

D. Catherine Fuchs, M.D. is an associate professor of psychiatry. She also serves as training director of Child and Adolescent Psychiatry at Vanderbilt University in Nashville, Tenn.