Prelude to a School Shooting? Assessing Threatening Behaviors in Childhood and Adolescence

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On March 21, 2005, Jeffrey Weise, a 16-year-old student at Red Lake High School, Minnesota, killed his grandfather and his grandfather's girlfriend. Next, he drove his grandfather's squad car to the high school and fatally shot a security guard. Before mortally wounding five students and a teacher and injuring seven others, Jeffrey smiled and waved. He then committed suicide by shooting himself in the head.

Weise left many dark and depressive postings on Web sites such as "nazi.org," calling himself "Todesengel" (German for "angel of death") and "Nativenazi." He dressed in black and wrote stories about school shootings and zombies. Weise's Internet animation, "Target Practice," depicted his blueprint for murder and suicide.[1] Weise was reportedly taking Prozac and had been hospitalized for suicidal behavior.[2] His father had committed suicide after a standoff with police and his mother was in a nursing facility after sustaining head injuries in a car accident.[3]

Columbine. Red Lake. Virginia Tech. Merely invoking the names of these schools is enough to introduce the topic to be discussed. Since the 1999 Columbine High School shooting, child and adolescent psychiatrists have been called on with ever-increasing frequency to evaluate children and adolescents who have made threats toward other students or school staff. On April 16, 2007, the deadliest school shooting in U.S. history occurred at Virginia Tech when a student, Seung-Hui Cho, gunned down 32 students and teachers and wounded another 25 before taking his own life.[4]

As each school massacre unfolds, debate in the media recurs as to where blame can be laid. "Experts" and pundits will make claims about the purported roles of all aspects of the school shooters' life, from violent movies, video games, gun control, heavy metal music to parenting techniques and antidepressant medications. There is, however, little evidence to draw on to explain this frightening phenomenon. This is also true about students who make threats. With few studies of these students, the child and adolescent psychiatrist must extrapolate lessons from related studies of aggression in childhood and adolescence and a nonscientific literature based on reports in the press about school shooters.

A major symposium, partly prompted by the Columbine High School shooting, took place in 1999 when the National Center for the Analysis of Violent Crime brought together 160 law enforcement personnel, school personnel, and psychiatrists and other mental health professionals. Eighteen cases of school shootings or foiled shooting attempts from the 1990s were studied.[5] The FBI had exclusive access to the case files, and a number of the law enforcement and school personnel at the symposium were present during the actual shooting incidents and had known the school shooters personally.[6] A key finding of the symposium was that school shooters indicated their plans before the shootings occurred through direct threats or by implication in drawings, diaries, or school essays.

A similar study was performed by the Secret Service and the Department of Education, aiming to identify information available before a school attack that could be used to formulate policies and strategies to prevent school attacks.[7] The study examined 37 incidents of

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school violence involving 41 students who attacked someone at his or her school with lethal means (e.g., gun, knife) and where the student attacker purposefully chose his or her school as the location of the attack. The findings were similar. In more than three fourths of incidents, at least one person had information indicating that the attacker was thinking about or planning the school attack; in nearly two thirds of incidents, more than one person had information about the attack before it occurred. However, the information known by other students or friends was rarely communicated to adults. Furthermore, most attackers did not threaten their targets directly before the attack.[7]

The assessment of a student associated with potentially threatening behaviors presents diverse challenges to teachers, school administrators, and mental health professionals. They may ask, "Will this student be the next school shooter?" and "If I miss something, will I be responsible for the next school shooting?" These fears often lead to the knee-jerk reaction of removing any student with suspected threatening behavior. Although the actual school shooters were likely to have made threats, the number of completed school shootings is extremely small compared to the number of threats occurring in school but never acted on. The exact number of actual threats occurring each year is unknown. In 2003, an estimated 9.3% of all U.S. students in grades 9 through 12 had been threatened or injured with a weapon in school,[8] suggesting school-related threats of violence are not a rare occurrence.

Remarkably, there is limited psychiatric literature on the assessment of child or adolescent threatening behaviors, and few of us received training in threat assessment during our child and adolescent psychiatry fellowships. This Clinical Perspectives section is based on my experience in evaluating 114 students during the course of 9 years running an outpatient child and adolescent psychiatry clinic receiving referrals from more than 25 school districts in eastern Long Island, NY.

EVALUATION PROCESS

A 15-year-old girl's crumpled paper with a "hit list" to kill five students was discovered by a teacher.

A 12-year-old boy announced, "I have a gun in my locker," and later announced he was going to shoot. After returning from 1 week of suspension, he declared, "A bomb, here and now!"

Threat assessment requires a thorough psychiatric diagnostic evaluation, including fundamental assessments of suicidality, homicidality, thought processes, reality testing, mood, and behavior. As always, a detailed developmental and educational history should be obtained with a specific focus on abuse, past trauma, school suspensions/expulsions, school performance, and peer relationships. One needs access to descriptions of the actual events leading to referral. In an office-based setting, the clinician should request collateral information in the form of past school records and previous psychological and psychiatric assessments. A detailed written or verbal description of the incident from school administration is needed; description by the child or parents is generally insufficient, although in an emergency department evaluation, it may be the only information available. In this case, the clinician should chart efforts to obtain this information and to ensure adequate follow-up if the child is to be discharged from the emergency department. Obtaining this information may also be difficult when a student has been suspended for a long time or when legal implications promote reluctance by school administration or parents to share information.

Specific issues include whether a threat has indeed been made, its severity level and the child's ongoing intent, the focus of the threat, the intensity of threat preoccupation, access to weapons, and degree of concern expressed in the child's environment. A "threat" can be defined as an expression of intent to do harm or act out violently against someone or something.[5]

Threats can be categorized according to level of realism.[5] In low-level threats, there are no strong indications that preparatory steps were taken and realism is lacking. There may be vague allusions to violent books or movies. Medium-level threats are those that could be carried out; they may not appear realistic, but they are more direct and concrete and may give general indications of place and time. High-level threats represent an imminent and serious danger; they contain direct, specific, and plausible plans.

Direct threats have clear content indicating intent (e.g., "I know where to get a gun and I'm going to shoot you and your buddies"). Indirect threats are vague, unclear, and ambiguous (e.g., "You're going to be sorry you ever said that," "I could kill you if I wanted to"). Veiled threats are more suggestive of intent (e.g., "This school would be a lot better off if you weren't here)",

whereas conditional threats include a demand (e.g., "You'd better not fail me. If you do, I'm going to bomb the school").[5] Sometimes threatening statements blur these categories and cannot be easily classified.

With respect to access to weapons, numerous epidemiological studies document a direct relation between accessible firearms and young people's risk of homicide and suicide.[9] All children and their parents need to be asked about a child's potential access to weapons, both inside and outside the home. I routinely provide parents with the American Academy on Child and Adolescent Psychiatry's gun safety handout[10] when the evaluation is completed. When the evaluation is initiated through a school and involves only an evaluation session(s), the psychiatrist should initiate direct contact with a school mental health professional to ensure that appropriate follow-up on psychiatric concerns is pursued. Child protective services may also need to be contacted if the child's psychiatric care is being neglected. If an imminent danger to others is thought to be present, then the issue of duty to warn becomes the responsibility of the psychiatrist, and confidentiality will need to be breached to inform the target(s) of the threats, as well as the police.

PSYCHODYNAMIC PERSPECTIVES

The basis for a study of actual aggression must be a study of the roots of aggressive intention.[11]

Any assessment of threats must to look beyond overt symptomatology to probe the multiple levels of meanings of behaviors and how aggression is integrated into one's personality. In the following five sections, the focus is on thought processes, preoccupations, fantasies, and conflicts, all of which are needed in a threat assessment.

That Scary Feeling

What makes some student's threats more disturbing than others? Ultimately perhaps, the concern is clinched by the intuition of the astute clinician who senses signs of the student's dark, inner rage, particularly in the context of social isolation from family and peers as well as the student's emotional disconnection during the interview. Furthermore, intense immersion into fantasy combined with less-than-secure reality testing should also arouse concerns. When an adolescent's odd beliefs or magical thinking are combined with suspicious behaviors and/or paranoid ideation, an intensified perception of dangerousness may occur.

Another red flag is a history of trauma or violence, either as victim or perpetrator. The clinician needs to devote time in the interview(s) to explore and formulate the meaning of the student's threat behavior in the context of his or her history. For example, a child's experience of witnessing parental conflict and aggression may engender aggressive and antisocial behaviors.[12] The child's earlier responses to fears of threat in his or her environment may play a significant role in the later development of threat behavior as traumatic memories are evoked. Complex identifications with a parent and/or subtle ways where a parent covertly encourages threatening behaviors are likely to take more than one evaluation session to explore.

Leakage

A 14-year-old boy was drawing violent pictures in school. At age 10, he sprinkled lighter fluid on another child and threatened to light a match. Preoccupied with his drawings and stories about aliens and superior violent characters; he considered himself one of the world's greatest cartoonists.

A student's preoccupation with violent themes can emerge in diverse contexts. *Leakage* is a term originally used in an FBI monograph to describe potential "clues signaling a potentially violent act including, feelings, thoughts, fantasies, attitudes and intentions."[5] Examples include direct threats, boasts, doodles, Internet sites (e.g., MySpace, YouTube), songs, tattoos, stories, and yearbook comments with themes like death, dismemberment, blood, or end-of-the-world philosophies. No conclusion can be drawn from these clues in isolation; violent drawings/themes can be developmentally appropriate and are common in adolescence. Understanding the context is critical. During an interview, students typically minimize such preoccupations with comments such as "They're just drawings, I would never hurt anyone" or "It was a stupid thing to say. I didn't mean anything by it."

The psychiatric evaluation must delve into the nature of these materials to clarify the nature and degree of violent preoccupation. In a student who is obsessed with violence, the theme is likely to emerge no matter what the nature of the discussion. Clearly, many adolescents are fascinated with violent and/or macabre themes; this can be a developmentally appropriate and common experience. I

have found it helpful to include several projective measures as part of the psychiatric evaluation to potentially obtain these clues, including a sentence completion measure and asking the student to draw a picture of him- or herself. Sometimes, the traditional question of asking the child or adolescent to provide his or her life story can also illuminate underlying violent preoccupations.

Pathological Denial by Parents

An 11-year-old boy made multiple threats toward other children. He had severe attention-deficit/hyperactivity disorder. His parents were avid hunters who did not believe in standard safety precautions for guns. The boy stated he knew that guns were kept in the parents' bedroom closet. When this concern was raised, the father angrily exclaimed, "Our child won't be the next Columbine!"

Denial refers here to the parent's acceptance of the child's threatening behaviors and a limited reaction to behaviors that most others would find disturbing or abnormal.[5] Parents who are in denial respond defensively to real or perceived criticism of their child; the parents appear unconcerned, minimize the problem, or reject the reports.

Parents may present as angry and defensive when psychiatric evaluations are school mandated. Often the child has been suspended for indeterminate duration, with education disrupted; the child and parents attend intimidating disciplinary hearings with school district officials. Some parents may not accept the notion of their child threatening others and consider their child to be a victim. I have found the most disturbed children often had parents who demonstrated pathological levels of denial, a statement of the potential contribution of parental psychopathology. Such attitudes may be associated with a chaotic home environment, highly conflicted parent–child relationships, and inadequate limit setting.[5] These problematic parental responses leave the impression that if the child revealed threats at home, then the parents would minimize such behaviors, potentially heightening the threat risk.

Group Dynamics

A 12-year-old boy with severe anxiety and social skills deficits was severely teased throughout elementary school. One boy kicked his backpack, and another teased him as having a nerdy backpack. Later in the day, H. said, "I'm going to get a gun and kill those kids."

Children and adolescents who threaten others frequently have histories of being intensely teased (about 50% in my series of 114 students evaluated for threats). They are often socially isolated loners who conceal retaliatory thoughts. Such students have been described as "injustice collectors" who nurse resentment about real or perceived injustices. No matter how much time has passed, the "injustice collector" will not forget or forgive those wrongs or the people he or she believes are responsible.[5] In the Safe Schools Initiative Study, 29 of the attackers (71%) were reported to have felt persecuted, bullied, threatened, attacked, or injured by others before their attack.[7] Although it has often been assumed that threats result from intense teasing and bullying, it is nevertheless unclear whether students who threaten school violence are teased and bullied more than their peers. What is important to explore during a threat assessment is the student's reaction to such experiences.

Another hypothesis centers on the presence of covert power dynamics in schools with a high level of violent episodes. For example, in these situations, there may be "conspiracies of silence" in which students remain silent while their peers are being harassed.[13,14] Psychiatric assessments should query a student's experiences of bullying and teasing, including their reactions and responses and the student's experiences of how his or her peers are responding to this bullying. Once the clinician discovers a history of teasing or bullying, intensive inquiries should be made about retaliatory fantasies and whether these become diffuse, with a desire to retaliate against not just perceived perpetrators but also those who are perceived as colluding in the bullying. Revenge fantasies may be associated with "soft" psychotic symptoms, including vague paranoid ideation, ideas of reference, or vague hallucinations.

There is no evidence that proves that interest in violent video or Internet games, "Goth" culture, music with dark or morbid themes, and so forth directly leads to threatening behaviors. Nevertheless, immersion into various cultures of violence, including involvement with a troubled peer group or identification with violent groups, could promote antisocial and threatening behaviors; the psychiatrist should delve into these potential issues during the interview. In some cases, "contagion" and "copycat" dynamics can also occur, as in a recent episode involving two students planning to attack a school and creating a journal that frequently referenced the Columbine shootings.[15]

Hatred, Suicidal Ideation, and Suicide

As was the case for Jeffrey Weise, a number of the school shooters committed suicide or attempted to do so. In students referred for threats, depressive symptoms and suicidal ideation may also be present, and a careful assessment of mood is essential. The close ties between externalized aggression and aggression against the self were originally highlighted in an earlier psychoanalytic literature emphasizing disturbances of ego function in aggressive children. From this perspective, intense emotions of self-hate become organized into highly resistant defenses against the world around them (i.e., projection).[16] These concepts were used to explain the dynamics involved in anti-Semitism and genocide and may also be valuable in understanding the mental functioning of children who develop intense fantasies of hatred against fellow students or teachers. The complex relation between homicide and suicide is beyond the scope of this article and is mostly concentrated in the forensic psychiatry literature. Notably, of the 37 attacks analyzed in the Safe Schools initiative, "most attackers" were reported to have some history of either suicidal attempts, thoughts, or a history of feeling extreme depression or desperation. In contrast, only 17% (n = 7) had been diagnosed with "a mental health or behavior disorder" before the attack.[7]

OTHER CONSEQUENCES

A 17-year-old honor student with no history of behavior problems has drawn doodles of a girl hanging from a rope. He revealed being upset about a girl gossiping about him. On psychiatric evaluation, he was not found to be a danger to others nor was a psychiatric diagnosis present. Nonetheless, he was suspended for months, his college applications were delayed, and he was ostracized by peers.

A 12-year-old girl left a message on her school's voice mail threatening to blow up the school. The call was traced; she was suspended. The risk of attack was assessed to be low. She subsequently became preoccupied by "the terrible thing" she did, calling herself a "terrorist" and resisted return to school.

The consequences for students of making a threatening statement can be devastating, with significant and lasting effects on a student's academic career and social relationships. The student may find peers and/or school faculty avoidant and distant, and the student's reputation as a potential "school shooter" often persists. Behaviors that would have not evoked concern in the past are now the focus of intense analysis. In cases of prolonged suspension or expulsions, it may be difficult for the student catch up on course work. College applications may be ruined by notations on a student's permanent record.

School suspensions lasting many months may end up serving no purpose beyond displaying administrative enforcement of "zero tolerance" school policies and may in fact be problematic. Such policies may discourage classmates from coming forward to make such disclosures.[5] For some students with academic and social difficulties, suspension and home tutoring may lead to improved scholastic functioning and reduced stress levels. The mental health clinician may have a role in facilitating return to school or appropriate treatment and education during the course of a suspension, with an eye on helping the child, family, and school return to a safe and developmentally appropriate relationship.

CONCLUSIONS

The child and adolescent psychiatrist plays a crucial role in evaluating threats made in school settings, including estimating the severity of danger level, as well as clarification of unrecognized or inadequately treated psychiatric disorders. The school consultant must be prepared to interpret complex individual, family and group dynamics potentially leading to the expression of threats, such as retaliation for bullying and teasing. Such situations are compounded by potential access to weapons in the home. Effective educational and treatment recommendations for children and adolescents who make threats depend on an in-depth appreciation of their diverse psychiatric problems.

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