



# The unique role and special considerations of mental health professionals on threat assessment teams at institutions of higher education

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## ABSTRACT

Threat assessment has been used in educational settings to assess and manage the risk of targeted violence for nearly two decades, and mental health professionals commonly serve on threat assessment teams. Despite how prevalent threat assessment has become, the extant literature on the psychological factors relevant to the assessment of targeted violence has infrequently distinguished between the types of institutions in which this form of intervention is employed. Furthermore, the unique considerations for mental health professionals on threat assessment teams have received limited attention. The purpose of this manuscript is the following: (a) to review existing research and knowledge regarding mental health and developmental issues prudent for consideration at institutions of higher education and explore the relevance of these findings to the practice of threat assessment, (b) to review professional practice issues commonly encountered by threat assessment professionals at institutions of higher education and establish best practice guidelines, and (c) to define the proper role of mental health professionals who serve on threat assessment teams at institutions of higher education.

## 1. Introduction

### 1.1. The problem of targeted violence in educational settings

Targeted violence is the term commonly used to refer to “situations in which an identifiable (or potentially identifiable) perpetrator poses (or may pose) a threat of violence to a particular individual or group” (Fein, Vossekuil, & Holden, 1995, p. 1). One of the fundamental assumptions of the threat assessment approach is that targeted violence results from an interaction among three distinct factors: (a) the perpetrator of the violent act, (b) a stimulus or “triggering condition” (Fein et al., 1995, p. 3) that leads the perpetrator to view violence as a solution to a problem or concern, and (c) environmental characteristics that facilitate the act. The impact of mental health issues and developmental influences on an individual's risk for violent behavior is most meaningfully understood when considered within the context of these three factors.

Neither mental illness in general nor the socioenvironmental characteristics of institutions of higher education (IHEs) are known to increase an individual's proclivity toward violence. However, when risk-relevant psychiatric symptoms are experienced by an individual who is not receiving psychiatric treatment and is also experiencing acute stressors, such as academic difficulties, occupational failure, or

acculturative stress, the individual's violence risk may increase. When these issues occur within an educational setting that is not well-prepared to share information or act on behaviors of concern, the possibility of a violent outcome is further increased. Understanding an individual's mental health problems and how they attribute the stressors in their life, in addition to the options they perceive as available to address these stressors, results in increased assessment accuracy, improved discernment of potential targets, and more effective strategies to manage risk.

Mental health professionals play an important role on threat assessment teams at primary and secondary schools, as well as IHEs, including universities, two- and four-year colleges, vocational training programs, and other postsecondary educational institutions. Teams formed in adherence with the Virginia model (Cornell & Allen, 2011) ideally include a school psychologist and school counselor, and a comprehensive safety evaluation that takes place in response to a substantive threat requires consideration of the student's mental health. At the postsecondary level, the importance of including mental health professionals on teams responsible for the assessment and mitigation of violence risk has been explicitly recognized in the academic literature (e.g., Dennison & Horner, 2014) and is common practice across the United States. As many as 93% of these teams include a mental health professional, a rate of inclusion as high as nearly any other role (Eells &

Abbreviations: IHE, Institution of Higher Education

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Rockland-Miller, 2011), with some U.S. states requiring the inclusion of a mental health professional by law (e.g., Code of Virginia § 23.1-805[D]). However, participation on a multidisciplinary threat assessment team may pose unique challenges to mental health professionals, as this function requires the consideration of factors less commonly encountered in traditional psychological assessment and psychotherapy. For example, the subject of a mental health evaluation that occurs within the context of a threat assessment investigation may be unwilling to fully participate, refusing to allow access to vital information (e.g., historical mental health records or questions regarding violent ideation) or demanding that disclosures made to the mental health professional be kept confidential. Whether an evaluation of the subject's mental health should be conducted in the absence of potentially relevant sources of information, as well as how and with whom the information may be shared in an evaluation initiated by a third-party are questions more common in the practice of forensic psychology than in traditional clinical practice and have led to the development of specialty guidelines in the forensic domain (American Psychological Association, 2013a). It would appear that these and other questions must be clarified for mental health professionals to act ethically and competently in the domain of threat assessment.

### 1.2. Purpose of this manuscript

Researchers have recently begun to address the critical differences between targeted violence that occurs in IHE communities and acts that occur in other educational settings. This research has predominantly focused on the implications of these differences for the effectiveness of primary and secondary prevention efforts (e.g., Fox & Savage, 2009). However, the existing literature does not address in sufficient detail the risk-relevant psychological characteristics and mental health problems more commonly observed in university communities. Moreover, previous work does not collectively address the issues that may be encountered by psychologists and counselors who participate in IHE threat assessment teams, such as dual-role relationships, confidentiality, and legally mandated reporting. The purpose of this manuscript is to review the current knowledge of college mental health and development as it relates to targeted violence and threat assessment, as well as the accepted standards of practice, to increase the competency of mental health professionals who serve on threat assessment teams at IHEs.

## 2. Historical overview of threat assessment in educational settings

Beginning in the late 1990s, research examining the phenomena of targeted violence in educational settings began in earnest, with a focus on violence occurring in primary and secondary schools. Some of the earliest work to result from the increased interest in school-based targeted violence during these early years consisted of checklists of warning signs for youth violence (e.g., American Psychological Association, 2013b; Dwyer, Osher, & Warger, 1998) that essentially comprised profiles of students believed to be at-risk for committing violent acts at school. However, in the years following this early work, there has been scant evidence demonstrating that students at a high-risk of violence may be validly and reliably identified using profiling-based approaches, as well as evidence to the contrary (Burns, Dean, & Jacob-Timm, 2001). An alternative focus on empirically derived clinical and contextual risk factors yields significant advantages over profiling in both the assessment and management of targeted violence risk, as profiling suffers from low specificity in identifying high-risk students in large populations (Borum, 2000). Over time, threat assessment in educational institutions has become more consistent with the model initially developed and promulgated by the United States Secret Service and the United States Department of Education, and the research methodology has significantly improved. This is evident in the research of Dewey Cornell, for example, who has reported on a large-scale

implementation of the Virginia model for student threat assessment, which included over 32,000 students distributed throughout 40 primary and secondary schools (Cornell & Allen, 2011). Beyond the successful identification and mitigation of violence risk, studies have also shown ancillary decreases in bullying and an improved school climate in primary and secondary schools that have adopted threat assessment guidelines (Cornell, Sheras, Gregory, & Fan, 2009).

Primary and secondary schools share many characteristics with postsecondary institutions, including a focus on academic pursuits, physical campuses composed of classrooms and offices, and many young students relative to a generally older instructional and administrative staff. Beyond these commonalities lie many risk-relevant differences between the physical settings of these institutions and the characteristics and behaviors of the individuals who work, teach, and learn there. For example, the differences in age and independence between K-12 and postsecondary students are relevant considerations when assessing and managing violence risk across academic settings. In a study of nine notable primary and secondary school shootings that occurred between 1997 and 2000, Verlinden, Hersen, and Thomas (2000) reported that many, if not all, of the student shooters were inadequately supervised by their guardians and had troubled family relationships. Parental supervision, a characteristic of the student's environment that decreases violence risk, can be meaningfully assessed and potentially increased in younger students; however, it is far less relevant for older IHE students who more commonly live apart from their former guardians. A second important point is that this normative decrease in parental supervision among IHE students limits the generalizability of this research finding to an older group of students and the interventions upon which they are based.

In addition to the differences between the characteristics of individuals who attend primary and secondary schools and postsecondary institutions, there are differences in the permissible practices and dispositions available for addressing violence risk in these settings. For example, counselors and psychologists at primary and secondary schools may wish to contact the student's legal guardian to obtain additional information and collaboratively design and implement a plan when a student is determined to pose an increased risk of violence. While ethical guidelines and laws pertaining to confidentiality vary across states, provider disciplines, and client age, it is often legally permissible to discuss information disclosed by a young student in a counseling or therapy session with the legal guardian. In an IHE setting, where students have overwhelmingly reached or surpassed the age of majority, contact by the treating professional and disclosure of treatment records are more likely prohibited in the absence of written consent to release this information.

The differences that exist between primary or secondary schools and IHEs affect how threats of targeted violence are assessed and managed; however, even among IHEs, a considerable amount of variability exists. Universities differ from community colleges and vocational schools in their size, physical characteristics, and resources. In a study of how IHEs in the state of Virginia respond to student mental health crises, Monahan, Bonnie, Davis, and Flynn (2011) reported substantial variation in the type of interventions used by four-year private colleges, four-year public colleges, and two-year community colleges; they reasoned that this variation may be partially attributable to the staff-to-student ratio in student affairs offices, which are higher at private institutions, and the availability of on-campus mental health services, which are relatively uncommon at community colleges. Alternatively, differences in the rate at which interventions are used may reflect variability in the characteristics of students who attend these institutions and the problems and strengths that they possess. For example, students who attend four-year colleges and universities after a history of success during high school may be more likely to possess well-developed academic and social skills and a developmental capacity referred to as self-authorship (Warwrynski & Pizzolato, 2006), factors that may be important to understanding the changing landscape of violence risk across time and

educational institutions. This variability may be contrasted against the relative homogeneity of primary and secondary schools with regard to factors not limited to student age, geographical catchment area, and physical setting. Overall, it may be concluded that while scholarship pertaining to targeted violence in primary and secondary schools may provide insights into effective means of assessing and managing targeted violence in postsecondary institutions in general, the differences between these settings may have a critical impact on the effectiveness of threat assessment methods.

As recently noted by other authors (e.g., Bondü & Beier, 2015), much of the research on targeted violence and the management of violence risk in educational settings has not differentiated primary and secondary schools from postsecondary institutions, and the literature often does not distinguish between the types of IHEs. The study of threat assessment practices specific to IHEs increased dramatically following the April 16, 2007, shooting at Virginia Tech and the February 14, 2008, shooting at Northern Illinois University. Based on the recommendations made in the Report to the President on Issues Raised by the Virginia Tech Tragedy, collaborative research involving the United States Department of Education, Secret Service, and Department of Justice was undertaken (Drysdale, Modzeleski, & Simons, 2010). There is evidence that the use of threat assessment practices at IHEs also increased; Giblin, Burruss, and Schafer (2008) reported that between 40% and 50% of colleges created threat assessment teams following the Virginia Tech shooting. The increased focus on IHE threat assessment may also reflect increased recognition of the greater likelihood of targeted violence at IHEs relative to other educational institutions, with recent studies reporting that IHEs are four times more likely than primary and secondary schools to be targeted by individuals intending to kill one or more individuals for reasons related to the educational institution or its members (Bondü & Beier, 2015). The broad acceptance of threat assessment practices has resulted in their use required by law in several jurisdictions. For example, the State of Virginia requires “a committee structure on campus of individuals charged with education and prevention of violence on campus” at each public college or university in the state (Virginia Code § 23-9.2:10). The Virginia statute also identifies required disciplines that must be represented on the committee, including student affairs, law enforcement, human resources, residence life, and counseling services. It has been argued that the practice of threat assessment is required by the legally mandated duty of IHEs to supervise and protect their students as established by state statute and case law in some jurisdictions, such as *Jain v. State of Iowa* (Dennison & Horner, 2014).

### 3. Extant literature and law relevant to the practice of mental health professionals on threat assessment teams at institutions of higher education

#### 3.1. The impact of mental health issues on risk of targeted violence

IHE students commonly experience mental health issues that run the gamut of psychiatric nosology. Among students surveyed as part of the American College Health Association National College Health Assessment II (American College Health Association, 2013), > 30% of students reported feeling “so depressed that it was difficult to function” within the year prior to being surveyed. Seven percent of students reported they had seriously considered suicide and 1.5% of students reported they had attempted suicide in the year prior to being surveyed. Anger directed toward other individuals was also found to be common in this population, with approximately four in ten students (37%) reporting they had experienced “overwhelming anger.” These findings are supported by other studies that report high levels of mental health issues among IHE students (e.g., Soet & Sevig, 2006). Despite the high prevalence of emotional states characterized as “overwhelming” and reported to cause functional impairment, < 25% of students reported having been diagnosed or treated by a mental health professional for a

mental health condition. Clearly, a substantial number of IHE students are not receiving adequate psychological evaluation or treatment.

Mental health issues may contribute to what Levin and Madis (2009) termed chronic and uncontrolled strain in their theoretically-based study of school shootings. They proposed that chronic strain results from long-term stress and frustration across life domains, which leads to social isolation. Uncontrolled strain is the result of social isolation in the absence of a prosocial support system, which increases the likelihood that a stressful event will be perceived as devastating and serve as a stimulus for violent behavior. The authors do not focus specifically on mental health issues; however, psychological disorders commonly contribute to stress, social isolation, and impede the successful negotiation of challenging situations, as described in their model. Notably, the sequential model proposed by Levin and Madis is consistent with the conceptualization of targeted violence as the result of a pathway of behaviors and ideas that is often triggered by an acutely stressful event.

#### 3.1.1. Schizophrenia and other psychotic disorders

A substantial amount of research examining mental illness and violent behavior has been conducted over the past 30 years and collectively points to a complex relationship. Although the lifetime prevalence for violence among individuals with serious mental illnesses (e.g., psychotic disorders or severe affective disorders) has been found to be twice that of individuals without serious mental illness, > 80% of individuals with serious mental illness do not engage in violent behavior, and many other types of mental illness are unassociated with violence risk (Swanson, 1994). Stompe, Ortwein-Swoboda, and Schanda (2004) reported a significantly increased risk of severe violence associated with delusional beliefs of being under the threat of harm and override of self-control by other individuals, which Link and Stueve (1994) termed “threat/control-override symptoms” (p. 143). Furthermore, substance abuse, impulsivity, and noncompliance with antipsychotic medication may exacerbate the risk of violence among individuals with schizophrenia (American Psychiatric Association, 2013). In an attempt to develop a typology of rampage school shooters using a sample of 10 perpetrators for whom adequate background information was available, Langman (2009) noted that half of the perpetrators had been diagnosed with some form of psychotic illness, with paranoia being among the most common psychiatric symptoms. He categorized these perpetrators as “psychotic” and noted that they did not experience physical or sexual abuse, parental substance abuse, or parental incarceration common to other student perpetrators who he categorized as “traumatized” and “psychopathic.” It is noteworthy that all but one of the perpetrators in this study were enrolled in primary or secondary schools at the time of their attack. More recently, research was completed that analyzed the diaries and online materials produced by a subset of mass shooters largely composed of perpetrators of school and campus shootings (Dutton, White, & Fogarty, 2013). It was reported that these perpetrators exaggerated the occurrence and severity of the negative social treatment inflicted on them by other individuals, and they may have viewed their violent acts as a means of righteous vengeance against the individuals and groups whom they identified as having persecuted them. The authors concluded that the perpetrators' views in this regard were consistent with paranoia and noted that surviving perpetrators are often diagnosed with schizophrenia following the attack.

The limited research that specifically addresses mental health issues and targeted violence at IHEs suggests that mental health issues may play a greater role in postsecondary student perpetrated targeted violence than it does in attacks by younger offenders. Newman and Fox (2009) examined rampage shootings that occurred in American secondary schools and IHEs between 2002 and 2008. They reported that five factors previously identified in secondary school shootings that occurred between 1974 and 2002, including social marginalization, individual risk factors, cultural scripts, availability of weapons, and

poor monitoring for troubling behavior, were also found in more recent secondary school shootings. When compared to shootings that occurred in IHE settings, they found that the role played by serious mental illness was clearer among offenders attending IHEs relative to students who had not yet graduated from high school.

### 3.1.2. Depression and suicide

Just as the overwhelming majority of students who experience paranoid and persecutory beliefs will not act violently toward other individuals, depressed and suicidal students are generally unlikely to engage in violence toward others. Nevertheless, a considerable number of students who have perpetrated shootings at secondary schools and IHEs have committed suicide during or immediately following the commission of their act, leading to the examination of the relationship among depression, suicidality, and targeted violence.

Within the paradigm of “suicide with hostile intent,” Preti (2008) found that perpetrators of shootings at U.S.-based secondary schools and IHE campuses commit suicide in 40% of incidents, with an even higher suicide rate among their European counterparts. Reporting specifically on “directed assaults” at IHEs, Drysdale et al. (2010) indicated that 30% of perpetrators attempted or completed suicide during the incident or within the subsequent days. Subsequent research (Bondü & Beier, 2015) showed an even higher frequency of suicide completion (37.8%) among perpetrators of targeted violence at IHEs, which indicates this group is between three and four times more likely to attempt suicide than perpetrators of targeted violence at primary and secondary schools according to some estimates.

The United States Secret Service School Safety Initiative (Fein et al., 2002; Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002) found that many primary and secondary school shooters had previously considered or attempted suicide, which suggests that suicidality among student shooters may begin well-prior to the actual violent act. Lankford and Hakim (2011) discuss low self-esteem as a common factor between rampage shooters in the United States and volunteer suicide bombers in the Middle East. They argue that despite the portrayal of many shooters in the media as self-glorifying and arrogant, substantial evidence suggests that these individuals experienced profound feelings of worthlessness, a well-established symptom of depression. For these individuals, the violent act is viewed as a method by which they may receive recognition, even if this recognition occurs after their death. Among students who threaten to perpetrate a massacre at school in the wake of an incident of targeted school violence, so-called copycat offenders, research has shown that the majority experience symptoms of depression and almost half report suicidal ideation or a suicide plan (Lindberg, Sailas, & Kaltiala-Heino, 2012). The high rates of depression and suicidality among adolescents in this study along with high rates of externalizing disorders and positive attitudes toward violence led the authors to characterize these students as “severely disturbed.” These adolescents presented with symptom severity matching outpatient and inpatient psychiatric control groups, and the authors argued that psychiatric evaluation of these individuals is warranted. Together, these findings suggest that depression and suicidality may increase the risk of targeted violence among a subset of students with conduct problems and antisocial beliefs, although it is not clear whether this relationship persists into early adulthood.

## 3.2. Lifespan development and influence on risk for targeted violence

### 3.2.1. Psychosocial development in adolescence

Peer relationships are important to mental health and physical well-being across the lifespan. These relationships are of particular importance during adolescence, a time period during which identity formation occurs. Important aspects of an individual's identity, including reputation, affiliation, and self-esteem, are developed and determined through the adolescent's relationships with the individuals in his or her peer group, as well as the peer group as a whole (Erikson, 1968;

Newman & Newman, 1976). For many secondary school students, peer popularity and acceptance are viewed as the paramount metrics of life success. Because of this importance and the overwhelming focus on identity formulation during adolescence, perceptions of failure in the social domain may be disproportionately detrimental to the adolescent relative to older individuals. Research lends credence to this idea; studies that examined targeted violence within primary and secondary schools have repeatedly found that youth perpetrators of these incidents feel socially isolated from the mainstream peer group and bullied or otherwise persecuted (Lenhardt, Farrell, & Graham, 2010; Vossekuil et al., 2002). Similarly, research has found that detachment from the school community and feeling alienated from peers increases violence risk among adolescent students (e.g., Borum, 2000; Dwyer et al., 1998). The more limited research on targeted violence in IHE communities has not found that bullying plays a significant role in shootings at the postsecondary level.

Primary and secondary school shootings are predominantly perpetrated by adolescents in a developmental period that Erikson (1968) characterized by a search for identity. For socially marginalized students, violence targeting individuals viewed as responsible for their mistreatment and poor social standing may be understood as a way to obtain justice for perceived wrongs, enact revenge, and acquire a higher status and fame (Preti, 2008; Verlinden et al., 2000). Lindberg et al. (2012) reported that among Finnish adolescents who underwent psychiatric hospitalization after threatening to perpetrate a shooting at their school, most of the adolescents believed a massacre would be a justifiable act of revenge against school peers who had wronged them. It has been suggested that the so-called “copycat effect,” whereby violent behavior and threats thereof increase following the media coverage of similar violent acts (O'Toole, 2000), can be understood as the adoption of an imposing public image as one's individual identity by at-risk students (Sacco & Larson, 2003). The influence of the copycat effect can be profound; at least 350 students were arrested in the four weeks following the April 1999 shooting at Columbine High School for making threats of or engaging in targeted violence at school (Drummond & Portner, 1999). Moreover, this phenomenon does not appear to be specific to American culture; in the wake of the November 2007 Jokela school shooting and the September 2008 Kauhajoki school shooting, threats recorded by Finnish police increased tenfold (Lindberg et al., 2012).

Lankford and Hakim (2011) have suggested that many adolescent and young adult rampage shooters, especially those who have not experienced social or academic success, seek fame and glory through their actions. This motivation may be even more relevant in what Brown, Osterman, and Barnes (2009) termed “culture of honor” states, where a greater emphasis is placed on social regard and strength with regard to one's person and reputation; school shootings have occurred three times more often in these states. This relationship was shown to persist even after controlling for confounding variables, including contributing factors to social and economic instability, such as poverty levels and unemployment. School violence, when viewed within the context of these findings, has been explained as “retaliatory aggression springing from intensely experienced social-identity threats” (Brown et al., 2009, p. 1400). The authors report that 63% of shootings occurred at high schools, with fewer shootings occurring at elementary or middle schools (23%) and even fewer shootings occurring at colleges or universities (13%), which suggests that the relationship between culture-of-honor and risk for targeted violence may weaken as students leave a developmental period predominantly characterized by an emphasis on identity / role confusion.

### 3.2.2. Psychosocial development of students and older faculty and staff at institutions of higher education

Most students who matriculate at an IHE soon after graduation from secondary school continue to experience significant concern regarding social acceptance and peer relationships in their first college year

(Weathersby, 1981). This concern is, perhaps, more pronounced for students attending an IHE far removed from the social support networks they previously relied on. The importance of comfort and reassurance obtained from peers during the transition to college is recognized by Jackson and Finney (2002), and social acceptance may serve as a protective factor against violent behavior insofar as supportive peer relationships decrease forms of negative emotionality, including anger, fear and stress. However, as the IHE student progresses, peer relationships and peer group acceptance lose some degree of salience and influence on the individual's adjustment and they become increasingly better able to choose their beliefs, formulate their identity, and define social relationships irrespective of the judgments and behavior of their peer group, a developmental capacity referred to as "self-authorship" (Magolda, 2008).

While student perpetrators of primary and secondary school shootings are frequently observed to be victims of bullying and social marginalization by their peers, this appears to be less frequently the case among IHE perpetrators. Fox and Savage (2009) have reported that active shooters at IHEs are often "overworked, overstressed graduate students confronting academic failure or disappointment" (p. 1466). In support of this assertion, they report that of 14 campus-based mass casualty incidents they examined, over half were committed by current or former graduate, law, medical, or nursing students, with the remainder of these incidents committed equally by undergraduate students and community outsiders. A similar idea was presented by Bondü and Beier (2015), who hypothesized that the overrepresentation of older students in acts of targeted campus violence, comprising one-third of all perpetrators by their estimate, can be understood as a result of greater stress relative to their younger counterparts, due to older students' greater investment in their academic endeavors. These findings are increasingly relevant given the advancing age of IHE students; in 2006, it was estimated that approximately 40% of college students in the United States were self-supporting adults, 24-years-of-age or older (Spellings, 2006). For foreign students, the acute stress of academic failure is compounded by the impact this failure would have on the foreign student's ability to legally reside in the country in which they are studying. Regarding graduate students, Fox and Savage (2009) have written:

Their personal investment in reaching a successful outcome can be viewed as a virtual life-or-death matter. This perception can be intensified for foreign graduate students from certain cultures where failure is seen as shame on the entire family. Foreign students also experience additional pressures because the academic visas allowing them to remain in this country are often dependent upon their continued student status. (p. 1475).

Consistent with the idea that foreign students experience increased pressure related to academic success, Newman and Fox (2009) have reported that students engaging in targeted violence in IHE settings were six times more likely to have a migration history than students engaging in targeted violence at primary and secondary schools.

In contrast to empirical findings that suggest targeted violence in IHE settings is most often perpetrated by current and former graduate students, Drysdale et al. (2010) found that graduate students comprised only 18% of subjects who engaged in "directed assaults." However, they identified differences between these older students and their younger, undergraduate counterparts. Graduate students were more likely to carry-out actions resulting in incidents with multiple victims. With regard to social influences, students who cause multiple casualty incidents at IHEs are often more similar to adults who perpetrate rampage shootings at the workplace in that they are socially isolated outside of their workplace and school commitments. This may be especially true of international students who are far removed from the protective influence of family and friends. Several authors (Heilbrun, Dvoskin, & Heilbrun, 2009; Levin & Madis, 2009) have suggested that social isolation in the absence of the external controls and support provided by

family and friends may contribute to deterioration of the student's mental health, as well as potential movement toward a violent solution to his or her problems. It is important to note that in most instances in which the IHE perpetrator experiences social isolation, it does not appear to be the result of peer victimization as is often the case in primary and secondary school violence perpetrators.

Current and former students have been identified as the perpetrator in 60% of campus attacks (Drysdale et al., 2010). This predominance may explain why research on targeted campus violence has focused on the assessment and management of risk posed by students, often excluding from analysis incidents perpetrated by faculty, staff, and individuals from the surrounding community (e.g., Bondü & Beier, 2015). An overwhelming focus on students may limit our ability to assess and intervene in high-risk situations involving current and former employees and individuals in personal relationships with students and employees, groups that have comprised 10% and 20% of past perpetrators, respectively. Attackers from these groups appear more frequently motivated by romantic discord and employment disputes rather than by social-identity issues and academic failure. Drysdale et al. (2010) reported that the campus attackers they studied overwhelmingly experienced a triggering event, such as workplace failure or dissolution of a romantic relationship, and one-third of attacks appeared related to an intimate relationship.

### 3.2.3. Student cognitive development

According to William Perry, one of the preeminent theorists of college student development, students naturally progress from a dualistic way of viewing the world, characterized by rigid, concrete values (e.g., right v. wrong or good v. bad) that are often based on stereotypes and limited consideration of the perspectives of other individuals, to a more relativistic view, in which students possess strongly held values that are nonetheless subject to change based on a respectful consideration of the views and values of other individuals. Student development as conceptualized by Perry is not strictly unidirectional; students may regress from a relativistic view back to a more dualistic view, and importantly for the purpose of violence risk assessment, this regression may occur during periods of crisis and increased stress, as well as in response to alienation from other individuals and anger (Perry, 1970). Brown and DeCoster (1989) have suggested that students with a dualistic way of viewing the world are at increased risk of engaging in violent behavior and reaching what Pezza and Bellotti (1995) referred to as "last resort responses." The authors reasoned that students holding concrete views are limited in their ability to engage in perspective taking and generate nonviolent behavioral responses, resulting in an increased potential for violence.

Along with Perry, Arthur Chickering has arguably made the most significant contributions to our understanding of college student development. According to his theory (Chickering & Reisser, 1993), college students progress through "vectors," periods of focus on developmental tasks (e.g., developing self-regulation in place of repression or outburst when experiencing anger and other unwanted emotions) in a stage-like progression. Similar to Perry before him, Chickering believed that regression to earlier vectors may occur, especially when earlier assumptions are challenged by new experiences and learning. Chickering's second vector, which he termed "managing emotions," has been recognized as particularly important in the assessment and management of concerning student behavior (Dennison & Horner, 2014). Younger students and students who experience high levels of stress may be less likely to possess the skills necessary to exercise behavioral control in the face of extreme anger, sadness, and other strong emotions. This vector may have clear relevance for understanding the genesis of impulsive aggressive behavior, particularly among younger students who have been shown to be more likely to engage in such behavior. Moreover, the assessment of verbal and written threats may be vastly improved when considered within the developmental context of the individual making them, especially when the individual appears

to be under significant emotional distress. However, the relevance of Chickering's second vector is less clear for understanding targeted violence, a behavior more often the result of controlled, careful planning over an extended period of time. A comprehensive review of Chickering's theory is beyond the scope of this manuscript; however, vectors four and seven, which focus on developing mature interpersonal relationships and integrity, respectively, have also been suggested to have relevance for assessing the risk for campus violence (Dennison & Horner, 2014).

### 3.3. Ethical and legal issues facing mental health professionals on threat assessment teams at institutions of higher education

Campus mental health professionals face many of the same challenges involving confidentiality and professional boundaries that are faced by those who practice in other settings; however, these challenges may be more pronounced due to the characteristics of IHE communities and the role of mental health professionals therein. Spiegel (1990) referred to these challenges, as well as the negative consequences experienced by therapists who properly uphold their obligations, as "strains on confidentiality," and they are common in what Schank, Helbok, Haldeman, and Gallardo (2010) have termed "small-community practices." The campus mental health professional is often a student's therapist in addition to the colleague of the student's administrators, instructors, and advisors, who may have referred the student for therapy services. Psychologists, specifically, are admonished for entering into multiple relationships such as these, although they are ethically permissible so long as they "would not reasonably be expected to cause impairment or risk exploitation or harm" to the patient (American Psychological Association, 2002). Even under circumstances where these relationships are ethically permissible, campus mental health professionals are often placed in difficult situations when, for example, faculty colleagues and administrators request confidential details regarding students who they referred for therapy, to which these referral sources often believe they are entitled to (Schank et al., 2010; Sharkin, Scappaticci, & Birky, 1995).

In his work on confidentiality in college-student psychotherapy, Sharkin (1995) addresses the issue of balancing the needs of the IHE community and the rights of the individual clients. He indicates that when an individual is disruptive to the functioning of the IHE and its community members, the campus mental health professional may be called upon to "manage anxieties within the campus community" (p. 187). This managing of anxieties may occur through the provision of psychoeducation to faculty members and administrators regarding expectations of students with a mental health condition, informing them of the availability of campus mental health services, and providing strategies for managing behavioral issues. When the individual causing the disruption is receiving therapy services from the mental health professional, however, activities that are intended to benefit the IHE community may be contrary to the rights and best interests of the client (Arnstein, 1986). Consider the difficulties inherent in educating IHE community members about the behavioral expectations of a student with a psychotic disorder in response to disruptive or disturbing behavior without violating confidentiality by revealing the nature of the client's diagnosis and other information that is protected by privilege.

Ethical guidelines provide a guide to proper conduct for mental health professionals, whereas state statutes and case law governing the practice of mental health care define what is legally permissible and defensible. The circumstances under which a mental health professional is allowed or mandated to breach confidentiality to warn or protect are of particular relevance to IHE mental health professionals. Johnson, Persad, and Sisti (2014) highlight numerous barriers that mental health professionals face to the proper discharge of their responsibility to warn or protect a potential victim. One of the most significant barriers stems from the absence of prevailing federal statutes and federal case law defining the duties of a mental health professional. Rather, these duties

are established by the states, and substantial interstate variation exists in how they are defined. The authors report that while 23 states have a legislative statute that establishes a mandate to warn or protect potential victims, this mandate is established instead through legal precedent in ten states. In eleven states, a mental health professional is permitted, but not mandated, to warn or protect the intended victim of danger posed by a client. In the remaining six states, the circumstances in which a mental health professional may warn or protect the intended victim of a client at high-risk of acting violently are not addressed in common law or statutory law, and no duty-to-protect for mental health professionals has been established.

Among states that establish a mandate or allow a breach of confidentiality, Johnson et al. (2014) identify numerous sources of variability, including the nature and severity of the risk required to justify breaching confidentiality, as well as the disciplines of providers addressed in duty-to-protect statutes and case law. To understand how this variability can impact the work of IHE threat assessment professionals, consider how information obtained through a mental health evaluation conducted by a psychologist as part of a threat assessment investigation is treated differently in California and the neighboring state of Arizona. California Evidence Code Section 1014 establishes the privilege of a patient to "refuse to disclose, and to prevent another from disclosing, a confidential communication between patient and psychotherapist." Exceptions are created in state case law (*Tarasoff v. Regents of University of California*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14; *Ewing v. Goldstein*, 13 Cal. Rptr. 3d 864) and statutory law (e.g., California Evidence Code Section 1024), which allow the disclosure of confidential information to a victim or law enforcement as necessary to protect an intended victim from harm and when there exists "reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger." In California, "patient" is statutorily defined as a person examined by a psychotherapist "for the purpose of securing a diagnosis or preventative, palliative, or curative treatment or his mental or emotional condition." Defined in this manner, it could be argued that the subject of a mental health evaluation conducted for the purpose of a threat assessment investigation is not a patient, as the purpose of the evaluation is not to secure a diagnosis or receive treatment for a mental or emotional condition; thus, no patient-psychotherapist privilege exists.

The state of Arizona similarly establishes a psychologist-client privilege, holding that "a psychologist shall not voluntarily or involuntarily divulge information that is received by reason of the confidential nature of the psychologist's practice." Moreover, similar to California, Arizona case law establishes a mental health professional's duty "to exercise reasonable care to protect the foreseeable victim of ... danger" (*Hamman v. County of Maricopa*, 161 Ariz. 58, 775 P.2d 1122 [1989]). A critical difference between these states lies in the definition of a "patient," which Arizona defines simply as "a person who receives psychological services." This more inclusive definition increases the likelihood that the subject of a mental health evaluation conducted as part of a threat assessment investigation would be considered a patient and thus hold privilege. Therefore, disclosure of information obtained from the subject of concern by the mental health professional on a threat assessment team may be argued to constitute a violation of Arizona state law (Arizona Revised Statute §32-2085) regarding confidential communications between a patient and psychologist. Given a recent finding by the Arizona Supreme Court that allows patients to seek civil damages from mental health professionals who breach confidentiality even when a harm is threatened by the patient, mental health professionals on threat assessment teams in Arizona are more restricted than their counterparts in California regarding the circumstances under which they may share information obtained from the subject of concern.

Currently, no federal statute or federal case law has established

rules governing confidentiality and privilege between a client and his or her mental health care provider. Federal laws do, however, establish constraints upon the release of information obtained in healthcare and educational settings. The Family Educational Rights and Privacy Act (FERPA) applies specifically to educational institutions that receive funding from programs administered by the United States Department of Education and is therefore unique to threat assessment teams that operate in educational settings. FERPA provides students 18 years of age and older, as well as the parents of dependent children, the right to review and inspect education records, control their release, and request amendments to misleading or inaccurate records. Education records are broadly defined in the statute to include “records, files, documents, and other materials which contain information directly related to a student and are maintained by an educational agency or institution or by a person acting for such agency or institution” that have not been waived by the student in writing or meet several exclusionary criteria specified in the statute. For example, materials created and maintained by a law enforcement unit or liaison and used for law enforcement purposes would be most aptly classified as law enforcement unit records and thus exempt from the regulations set forth in FERPA. Student treatment records created or maintained by a health care provider for the purpose of treatment, including mental health care, are exempt, although; however, the release of these records is governed by a combination of ethical guidelines, state laws, and the Health Insurance Portability and Accountability Act (HIPAA) as subsequently discussed. Parents of dependent students may access information contained in education records, as well as school officials with a legitimate educational interest.

An important consideration that must be understood by IHE threat assessment professionals is that FERPA specifically addresses the release of recorded information. This provides IHE staff, including members of the threat assessment team, substantial flexibility to discuss concerns with third-party individuals, such as parents and mental health care providers, when information is based on the reporting staff member's observations and interactions and not otherwise prohibited by other regulations. Moreover, in health and safety emergencies, the prudent disclosure of educational records is permissible when this action is “necessary to protect the health and safety of the student or other persons.”

HIPAA, similar to FERPA, is federal law, although it was passed into law over 20 years later in 1996. Through the regulations set forth within the HIPAA statutes, requirements and standards for safeguarding information that falls within the classification of “protected health information” are established. Within the context of postsecondary educational institutions, protected health information most often includes information created or maintained by a healthcare provider related to past, present, and future physical and mental health conditions through which the individual receiving treatment can be identified. HIPAA imposes additional restrictions on the release of protected health information without the written authorization of the patient, although the Privacy Rule only applies to covered entities and programs operating within hybrid entities that would meet the definition of a covered entity if they operated independently. Whether a provider may be considered a covered entity is dependent on whether the provider conducts “covered transactions,” the transmission of information and healthcare-related requests electronically. Determining whether the campus healthcare provider conducts these types of transactions is critical, as HIPAA regulations have no bearing on the many campus health clinics and mental health providers that do not electronically transmit health information and therefore would not be considered covered entities. Even when a campus healthcare provider is a covered entity under HIPAA, student treatment records and “educational records” under FERPA are expressly excluded from the release restrictions set out in HIPAA. [Wise, King, Miller, and Pearce \(2011\)](#) warn that misapplying HIPAA to records that would most aptly be designated treatment records under FERPA could result in their conversion to education records, inadvertently allowing IHE staff with a legitimate educational interest to

access confidential records without the student's consent to release information. The authors also assert that this misapplication would constitute a violation of federal law. Similar to FERPA, HIPAA allows the disclosure of protected health information without written authorization when a provider acting “in good faith” discloses information to individuals and agencies able to address or prevent “a serious and imminent threat to the health and safety of a person or the public.”

Collectively, FERPA, HIPAA, state laws, and ethical codes help shape the role mental health professionals may play on IHE threat assessment teams and delineate appropriate information sharing under a wide range of circumstances. The rules that govern the release of information are complex and highly nuanced, and this manuscript provides a high-level overview of the issues most pertinent to IHE threat assessment professionals. Moreover, the Americans with Disabilities Act, Rehabilitation Act of 1973, and other disability laws separately address accommodations and the prevention of discrimination toward individuals with impairments that include certain mental health issues. Although many mental health professionals are well-versed in these statutes, they may be more effectively handled by a disability specialist or the IHE legal counsel and are not addressed in this manuscript. Interested readers are directed to an excellent review of the recommended considerations of disability law for threat assessment teams authored by [Dunkle, Silverstein, and Warner \(2008\)](#).

#### 4. Discussion

The demands placed on mental health professionals serving on IHE threat assessment teams are different from the demands of professionals who primarily work in university counseling centers and other treatment settings, and the management of targeted violence in IHE settings requires unique considerations. The purpose of this manuscript is to review literature from various domains, including threat assessment, psychology, development, and the law, to better understand the nature and impact of these differences. [Cornell \(2009\)](#) provides an excellent, high-level overview of many of these differences within his report detailing the recommended practices for college threat assessment in the state of Virginia. The present manuscript goes a step further by defining the role of mental health professionals in this unique function, exploring implications for clinical practice, and establishing best practice guidelines.

##### 4.1. Defining the role of mental health professionals on IHE threat assessment teams

It is important that the role of the mental health professional on the threat assessment team be carefully delineated to avoid limitations on information sharing when possible. Although it has been suggested that the team's mental health professional may provide direct treatment services to a subject of concern (e.g., [Cornell, 2011](#)), this may cause ethical and legal codes related to client-therapist privilege and confidentiality to become applicable and limit the disclosure of pertinent information to other team members. Furthermore, psychotherapy clients may be reluctant to engage in open discussion of concerning thoughts and behaviors during treatment with the team's mental health professional due to fears that privileged disclosures will be shared with the team and lead to investigation. Similar reluctance was specifically noted by a licensed social worker who assessed the perpetrator of the 2012 mass shooting in Aurora, Colorado four months prior to the incident when she wrote that “He said he did not want to tell me everything he was experiencing as I might have to report” ([Phillips, 2018](#)). Improvement in assessment accuracy resulting from this type of multiple relationship is minimal at best, while the potential for strained connections with colleagues who desire privileged information and clients who fear that the therapist will inappropriately share this information is increased.

Some authors ([Dunkle et al., 2008](#), for example) have recommended

that a mental health professional who does not provide treatment services, such as a clinic administrator, serve on the threat assessment team to minimize the possibility of multiple, potentially conflicting, relationships with the subject of concern. However, in campus mental health clinics that provide clinical training to student therapists and interns, this approach carries the risk that the team's mental health professional may also serve in a supervisory capacity to the treating clinician, resulting in multiple relationship issues similar to those previously discussed. An alternative approach would be to employ a mental health consultant from outside the college to serve on the threat assessment team. Recent research has shown that one in three U.S. community colleges that operate a threat assessment team include one or more members from outside the institution (Bolante & Dykeman, 2015), and Virginia state law explicitly authorizes threat assessment teams to work with consultants who are not team members in "special cases." Given that community colleges and postsecondary vocational training programs are less likely to have counseling and mental health services, the use of consultants may be more prevalent at these institutions. Consultants may be considered "school officials with a legitimate educational interest" under FERPA as long as they are recognized as such in the institution's annual FERPA notification.

While it is preferable that threat assessment team mental health professionals abstain from providing mental health treatment to IHE students and staff and from providing supervision to therapists, they may be ideally suited to conduct mental health evaluations of individuals of concern. Mental health professionals often lack specific training on violence risk assessment and behavioral intervention in high-risk situations, which are the cornerstone of an effective threat assessment team, and these types of services may be delivered infrequently by campus mental health practitioners. Moreover, information obtained from a mental health evaluation for threat assessment purposes may be subject to different restrictions on disclosure than information obtained during psychotherapy, and communication with team members may be subject to fewer restrictions when the mental health professional is removed from duties involving the provision and supervision of mental health treatment as outlined in Section 4.3. The threat assessment team mental health professional may serve as a consultant to campus mental health clinics on issues related to targeted violence, where their specialized training and greater experience can be a valuable learning resource to other clinicians.

The mental health professional on an IHE threat assessment team is perhaps the only team member with the skills necessary to "monitor the behavior and development of students and more easily detect signs of maladaptation such as mental problems, adjustment difficulties after migration, or decreasing performance" as suggested by Bondü and Beier (2015) (p. 269). Early signs of mental illness and adjustment difficulties are often difficult to recognize and may be overlooked by campus administrators, law enforcement personnel, and other individuals who lack training and experience in psychological assessment. When mental health issues are suspected or confirmed in a subject of concern, the mental health professional may be best suited to speak with the individual on behalf of the team. The presence of mental illness, especially symptoms of psychosis, such as delusions and disorganized speech, can decrease the effectiveness of communication and the quality of the relationship between the student and the team. Mental health professionals are adept at developing trust and establishing collaborative relationships with individuals experiencing a wide range of mental health issues, increasing the accuracy of risk assessment and improving the team's ability to manage violence risk.

Beyond the goal of targeted violence prevention, the threat assessment team is often able to identify students and staff members who, despite posing a low risk of violence, are experiencing acute mental health issues, and the team's mental health professional is best suited to provide linkage and referral to a mental health care provider. In situations in which the subject of concern requires psychiatric hospitalization due to danger posed to self or other individuals, the threat

assessment team mental health professional may be best able to identify and provide relevant information to hospital personnel. Among individuals for whom an immediate threat has been mitigated, an increased risk for substance abuse and other mental health issues may remain. Referral for treatment of these issues may be a key component to the long-term management of risk and improved well-being. These activities hold a clear benefit for the individual and may strengthen the perception of the threat assessment team as a source of assistance as opposed to discipline.

In addition to their ability to recognize the early signs of mental health issues and monitor changes in risk, mental health professionals may be the most approachable member of the IHE threat assessment team and best suited to conduct community outreach services for students, faculty, and staff. It seems likely that students are more apt to approach the mental health member of a threat assessment team with concerns because mental health professionals are more readily identified as part of a college support system, as well as expectations that mental health professionals act discretely and non-punitively. Recent increases in anti-police sentiment may also decrease the likelihood that students will approach law enforcement, a possibility that appears supported by research demonstrating that university students with less trust in campus police are less likely to inform authorities of behaviors suggestive of high violence risk (Hollister, Scalora, Hoff, & Marquez, 2014). Additional research in higher education settings is certainly warranted; however, it seems clear that the success and timeliness in the identification and reporting of risk indicators improve as a function of the accessibility of the IHE threat assessment team by IHE community members.

Finally, in addition to considering the roles suitable for the mental health professional on the threat assessment team, it is important to delineate the roles for which they are not suited. Mental health professionals must act within the boundaries of their competence and scope of practice. Care should be exercised by the team's mental health professional to minimize involvement in the investigation of criminal behavior and sanctioning of individuals for violating laws and institutional rules. Rather, mental health professionals may most aptly conduct themselves similarly to expert witnesses in legal proceedings, to provide specialized psychological knowledge and clinical opinions regarding the facts of the assessment to assist law enforcement in their investigation and the trier of fact (often an IHE administrator or student affairs officer) in determining the appropriate outcome and sanctions. When a mental health professional is directly involved in the disposition of a threat assessment investigation, their participation should be limited to areas within their expertise and training, such as designing and implementing behavioral interventions intended to decrease and manage risk, referral to mental health and substance abuse treatment services, and acting as a liaison between mental health treatment providers and the threat assessment team as allowable by ethical requirements and state and federal laws.

#### 4.2. Assessment and intervention considerations

The empirical study of targeted violence in educational settings has identified numerous factors relevant for mental health professionals on IHE threat assessment teams. Suicide risk should be a primary consideration for any individual brought to the attention of the IHE threat assessment team, and the mental health professional should take steps to mitigate this risk consistent with best practices and state laws related to involuntary hospitalization, as necessary and appropriate. Suicidality in students at risk for violence is especially troubling from the standpoint of violence prevention, as it may render some physical security measures irrelevant. Although metal detectors and security personnel have the potential to prevent the introduction of some weapons into campus buildings, they have failed to serve as a deterrent in incidents where the shooter intended to commit suicide or hoped to be killed by law enforcement officers. In the March 2005 school shooting in Red

Lake, Minnesota, for example, the perpetrator shot and killed a security guard operating a metal detector before killing six individuals inside the school, as well as himself.

Evaluations for serious mental illness should be another primary consideration for mental health professionals involved in IHE threat assessment investigations. While it bears repeating that the relationship between mental illness and violence is highly complex, research has found that many perpetrators of targeted violence in educational settings have experienced symptoms consistent with a psychotic disorder. From an epidemiological standpoint, schizophrenia and other forms of serious mental illness, including bipolar disorder, most typically have an age of onset in early adulthood. This finding not only suggests that a greater number of IHE students will experience conditions predisposing them to persecutory beliefs and perceptual distortions relative to primary and secondary school students but that the likelihood of an individual developing serious mental illness during postsecondary education is far greater than the likelihood of onset in adolescence.

Well-trained mental health professionals are adept at using assessment techniques to monitor changes in functioning and symptoms over time, which, in the context of violence risk assessment, may enable the assessment of increasing and decreasing risk in a more objective way. Furthermore, objective assessment techniques may be utilized outside of a formal therapy relationship depending on the presence of observable risk factors. For example, the team's mental health professional may monitor an individual's public-facing social media and online discussion forums used in some courses. It may also be useful to speak with instructors and campus administrators (within the applicable confines of limits to confidentiality) to obtain information shown to predict violence risk. Consistent with these suggestions, several authors (e.g., Dunkle et al., 2008) have emphasized the importance of developing procedures for tracking and monitoring the level of risk and adherence to interventions by subjects of concern over time.

Although mental health issues may influence an individual's pathway toward or away from violent behavior, the assessment and management of risk is improved by considering the interaction of mental health with social, cognitive, and moral development. Development in these domains is an important mechanism of change in violence risk, causing certain issues and experiences to be more or less salient based on their *developmental* relevance for the individual. The thoughts and behaviors of adolescents are more heavily influenced by mainstream ideas regarding the nature and importance of popularity than those of adults. Throughout middle and late adolescence, the relevance of social identity and peer acceptance substantially increases the psychological injury resulting from peer victimization and may move the adolescent who does not conform to popular notions of “cool” closer to extreme behavior to improve their social standing or exact revenge on the individuals viewed as responsible for their position in the social hierarchy. Communicated threats of violence should never be ignored; however, they may not convey a high degree of risk for targeted violence insofar that they are determined to be utterances of an individual with less developed reasoning ability, impulse control, and judgment, and the statement is made in the absence of capability, planning, or preparation for violent behavior. The differentiation of violent ideation and threats from violent *intent* has implications not only for the accurate assessment of violence risk but also for the therapist's liability when breaching confidentiality due to perceived danger toward other individuals.

Targeted campus violence can almost exclusively be viewed as the actions of an individual attempting to set right the unjust behaviors of individuals through the last means of social control they consider available: violence toward the individuals believed to be responsible. Primary developmental goals are an important determinant of the perpetrator's focus. Beyond understanding the perpetrator's focus, a consideration of social, cognitive, and moral development enables us to better assess the capacity of the individual to disengage from his or her trajectory toward violent action, behave in accordance with

interventions, and continue to be employed, enrolled, or otherwise affiliated with the IHE without posing a substantial risk to other individuals. Furthermore, developmentally informed interventions may aim to assist students' progression from a dualistic way of seeing the world to one that is more relativistic and less likely to produce a violent outcome in response to conflict.

Insofar as chronic strain (as defined by Levin and Madis (2009)) is the result of inadequately treated or untreated mental health issues, the role of campus mental health staff is clear: by teaching techniques for self-care and providing accurate assessment and mental health treatment, these professionals can decrease risk through the promotion of recovery and well-being. Additionally, campus mental health staff may effectively decrease the risk of violence among individuals experiencing social isolation by crafting interventions that increase social support and build positive relationships. The sequential model proposed by Levin and Madis (2009) is based on the premise that social isolation and a lack of support may cause a short-term negative event to be judged as devastating, causing violence to be viewed as a preferred or necessary solution. Foreign students and individuals who belong to marginalized racial and cultural subgroups may be at greater risk for experiencing social isolation, which compounded with stress resulting from academic demands and visa requirements may help explain the overrepresentation in some studies of students with a migration history among perpetrators of IHE attacks. It may be the experience of social isolation, rather than the racial or cultural background of an individual, that contributes to the increased risk.

Other interventions for students deemed at-risk may include, as one component, humanizing individuals vilified by the potential aggressor, a technique that has long been shown to inhibit aggression toward other individuals (e.g., Bandura, Underwood, & Fromson, 1975). The ability to accurately identify individuals at an increased risk of targeted campus violence may be improved by encouraging counseling center staff to consider a client's dehumanizing views in their assessments of violence risk and for threat assessment team members and campus law enforcement to be aware of these beliefs among the subjects of their encounters. Examples of these beliefs can be observed throughout the written materials authored by the perpetrator of the 2014 attack in Isla Vista, California. In these materials, he likens women to “a plague” and also writes, “They think like beasts, and in truth, they *are* beasts” (italics appear in the perpetrator's original text).

Education regarding warning behaviors and how to effectively use the threat assessment program should be delivered to IHE faculty and staff, as well as students. Educating members of the IHE community on how to recognize and effectively respond to signs of mental illness was a common recommendation made by groups tasked with examining safety practices in the wake of the Virginia Tech tragedy. The failure of students to report statements and behaviors of concern in past incidents of targeted school violence has been commonly attributed to internal conflict between the betrayal of a peer and the prevention of possible violent behavior at their school (e.g., Twemlow, Fonagy, Sacco, O'Toole, & Vernberg, 2002); however, it may otherwise have resulted from a lack of knowledge regarding the relevance of these actions to violent behavior. The success of public policy is, in large part, dependent on how an issue is understood by the public (Heilbrun et al., 2009), and a well-informed campus community is more likely to embrace violence prevention programming developed from empirically derived risk factors and interventions. The importance of community awareness of these factors, as well as the existence of a program to address concerning student behaviors, cannot be overemphasized.

Focus groups may be useful in gauging “buy-in” to existing threat assessment procedures and violence reduction programs by members of the campus community. For example, Fox and Savage (2009) have suggested that certain security measures and procedures may inadvertently increase anxiety regarding potential violence on campus by “making students feel like walking targets” (p. 1466). Mental health professionals may be best equipped to understand the underlying

dynamics of these reactions and how to minimize or manage them. Relatedly, publicity related to active-shooter drills and similar law enforcement training techniques on campus may inadvertently portray the institution as a dangerous place, thereby resulting in unanticipated effects on student enrollment and the adoption of policies designed to minimize violent behavior. Despite the potential negative consequences of decreased perceptions of safety on campus, research has shown that university student willingness to inform authorities of pre-incident behavior increases as feelings of safety on campus decrease (Hollister et al., 2014). This finding suggests that the ideal threat assessment program is one that is widely accepted by students, faculty, and staff and instills reasonable, realistic concerns regarding violence on campus. The skill set of mental health professionals is well-suited to facilitating the process of identifying potential barriers to program acceptance so that they may be addressed and promoting factors that increase the reporting of threats and other concerns.

The precursory establishment of relationships with community agencies is a vital step to effectively and expediently address problematic behaviors prior to their culmination in a violent act. For example, the Los Angeles Unified School District, Los Angeles Police Department, and Los Angeles County Department of Mental Health's School Threat Assessment Response Team have a defined Memorandum of Understanding that allows these agencies to collaboratively provide enhanced academic and mental health services to students of concern, with law enforcement intervention as necessary. The School Threat Assessment Response Team also provides threat assessment services to IHEs in Los Angeles County. While many IHEs will not have access to a specialized mental health unit such as this, threat assessment teams would nevertheless benefit from establishing similar relationships with their local mental health and law enforcement agencies in which the respective roles of each organization and the boundaries of information sharing are discussed well prior to an incident of concern.

Mental health professionals may spearhead applied research examining individual and situational characteristics of incidents in which an increased risk for targeted violence existed but did not result in violence, as well as the characteristics of incidents in which a violent act occurred. In so doing, we may begin to better identify effective preventative measures and behavioral features that are unique to individuals who do not attack and those who do attack. Formal data warehouse techniques and sophisticated data analysis may exceed the resources of smaller IHEs; however, the lessons learned from institutions with the necessary capabilities to conduct applied research have the potential to vastly improve risk assessment and management techniques at individual institutions and, when examined collectively, will be invaluable in advancing the state of our science.

#### 4.3. Ethical and legal considerations

To ensure that information obtained during the mental health assessment may be shared with threat assessment team members in accordance with state laws and discipline-specific ethical guidelines, team mental health professionals are strongly encouraged to obtain informed consent prior to subject interviews and assessment that clearly indicates the breadth and nature of the information that will be shared with team members. Because the expectation of confidentiality may be drastically lessened in assessments conducted as part of a threat assessment investigation, it is of even greater importance that individuals of interest be made aware that information may be shared with the threat assessment team. Cornell (2009) further recommends that individuals of interest be asked to sign a release for the team to obtain mental health records and other potentially relevant sources of information, and in the absence of this release, the mental health professional should consider whether the mental health evaluation should be conducted. The importance of including information from multiple sources and informants is increased in the context of a threat assessment investigation, as the potential loss of enrollment, employment, and liberty

resulting from a positive finding of dangerousness may lead the subject to minimize or underreport behaviors and mental health issues of concern. When an evaluation is conducted in the absence of potentially relevant sources of information regarding the subject's mental health, the limitations of the evaluation must be made explicitly clear both in written reports and verbal communication with team members. Relatedly, when a subject receives therapy as a condition of continued enrollment or employment, it is recommended that a consent for the release of information be obtained that allows the treating mental health care professional to provide the threat assessment team with pertinent information, including, at a minimum, attendance at therapy sessions, reports of violent ideation, and planning or preparatory attack behavior, even when this information does not meet a legally established exception to confidentiality. Information to be released should be limited in scope and well-defined in the consent for release of information; otherwise, the client may be reluctant to meaningfully engage with the treating professional, and psychotherapy may fail to have the intended benefit.

Despite the prominence of ethical guidelines governing confidentiality between mental health professionals and clients, in general, mental health professionals are not obliged to treat information about the mental health of an individual obtained in the absence of a professional relationship as confidential. To illustrate by way of example, a psychologist who learns from a psychotherapy client that she has been involved in several heated exchanges with a resident advisor who the client believes is poisoning her food would be ethically obligated to keep this information confidential. Even in a situation in which a legal and ethical exception to confidentiality exists, such as if the client went on to make a specific threat against the resident advisor in a jurisdiction that permits or mandates the therapist to warn or protect the would-be victim, the information obtained during the course of therapy must be kept confidential to the greatest degree possible. The disclosure of protected information to law enforcement officials or an intended victim in circumstances such as this should be limited to the identity of the client, the therapist's relationship to the client, and the nature and target of the threat; information regarding the client's diagnosis, treatment details, and other clinical information would remain confidential.

When observations of a student's aggressive behavior and paranoid beliefs are reported by classmates, parents, or instructional staff, in the absence of a professional relationship, the psychologist may share their report with other members of the threat assessment team and law enforcement officials and use this information in an assessment of violence risk. In situations such as these, the mental health professional is acting more as a consultant to the IHE and not as a therapist to the student of interest. Reports of concerning behavior observed by family, friends, and members of the IHE community are often how threat assessment teams become aware of high-risk situations. Even when a professional relationship exists and the mental health professional is bound by confidentiality, they may encourage individuals who initiate contact to share observations of troubling behavior and state their concerns with the caveat that the mental health professional does not confirm or deny that any individual is receiving mental health treatment or reciprocally share information without the permission of a therapy client. Whether or not a professional relationship exists with the individual of interest is a key factor in determining if there is an ethical obligation to keep the information obtained by a campus mental health professional confidential. How records are created and stored also has implications for confidentiality. When a mental health or violence risk evaluation is clearly not "made, maintained, or used only in connection with the treatment of the student" and is not conducted in a setting considered a covered entity under HIPAA, the results of the evaluation could be classified as education records under FERPA, and as such, they may be shared with school officials with a "legitimate educational interest" without student or parental authorization. IHE threat assessment teams must be aware that under FERPA, students (and

potentially, their parents) have rights and privileges to review and request amendments to educational records, although records maintained by the IHE law enforcement unit or the designated individual or office responsible for law enforcement and public safety functions may be exempt from FERPA and these rights and privileges would not apply.

In states where a mental health professional's duty to warn or protect is established through case law, changes that result from new legal precedent may be complex, unclear, or poorly publicized, thus increasing the importance of having a designated professional to remain abreast of new cases and disseminate relevant information. The mental health professional on the IHE threat assessment team may, in collaboration with the IHE legal counsel, provide training to improve the ability of campus mental health professionals to act in accordance with mandated reporting duties in the state where the IHE is located. This information may also be provided to other members of the threat assessment team and law enforcement community, so that they may better understand the constraints and conditions for clinicians making a report and determine how to best act on the information provided by mental health clinicians. Proactively educating team members regarding the ethical and legal requirements of mental health professionals as they relate to confidentiality and consent may help to avoid perceptions of the professional as uncooperative or unconcerned with campus safety. It may be helpful to frame these requirements as analogous to the Miranda warning that law enforcement officers are required to give when placing a subject under arrest, as both require the subject to be made aware that their statements may be used for other purposes (e.g., prosecution or investigation) and that they have the right to refrain from making such statements. This underscores the importance of establishing good rapport with the subject, approaching the evaluation in a nonconfrontational manner, and educating the individual about positive outcomes that may result from participating in the evaluation (e.g., referral for mental health treatment or the opportunity to discuss concerns with a mental health professional). When carefully performed, providing clear informed consent to individuals of concern may not have the feared result of discouraging frank and honest participation in the assessment.

It is of critical importance that threat assessment teams at IHEs coordinate with law enforcement and mental health agencies in the larger community within the confines of applicable Federal and state laws establishing the confidentiality of mental health care records and ethical guidelines. In a discussion of partnerships between law enforcement and mental health providers, [Lamb, Weinberger, and DeCuir \(2002\)](#) argue that collaboration between the police and clinicians may result in more appropriate dispositions of mentally ill offenders, in some cases including referral to mental health care rather than arrest and incarceration. However, these authors also emphasize that when the clinician has access to mental health records, he or she must take great care to maintain compartmentalization and release only pertinent information in accordance with statutes permitting such release.

## 5. Conclusion

In the last 20 years, threat assessment has grown from limited use by a handful of law enforcement agencies charged with the protection of individuals with high public profiles to widespread use by law enforcement, business organizations, and educational institutions. While the core principles underlying this approach are invariable, differences in the mental health issues and the developmental abilities of individuals across academic settings, as well as the resources, rules and laws that apply to educational institutions and the professionals who work there, shape how threat assessment investigations are conducted. This manuscript set out to identify the unique aspects of threat assessment in IHE communities to increase the knowledge and competence of professionals in this area of practice.

Many directions for future research on targeted violence at IHEs exist, although several areas are especially in need of empirical study.

The threat assessment literature to date has largely failed to recognize the impact of routine law enforcement activity and mental health treatment on maintaining the low base rate of events such as shootings on university campuses. Acts of targeted violence would be more frequent if not for the intervention of law enforcement and mental health professionals. Researchers (e.g., [Pollack, Modzeleski, & Rooney, 2008](#); [Verlinden et al., 2000](#)) have noted that data are not commonly collected and available in high-risk situations, including those in which a threat was present but did not culminate in a violent act, despite the perpetrator often coming very close to the execution of his or her plans. Additionally, the impact of social, cognitive, and moral development on an individual's pathway toward or away from targeted violence has been dramatically understudied in the threat assessment literature relative to the impact of mental health issues, despite clear variations in the manifestation of targeted violence over the lifespan. Such research would have a significant impact in IHE communities, where the developmental heterogeneity of potential individuals of interest is substantial.

We have witnessed a startling number of school and campus shootings reported in the media in 2018, which were overwhelmingly, but not exclusively, in the United States. Whether as a result of a temporal increase in these types of incidents or increased media attention on the issues of school safety and youth violence, there is mounting pressure on educational institutions to more effectively prevent this type of violence from occurring. Without sufficient knowledge of the psychological dynamics and causal factors of targeted violence in IHE settings, mental health practitioners are at an increased risk of misidentifying individuals as high-risk and unsuccessfully identifying high-risk individuals as such. The failure to understand and work within the unique ethical and legal frameworks that apply in IHE settings may impact the ability of mental health professionals to communicate with team members and potentially carries litigation risks for mental health professionals who inappropriately breach confidentiality. Mental health professionals must take the necessary steps to understand these special considerations to contribute to the prevention of targeted violence in IHE settings.

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