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LOYOLA UNIVERSITY CHICAGO

THE USE OF BEHAVIORAL AGREEMENTS BY SENIOR STUDENT AFFAIRS OFFICERS AND COUNSELING CENTER DIRECTORS TO MANAGE STUDENT MENTAL HEALTH CONCERNS AND MINIMIZE THREATENING BEHAVIOR

A DISSERTATION SUBMITTED TO

THE FACULTY OF THE GRADUATE SCHOOL

IN CANDIDACY FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

PROGRAM IN HIGHER EDUCATION

BY

DOUGLAS GEIGER

CHICAGO, ILLINOIS

MAY 2010

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ACKNOWLEDGEMENTS

Over the past seven years, several individuals have supported me as I traveled the doctoral road. Without their love and encouragement, the successful end to this journey would not have been possible.

To my family and their incredible encouragement during these seven years, thank you for believing in my ability to accomplish this task. In particular, I want to thank my twin brother and best friend, Don Geiger, who encouraged me during many lonely days of research and writing. Without your support, I believe I would not have gotten to this point. You are a daily inspiration and a source of strength to me that is invaluable in my life. Thank you!

To my mentor, Dr. John Magerus, who believed in me ever since I stepped into his classroom as an undergraduate student. Not only are you an inspirational teacher, you taught me the values of hard work and academic excellence. Thank you for all of your encouragement during this process.

To my friends Gary, Tom, Elliott, David, and Antonio, who always checked on me and encouraged me to finish my Ph.D. The gift of your friendship is a blessing in my life. Finally, to my advisor, Dr. Terry Williams for all of his guidance and edits during this process, thank you.

To the memory of my grandparents, Germaine and Lawrence Geiger, who always believed in my dreams. Also, to the memories of my friends Todd Kassner and Jeff Strohm and my student affairs colleague, Valsin DuMontier III, who all left this world way too young.

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ABSTRACT

This qualitative investigation examines the use of behavioral agreements by Senior Student Affairs Officers and Counseling Center Directors to manage student mental health concerns and minimize behavior that poses threats to campus communities. Six pairs of Senior Student Affairs Officers and Counseling Center Directors at the same institution were interviewed for this study. In addition, documents concerning mental health and threat assessment policy and protocols are also examined and discussed. An expanded theory of practice known as Student Intervention Facilitators is presented as an option to mandated psychotherapy.

CHAPTER I

INTRODUCTION

On April 16, 2007, the nation paused and stood in shock as the news broke of the single worst massacre in U.S. History. Seung-Hui Cho, a Virginia Tech student, shot and killed 33 members of the Virginia Tech community. By day's end, 27 students, 5 faculty members, and the gun were dead, along with 24 others injured (Bansal, 2007; Fiegel, 2007; Flynn & Heitzman, 2008; Schuchman, 2007; Smith, 2007). Dunkle, Silverstein, and Warner (2008) described the Virginia Tech tragedy as "the 9/11 of higher education" (p. 586). Ten months later, a former student at Northern Illinois University, Steven Kazmierczak, opened fire in a lecture hall on the NIU campus and, within a matter of seconds, killed six students, including himself and had wounded 14 others (Boudreau & Zamost, 2008; Davey, 2008; Saulny & Bailey, 2008). It would later be discovered that Kazmierczak had developed a fascination with the "success" of the Virginia Tech murders and that this incident served to inspire his own murderous plans (Associated Press, 2008). Not only did these events amount in almost unbelievable human carnage, they also shone a light on a growing problem which is being experienced by many of the nation's universities, that being the management of student mental health issues and the potential of related violence that may seriously threaten campus communities. As intense national media frenzies encircled both the Virginia Tech and Northern Illinois campuses, various news organizations began to analyze and interpret Cho's disturbing behavior

prior to the tragedy as well as possible motives behind Kazmierczak's attack. Unlike Cho, who had exhibited disturbing behavior prior to the Virginia Tech shootings (Flynn & Heitzman, 2008; Schuchman, 2007; Smith, 2007), Kazmierczak did not show outward signs of trouble during his time at NIU (Tarm, 2008); however, both had previous histories of mental illness prior to their arrival at college (Associated Press, 2008; Boudreau & Zamost, 2008; Davey, 2008; Redden, 2008; Schuchman, 2007; Vu, 2007). As a result of the continuous media coverage, American citizens were asking many questions, such as: how could such an event have happened on a college campus?, if the university knew that Cho was a troubled student, why didn't they do anything about it? And how could such troubled young men obtain guns in the first place? (McGinn, Raymond & Henig, 2007; Rasmussen & Johnson, 2008). As Zdziarski, Dunkel, and Rollo (2007) pointed out, "Advances in technology have expanded the reach of televised media and communications…campus tragedies have become more prominent in our lives, regardless of where they occur" (p. 6); indeed, it seemed the entire nation was discussing and debating the incidents. American citizens felt a strong sense of fear in the face of such random violence which had no apparent cause or motive. This sense of fear was further heightened by the settings in which the shootings occurred—those being the college campus—a place which is generally considered safe and secure by most Americans. As Rasmussen and Johnson pointed out,

> Horrific events of significant scale with ubiquitous and relentless nation-wide coverage…exert a powerful impact on the psyche and basic instincts of students, parents, policymakers, and the general public, leading to the understandable questioning of the relative safety of a specific campus. (p. 6)

Because such violence, as presented in the Virginia Tech and NIU campus shootings, occurred within several months of each other, American society was gripped by a phenomenon which Killingbeck (2001) describes as a 'moral panic' (p. 187). As Martinez (2007) described it, in such a state of panic, "we want to know whose fault it is…we are more likely to compromise our fundamental values and prudence for the promise of safety" (p. 9). Such societal panic begins to believe that "no one is safe…that things are getting worse, that there are even more violent incidents to come" (Best, 1999, p. 9). Furthermore, when such violence is linked to underlying mental illness that is further sensationalized by a 24-hour media cycle which often portrays such murderous events as acts of madness being committed by perpetrators who suffer from mental illness (Altheide & Michalowski, 1999; Erikkson, 2001; Furedi, 2002), it only further exacerbates society's stigmatization of their fellow citizens who struggle with mental illness. As the U.S. Surgeon General commented in 1999, "the perception of people with psychosis being dangerous is stronger today than in the past…people with mental illness, especially those with psychosis, are perceived to be more violent than in the past" (p. 7).

Two Areas of Concern: Confusion over FERPA and Lack of Psychological Follow-Up Care

As in many times of national crisis, Americans inevitably turn to their elected representatives, both at the state and federal levels, to conduct thorough investigations of such violent acts as well as to produce systems of change in the forms of law and public policy in an attempt to protect them in the future. As a direct result of the Virginia Tech and NIU incidents, the federal government as well as several state governors established

review commissions (Griffin, 2007; Lewis, 2007; Rasmussen & Johnson, 2008) which have acted to "review policies and campus practices related to guns, mental health, crisis planning, and emergency communications" (Hebel, 2007, p. 36A). This body of state and federal review commission research, acting in combination with additional scholarly research (Moehlmann, 2007; Pavela, 2007; Schuchman, 2007) has consistently found two significant areas of concern in the management of students with mental health concerns. First, the research found widespread confusion among university officials about when and how they share student mental health and behavior information with each other (Angle, Bonner, Brown, Dean, Ferraro, Flora, et al., 2007; Davies, Fischer & Wilson, 2007; Leavitt, Gonzalez & Spellings, 2007; Moehlmann, 2007); in particular, the research demonstrated confusion about the legal limits and resulting interpretation of FERPA (the Federal Educational Records and Privacy Act of 1974, 20 U.S.C. $ 1232g) (U.S. Department of Education, 2008). For example, in the Virginia Tech incident, it appeared that university officials operated in information silos which may have significantly contributed to the deadly shootings (Fischer & Wilson, 2007; Massengill, Martin, Davies, Depue, Ellis, Ridge et al., 2007; Pavela, 2007; Schuchman, 2007). As the federal Virginia Tech review commission report to President Bush stated:

Critical information sharing faces substantial obstacles…university officials are not fully informed about when they can share information on persons who are likely to be dangerous to themselves or others and the resulting confusion may chill legitimate information sharing (Leavitt, Gonzalez & Spellings, 2007, p. 2).

Studies conducted among student affairs officers affirmed this issue of confusion with regard to interpretation of federal law (Bostic & Gonzalez, 1999; Rowe, 2005). "The task of implementing FERPA bedevils many higher education officials…there are no national standards or requirements for FERPA training" (Bostic & Gonzalez, p. 499). In a direct response to FERPA concerns raised by university officials nationwide, the US Department of Education released an "in-depth guide…which incorporated comments from more than 120 higher education associations" (Lipka, 2008, p. 18A) in December, 2008. The guide also presents new rules regarding FERPA regulation and implementation which go into effect on January 8, 2009 (Bernstein, 2008; Lipka, 2008; U.S. Department of Education, 2008). Yet, the department did not implement required FERPA training of university officials in this guide by stating, "We decline to establish such a requirement in these regulations" (U.S. Department of Education, p. 74816). It leaves this decision up to the university itself by stating that educational institutions "should have the flexibility in deciding the best way to communicate…the requirements of FERPA" (U.S. Department of Education, p. 74816).

A second area of concern in the management of students with mental health concerns is the actual system of campus psychological services which is significantly overburdened and lacking in effective follow-up care (Amada, 2001; Boyd, Hauttauer, Brandel, Buckles, Davidshofer, Deakin, et al., 2003; Chesbrough, Hatley, Jansky, Lewis & Pokrass, 2008; Cooper, 2005; Draper, Jennings, Baron, Erdur & Shankaer, 2002; Ghallager, 2006, 2007; Howard, Shiraldi, Pineda & Campanella, 2006; Leavitt, Gonzalez & Spellings, 2007; Massengill et al., 2007). As the report to President Bush states,

"Institutions must be prepared to both provide immediate and longer-term mental health support following an event and evaluate events and the responses to them in order to gather lessons learned and implement corrective measures" (Leavitt, Gonzalez & Spellings, p. 18). While the literature may acknowledge the need for more thorough psychological follow-up care for college students, the actual resources needed to accomplish such a task (i.e., financial and personnel) remain largely unavailable and therefore too difficult to achieve (Amada, 1994; Bishop, 2002, 2006; Cooper, 2005; Cooper & Archer, 1998; Flynn & Heitzman, 2008; Foley, 2008).

Overview of the Problem

The research on the traditional-aged college student generation (18-25 years old), also known as the millenials (Beaton, 2006; Downing, 2006; Elam, 2007; Howe & Strauss, 2000, 2003), generation y (Martin & Tulgan, 2001; Newton, 2000) and generation me (Twenge, 2006), paints the picture of a generation who presents personal dynamics of stress, anxiety, and mental health concerns unlike any other in the history of American higher education. Several scholars have suggested that personal levels of stress as well as the pressure to succeed are at unprecedented levels for this current college student generation (Howe & Strauss, 2000, 2003; Luther & Becker, 2002; McGinn, Raymond & Henig, 2007; Twenge, 2006). As Howe and Strauss described it, these students are "highly achieving and highly pressured…many indicate a 'trophy kid' pressure to excel' (p. 12). Of further concern is the literature's conclusion that today's traditional-aged college students are coming to campus with both previous histories of mental health concerns as well as prior psychological and psychiatric treatment (Arehart-

Triechel, 2002; Barry, 2002; Becker, Martin, Wajeeh, Ward & Shern, 2002; Benton & Benton, 2006; Clemetson, 2006; Eudaly, 2003; Magna-Zito, Safer, DosReis, Gardner et al., 2007; Trudeau, 2008). As one campus psychiatrist noted, "more individuals with a prior history of mental health concerns are attending college; so, they are coming to us with their problems, it's not that they are developing them while they are here" (Arehart-Treichel, 2002, p. 11). A startling fact that is not widely known by the American public is that the first episodes of chronic mental illness, manifesting in the form of a physical episode with diagnosable symptoms, are typically experienced in the traditional-aged college student population (18-25 years old) (Belch & Marshak, 2006; Kitrow, 2003; Robinson, 2007). Furthermore, it is estimated that 37% of young adults have been diagnosed with some form of mental illness "ranging from mild and short-lived to chronic and severe" (Becker et al., 2002, p. 359). As Carter and Winesman (2003) noted, "growing numbers of students arrive with mental health diagnoses and psychiatric medications in hand" (p. 1089).

Recent studies conducted on samples of both senior student affairs officers (SSAOs) and counseling center directors (CCDs) confirmed the trend of dramatic increases in mental health issues presented by today's traditional-aged college students. The percentage of CCDs who believed that the "number of students with severe psychological problems has risen in recent years" has consistently risen from 1997 to 2007, to its current level of 90% (Ghallager, 2008, p. 3). These data are further defined by the perceived number of students with severe psychological problems who are actually being seen at campus counseling centers, where nearly half of CCDs report having such

clients, and that nearly 10% of student clients had "impairment so severe that they cannot remain in school or can only do so with extensive psychological or psychiatric help" (Ghallagher, 2005, 2007, p. 4). Senior student affairs officers (SSAOs) report similar increases. Belch and Marshak (2006) found that the vast majority of SSAOs felt there had been "a sharp increase in both the severity and frequency of student mental health problems" (p. 464). Their results also shed further light on the high levels of frustration felt by the majority of SSAOs when it came to managing the disruptive behavior of such students, particularly when they "did not pose an imminent risk to the greater community" (p. 471). In addition, several recent studies validated Belch and Marshak's data by finding similar SSAO perceptions (Levin-Epstein, 2007; Rasmussen & Stokes, 2008; Stokes, 2007). As Stokes stated, "it is noteworthy that about 90% of SSAOs rated mental health as both a top challenge and priority even before the issues made national headlines" (p. 9). Kitrow (2003) summarized the impressions of both SSAOs and CCDs when she stated, "the increased demand and severity of student mental health problems may have the most impact on student affairs and counseling staff, who are on the front lines of dealing with student behavioral issues" (p. 171).

Collaborative Efforts in Managing Student Mental Health: SSAOs and CCDs

Just as American society turns to its government officials to manage crises when they occur, universities turn to senior student affairs officers and, in the case of mental health issues, campus counseling center directors, both to assess and manage student mental health concerns as well as minimize threatening behavior which may threaten

campus communities (Cornell et al., 2004; Sokolow, 2007). As has been the case since the beginning of the student affairs profession and continuing to the present day, it is the senior student affairs officer (SSAO) who has the ultimate institutional responsibility for the management of both student conduct and student mental health (Barr & Desler, 2000; Barr & Sandeen, 2006). While the latter has evolved to include the assistance of campus psychologists and sometimes psychiatrists, it remains the SSAO whose leadership is relied upon to manage both student conduct and mental health issues present in the student body as well as to make judgment calls which prevent or minimize violence on the college campus (Barr & Sandeen, 2006; Bickel & Lake, 1999; Sokolow, 2007).

Despite expectations placed on SSAOs and CCDs to manage ever-increasing student mental health concerns, institutions may not provide adequate resources to accomplish such as task for reasons of purpose as well as budget priorities. First, institutions may not view "the emotional well-being and growth of its student as their responsibility" (Levin-Epstein, 2007, p. 6). Second, institutions must prioritize budgetary expenses in the face of challenging economic times, thus as Cooper (2005) describes it:

> The level of resources available for higher education is under one of the largest challenges in its history, and non-academic costs, such as the provision of counseling services, are often vulnerable to cuts or elimination…yet, this stringency comes at a time of increasingly high demand for college counseling services for a population with increasingly severe pathology. (p. 4)

Therefore, rising case loads do not necessarily correlate to rising numbers of psychological staff on the nation's college campuses (Draper et al., 2002; Foley, 2008; Kadsion & DiGeronimo, 2004). Data gathered from counseling center directors demonstrate this point by showing a consistent psychologist/campus population ratio of

1:1,697. This average is far below the ratio recommended by the International Association of Counseling Services (IACS), which states that "every effort should be made to maintain minimum staffing ratios in the range of one Full-Time Equivalent (FTE) professional staff member to every 1,000 students" (Barr & Rando, 2008, p. 23). Despite impressions of rising case loads among CCDs, these national ratios have remained unchanged for the past three years (Ghallager, 2006, 2007). Due, in large part to the lack of financial resources, institutions "have been put under pressure to utilize short-term or brief treatment methods" (Lee, 2005, p. 26). In order to provide long-term psychological care to its students in need of such services, institutions must cultivate and maintain relationships with off-campus providers (Benton & Benton, 2006). Both health insurance, which may or may not include mental health benefits, as well as institutional location (i.e., urban or rural areas), can prove to be very challenging issues for institutions as they attempt to manage student mental health concerns. This dilemma becomes even further complex when the chronic mental health condition of a particular student manifests in behavior which is disruptive to the greater campus community. Delworth (1989) was the first scholar to define such students as "disturbed and disturbing" (p. 4). The actual methods chosen by both the SSAO and CCD to manage such students may also represent several problematic issues. First, an internal conflict may develop between these two student affairs officers. On the one hand, SSAOs have an ultimate responsibility to effectively manage student conduct. While they may utilize student conduct processes in holding students accountable for their behavior, they may also empathize with the student in that they view the conduct violation as a

"manifestation of an illness rather than willful misconduct" (Belch & Marshak, 2006, p. 472); thus, they may view mandated psychological assessment and the possible use of mandated psychotherapy as an acceptable tool in managing disturbed and disturbing students. On the other hand, campus psychologists represent a "profession within a profession." That is, all psychologists, regardless of where they practice, typically adhere to therapeutic standards of the psychological profession which view psychotherapy as a voluntary and confidential process (Amada, 1994, 2001; Pollard, 1995, 2001; Stone & Archer, 1998). Since the vast majority of counseling centers fall under the direct authority of the SSAO, CCDs may "undertake mandated psychotherapy…even when they have ethical objections to this practice" (Amada, 2001, p. 111). A directive under supervisory authority (on the part of the SSAO) may create an organizational power dynamic where CCDs feel pressure to accept mandated psychotherapy or run the risk of jeopardizing their operation by non-compliance with directives of their immediate supervisor (Amada, 2001; Archer & Cooper, 1998; Gilbert & Sheilman, 1995; Kiracoffe & Wells, 2007). When psychotherapy becomes involuntary and is used as a form of conduct management, psychologists may view it as unethical and in direct violation of the profession's ethical standards. Furthermore, psychologists hold to the principle that the psychotherapy process must adhere to strict client privacy guidelines in the form of informed consent (Amada, 2001; Archer & Cooper, 1998; Kiracoffe & Wells, 2007). That is, clients voluntarily give their permission for others to talk with their therapist about their actual participation in as well as subject matter discussed in therapeutic sessions. Thus, the right of the client "to give or withdraw consent at any time for any

reason" (Kiracoffe & Wells, p. 262) remains standard practice for many psychologists. Therefore, if a SSAO includes psychotherapy as a required element of a behavioral agreement, knowledge of participation in therapy, at a minimum, becomes necessary for fulfillment of the student behavioral plan. If the student, in turn, withdrew consent for release of information to the SSAO, such an agreement becomes null and void and thus, proves ineffective. Third, the same professional standards recommend that campus psychologists should not be part of the campus disciplinary process and should be perceived as administratively neutral in the eyes of their student clients (Boyd et al., 2003; Kiracoffe & Wells, 2007). As Stone and Lucas (1994) describe it, "counseling and discipline are not easily combined; rather, their association is controversial, if not contradictory, leading to role ambiguity and bias…the role of counseling centers in fostering a disciplined community remains ambiguous" (p. 234).

Purpose of the Study and Research Questions

The purpose of this qualitative study is to explore how and why senior student affairs officers (SSAOs) and counseling center directors (CCDs) manage potential threats of harm to the campus community by students with mental health concerns through the use of behavioral agreements which include long-term psychotherapy. While the methods chosen may include both separation from the institution as well as continued enrollment, it is the latter category and further exploration of its use that will represent the focus of this research study. The decision to allow a student with both mental health concerns and disruptive behavior to remain enrolled in the institution is not made lightly. It involves significant analysis on the parts of both the SSAO and CCD which must

balance individual rights with the greater protection of the campus community; therefore, a qualitative examination of how and why such a decision is made and implemented may offer valuable insight to practitioners who encounter similar circumstances. As previously discussed, it is both the SSAO and CCD, who, in acting in a collaborative manner, become aware of student mental health concerns which may manifest into behavior which poses the threat of harm to a campus community. These same staff members are expected to devise and implement plans which will manage the behavior in a manner that minimizes both further disruption and harmful risk to a campus community. While these two student affairs officers may come from professional preparation programs which emphasize both an ethos of care and understanding of the psychological stages through which young adults pass during their college years (Chickering, 1969; Chickering & Reisser, 1993), they may also have very different perspectives on both how to interpret disruptive behavior as well as what behavioral plans may be used to produce effective control in managing such behavior. In this exploratory, qualitative study, senior student affairs officers (SSAOs) and counseling center directors (CCDs) who practice in the same institution will be asked to identify and reflect upon how and why these choose and implement specific actions steps in managing student mental health concerns and minimizing threatening behavior. These reflections should assist in a more in-depth understanding of the various methods chosen as well as the possible conflict that may occur between the SSAO and CCD in arriving at these action plans. Questions that guide this study are as follows:

1. Why do Senior Student Affairs Officers (SSAOs) and Counseling Center Directors (CCDs) choose behavioral agreements to manage students with mental health concerns?
2. How do SSAOs and CCDs create behavioral agreements and what are the most common elements found in these agreements?
3. How do SSAOs and CCDs identify students with mental health concerns that may pose a threat of harm to the campus community?
4. What criteria are used to require disruptive students with mental health concerns to enter into behavioral agreements that may include psychotherapy?
5. To what extent do SSAOs and CCDs agree on the use of mandated psychological assessment or mandated psychotherapy as a management tool? If differences do exist, how are they addressed?
6. Who, both on and off campus, has the responsibility for identifying and addressing student mental health issues that may result in harm and what role does each person serve in the process?
7. What role, if any, does the student conduct system serve in addressing students who may violate campus policies while exhibiting mental health concerns that may contribute to disruptive behavior?
8. How are policies and procedures evaluated for their effectiveness?

Significance of the Study

While previous research has reported on both the perceived increases in college student mental health in recent years (Amada, 1994, 2001; Benton & Benton, 2003; Benton, Robertson, Tseng, Newton & Benton, 2003; Bishop, 2002, 2006; Cooper, 2005; Ghallager, 2005, 2007; Kadison & DiGeronimo, 2004; Kitzrow, 2003) as well as the various options which SSAOs and CCDs may choose to manage such situations (Amada, 1994, 2001; Boyd, Hauttauer, Spivack, Deakin, Hurley, Buckles, et al., 2000; Howard et al., 2006; Pavela, 1985, 2006, 2007), few studies have explored how and why SSAOs and CCDs choose such options in the management of students with chronic mental health issues. Additionally, in a related sense, few studies have also explored how the use of behavioral agreements is utilized by SSAOs and CCDs in an attempt to protect campus communities. While the literature presents various threat assessment models and the use of multi-disciplinary teams in conducting such assessments (Amada, 1994, 2001; Bova, Cornell & Groth, 2007; Boone & Eells, 2008; Cornell et al., 2004; Fein, Vossekuil, Pollack, Borum, Modzeleski & Reddy, 2002; Hollingsworth, 2004; Howard et al., 2006; Sokolow, 2007), few studies exist which qualitatively investigate the specific reasons why certain behavioral management tools are utilized in a direct attempt to minimize violence to campus communities. There are several possible reasons for this gap in the research literature. First, while the use of behavioral agreements and threat assessments may have been practices utilized by universities in the past, their formalization as written policy may have become more prominent due to the very recent events at Virginia Tech and Northern Illinois University. Second, in light of these recent tragedies, specific

exploratory studies which further investigate how student affairs officers enact behavioral agreements in an attempt to both manage student mental health concerns as well as minimize threats to campus communities may still be in their infancy. Third, such research may uncover internal conflicts between student affairs officers which may prove to be uncomfortable to some in the student affairs profession. This phenomenological study, in investigating the specific viewpoints of the primary student affairs officers who both implement and monitor student behavioral agreements(e.g., senior student affairs officers and counseling center directors), may contribute to the limited amount of literature on the specific reasons for choosing various methods in managing student mental health concerns in an attempt to minimize threatening situations; more specifically, this study is significant for three reasons: 1) exploration of the various options available to both SSAOs and CCDs in arriving at behavioral management methods may inform similar student affairs officers in their professional practice; 2) analysis of the possible conflict which may exist between SSAOs and CCDs in implementation of such methods may result in a better understanding of the conflict and how to facilitate an approach that is agreeable to both parties and, at the same time, is effective in managing student mental health and associated disruptive behavior; and 3) the usage of an interdisciplinary team in arriving at such methods may encourage its use by SSAOs and CCDs in the development of behavioral action plans.

Behavioral Management Methods

While traditional student conduct infractions have utilized a student disciplinary process which is framed around due process principles (Barr & Sandeen, 2006; Bickel & Lake, 1999; Dannells & Consolvo, 2000; Henning, 2003; Melear, 2003), the manifestation of behavior, which is the result of chronic mental health conditions, represents both an increasing concern on America's college campuses as well as a new direction in student conduct management. Student conduct decisions which may result in the disruption of student enrollment, whether voluntary or involuntary, as compared to the usage of behavioral options which allow for both continuation of enrollment and, at the same time, protect the campus community from disruptive behavior which may represent foreseeable risk, are not easily made; therefore, an in-depth analysis of the methods chosen to manage student conduct that is both disturbed and disturbing (Delworth, 1989) may serve to inform the practice of both SSAOs and CCDs.

Internal Conflicts Arising Between SSAOs and CCDs

Senior student affairs officers and counseling center directors may have very differing views on how and when the counseling center is to collaborate in the implementation of behavioral agreements. The psychological profession holds strongly to the principle of psychotherapy as a voluntary process that is neither coercive, nor punitive in its usage (Amada, 1994, 2001; Benton et al., 2003; Boyd et al., 2000; Cooper & Archer, 1998; Pavela, 2007; Pollard, 1995; Stone & Lucas, 1994). Such a stance may be further compounded by university organizational dynamics which, in the vast majority of cases, find CCDs directly reporting to SSAOs. The result may be a direct internal

conflict that arises between the supervisor (SSAO) who is charged with managing all student conduct and the supervisee (CCD) who is charged with providing psychological care to students, under the guise of the greater psychological principles of voluntary treatment and client confidentiality. As Amada (2001) describes it, "some psychotherapists undertake mandated therapy…even when they have ethical objections to this practice…when administrators authoritatively insist that students be seen, the psychotherapist who refuses to comply may be placing him/herself and their program in jeopardy" (p. 111). Therefore, an exploration of this possible conflict which will be represented by both sides in the form of data gathered from SSAOs and CCDs of the same institution, is informative to both SSAOs and CCDs at other institutions as they attempt to strike collaborative partnerships that are both respectful of each other and, at the same time, effective in managing student mental health concerns and disruptive behavior.

Use of Campus Care Teams and Psychiatric Hospital Interventions

Several studies have proposed the use of multidisciplinary teams in both the analysis and implementation of action plans which manage disturbed and disturbing students (Angle et al., 2007; Cornell et al., 2004; Delworth, 1989; Leavitt, Gonzalez & Spellings, 2007; Massengill et al., 2007; Sokolow, 2007). The literature suggests that not only has such a practice has gained in popularity since the violent episodes at both Virginia Tech and NIU (Flynn & Heitzman, 2008; Newberry, 2008), it has also become recognized and recommended by the U.S. Department of Education (2008) when it states, "the department encourages…the establishment of a university threat assessment team to

manage student situations which may pose a threat" (p. 74839). While still in its infancy in the literature, the use of certain members of this team (mainly, the CCD and SSAO) to facilitate post psychiatric hospitalization discharge plans also appears to be a new direction for student affairs officers in the management of disturbed and disturbing students (Ells & Cook, 2008). A greater understanding of both of these team approaches may inform practitioners in the scope of their responsibilities in devising effective management plans.

Definition of Terms

Since the dissertation topic addresses an array of topics, ranging from mental health conditions to specific methods used to manage such conditions in the college student population, it is important to define the terms which will be utilized throughout the text. A clearer understanding of this terminology will assist in the development of a better understanding of the research topic.

Americans with Disabilities Act of 1990, 42 U.S.C. $ 12101. A federal legislative act originally passed in 1973, prohibiting discrimination against individuals who suffer from a disability, which includes mental disability. The act was further amended in 1990 to include an expanded definition of mental disability, which is described as "a mental impairment that substantially limits one or more major life activities of the individual."

Americans with Disabilities Act of 2008 Additional Amendments (ADAAA). A series of amendments intended to provide further clarification of the Americans with Disabilities Act of 1990, by providing, in part, further clarification to the meaning of "major life activities." This very detailed listed of such activities include "caring for

oneself, performing manual tasks, and a list of major bodily functions" which are covered under the federal legislation (Association of University Centers on Disabilities, 2008). Such legislation took effect on January 1, 2009.

Behavioral Agreement or Behavioral Contract. An agreement which is created between an institution and a student in order to regulate behavior which is both in violation of student conduct procedures and which may be disruptive to the campus community. Such an agreement contains behavioral limits which must be adhered to as well as follow-up tasks that must be completed by the student (Deisinger, Randazzo, O'Neill, & Savage, 2008).

Bipolar disorder. A mood disorder, previously known as manic depressive order, which is characterized by periods of severe depression followed by periods of mania (American Psychiatric Association, 1994; Carmichael, 2008; Kadison & DiGeronimo, 2004).

Campus care team. A multi-disciplinary team composed of campus representatives from: student affairs, public safety, legal counsel, residence life, and disability resources. This team analyzes student behavior and frequently makes recommendations for the management of student mental health issues (Flynn & Heitzman, 2008; Sokolow, 2007). This team may also be utilized for threat assessment purposes.

Chronic depression. A combination of symptoms which "may include: depressed mood most of the day, sustained or diminished interest or pleasure in all or almost all activities" (Lee, 2005, p. 25).

Chronic mental illness spectrum. A spectrum of recurring mental health conditions which cause "inference with normal life functioning" (Kadison & DiGeronimo, 2004, p. 96). Both psychological and psychiatric treatments are required in order both to minimize such interference and allow the student to move forward with personal and educational goals. This spectrum of chronic mental illness moves from less intrusive conditions (e.g., chronic depression and anxiety disorders) to the most intrusive conditions (e.g., bipolar disorder and various forms of schizophrenia).

Counseling center director (CCD). A psychologist who leads the activities of the university counseling center. The CCD usually supervises several campus psychologists who provide psychotherapy to a student population. In most cases, the counseling center is part of the greater division of student affairs.

Diagnostic and Statistics Manual (DSM). A professional manual used by both psychologists and psychiatrics to diagnose mental health conditions. The most recent version (fourth edition) was conceived in 1994. A fifth edition is anticipated by 2010 (Roan, 2009).

Informed consent. A process by which a student voluntarily allows information pertaining to psychological treatment sessions to be communicated to designated university officials (e.g., student affairs officers). Such consent may cover both attendance confirmation and/or specific subject matter discussed in the course of psychotherapeutic treatment.

Mandated assessment. A process resulting from student behavior which has both violated the code of student conduct and may have manifestation of mental health issues

at its root cause; as such, a SSAO mandates the psychological assessment of the student by the campus counseling center staff. The assessment produces both psychological diagnosis and recommended treatment options. The latter is considered a voluntary process enacted by the student client.

Mandated disciplinary education. A mandated, interactive process conducted between a student and a student affairs administrator. Such an administrator may be represented by the SSAO and/or a campus psychologist. This process analyzes behavior infractions of a code of student conduct and is "engaged in for the public good" (Stone & Lucas, 1994, p. 238); that is to say, its purpose is to minimize future behavior which may be disruptive to the greater campus community.

Obsessive-compulsive disorder. A mental disorder which is characterized by "repeated, unwanted thoughts or compulsive behaviors that seem impossible to stop or control" (OCD Foundation, 2008, p. 1).

Psychotherapy. A process by which a psychologist utilizes conversation sessions with a client in order to both analyze client behavior and to affect cognitive behavior change to address specific behavior. This non-medical process is "conducted primarily for the benefit of the individual student client" (Stone & Lucas, 1994, p. 238).

Psychotic. A term, used frequently in the psychological and psychiatric professional literature, which describes mental behavior "that includes delusions or hallucinations" (American Psychiatric Association, 1994, p. 275). Though frequently referenced in the literature, this term "has a number of different definitions, none of which has achieved universal acceptance" (p. 275).

Psychotropic medication. Pharmalogical agents used by psychiatrists and medical doctors to treat a variety of chronic mental health conditions. Such medications frequently include a specific class of agents known as Selective Serotonin Reuptake Inhibitors (SSRIs), which include popular anti-depressants (e.g., prozac, zoloft).

Schizophrenia. A chronic mental disorder which is represented by several diagnosable forms. In its broadest sense, it can be described as "a disturbance that lasts for at least 6 months and which includes at least 1 month of active-phase symptoms along with two or more of the following: delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior" (American Psychiatric Association, 1994, p. 273). In more common language, it is the mental condition one most commonly associates with "hearing voices" and/or severe delusional thought and behavior (Clemetson, 2006; Cooper & Archer, 2002; Kadsion & DiGeronimo, 2004).

Senior student affairs officer (SSAO). The university staff member who leads and manages the division of student affairs. In smaller institutions, the SSAO is represented by the title of Dean of Students and/or Vice-President of Student Affairs. This title may also be combined, such as Vice-President of Student Affairs and Dean of Students.

Severe anxiety disorder. A sudden and sustained period of anxiety which is marked by "intense fear that strikes often and without warning" (Kadison & DiGeronimo, 2004, p. 213).

Short-term psychotherapy. Limited psychotherapy sessions (usually 3-4) in which a student clients engage with a campus psychologist at the campus counseling center.

Conclusion

The goal of this chapter has been to introduce a study of senior student affairs officers and counseling center directors and how they arrive at action plans to manage student mental health issues and disruptive behavior. In the wake of the recent tragedies at Virginia Tech and NIU which highlighted impressions of rising mental health issues on college campuses nationwide, American society has taken great interest in the ways in which universities are managing student mental health issues. While impressions of growing student mental health concerns may not necessarily be a new concern for university administrators, the threatening behavior which may result from such conditions represents a new dimension in managing violent behavior and minimizing deadly risk to a campus population. A qualitative examination of how and why SSAOs and CCDs manage such behavior will provide further insights into the rationale and methods of this highly complex process.

The next chapter offers a synthesis of the research literature about both the history of campus violence which has mental health issues at its core as well as what is already known about college student mental health. Chapter II includes a review of empirical studies which form the basis for impressions of rising student mental health concerns as well as for scholarly debate which both supports and rejects such claims. This chapter also provides greater insight into the societal and institutional responses already taken to manage student mental health concerns. Chapter III describes the actual methodology to be used in this study. Discovering how and why SSAOs and CCDs implement plans to manage student mental health issues will both fill a gap in the research on college student

mental health as well as benefit the higher education community as it manages this growing area of concern.

CHAPTER II

REVIEW OF THE LITERATURE

The recent tragedies at Virginia Tech and NIU remind us that student mental health concerns may also be linked to violent behavior which, left poorly managed, may result in deadly consequences; therefore, it is not only important to gain a historical perspective on the evolution of campus violence, but also to better understand the student affairs role in managing student conduct that is both violent and possibly threatening to the greater campus community. The first part of this literature review examines both the history of campus violence as well as the research which has resulted in the wake of such violence. The second part of the literature reviews examines trends in campus mental health management. This body of research, which has guided practitioners in the development of mental health policy, has also been criticized by many in the scholarly community for lack of empirical methodology. This scholarly debate is further examined and discussed. Lastly, the third part of the review examines current societal and institutional responses to student mental health concerns.

A History of Violence in the Ivy Tower

Early Campus Violence and the Role of the Student Affairs Officer

Violence, as a conceptual event is not new on the American college campus. As both Veysey (1965) and Rudolph (1990) pointed out, violence between students, as well as between students faculty, was part of the emerging American college. Riots and

brawls had been a traditional aspect of student behavior prior to the Civil War period (Thelin, 2004; Veysey, 1965). On several occasions, this violence often resulted in serious injury or even death. Gehring (1996) gave a historical summary of such incidents in the early American college:

> In the 1800's, a student was killed over a trout, a professor was killed at the University of Virginia, the president of a university in Mississippi was stabbed to death by a student, several students were shot at Miami University in Ohio, professors were stoned at the University of Georgia, and at the Universities of Missouri and North Carolina, several students were stabbed and killed. (p. 36)

As an unwelcome and yet expected form of behavior which may be exhibited by young, newly independent adults, violence needed to be controlled and managed (Rudolph, 1990; Thelin, 2004). During the 19th century, it was faculty who, along with their teaching duties, acted as the college's disciplinarians. As Veysey (1965) pointed out, "college disciplinarians essentially desired a controlled environment for the production of the morally and religiously upright" (p. 35). After all, "souls were at stake" (Rhatigan, 2000, p. 4). However, by the end of the same century, faculty began to lose their interest in such responsibilities and desired to perform purely academic duties. "The great majority found such paternalistic duties immensely painful to perform" (Veysey, 1965, p. 36); therefore, an administrator was needed to manage this and other issues which "had been pushed to the periphery" (Rhatigan, 2000, p. 7). Such a position was to be realized in the birth of the student affairs administrator in around 1890 (Sandeen, 1991). Not only did these pioneers manage student conduct, they also managed student mental health issues. As early as 1918, the Dean of Men at Harvard University reported that the student mental health problems were the number one challenge to university

administrators (Benton & Benton, 2006). The student affairs officer "assumed the role of social welfare worker for their students" (Sandeen, 1991, p. 12). As has been the case since the beginning of the student affairs profession and continuing to the present day, it is the Senior Student Affairs Officer (SSAO) who has the ultimate institutional responsibility for the management of both student conduct and student mental health (Barr & Desler, 2000; Barr & Sandeen, 2006). While the latter has evolved to include the assistance of campus psychologists and sometimes psychiatrists, it remains the SSAO whose leadership is relied upon to manage student conduct and mental health issues present in the student body as well as to make judgment calls which prevent or minimize violence on the college campus (Barr & Sandeen, 2006; Bickel& Lake, 1999; Ells & Cook, 2008).

Campus Violence in the 20th Century and the Changing Principle of *In Loco Parentis*

The 20th century, in particular, the period beginning with the 1960s, witnessed acts of campus violence which were represented in the combination of protests over America's involvement in the Vietnam War as well as civil rights (Kerry, 1991). These actions resulted in a wave of violence on America's college campuses. As Ravitch (1983) noted:

> Before the year 1968, major disruptions of campus life involving property destruction and personal violence were rate…during 1968, violent protests occurred on about one hundred and fifty campuses, many of which included the nation's most selective public and private universities. (p. 205)

During this time of civil unrest, America's college students chose violence as a means of expressing their displeasure with the national agenda. Whitaker and Pollard (1993) offered further insight into the emotional dynamics of traditional-aged college students and why they chose violence as a response when they stated:

> The time between seventeen and twenty-one is often one of nagging self-doubt, of intense conflict in relations with other people, of painful and sometimes rebellious struggles for independence from one's parents …such emotional struggles and discomforts upset the individual's equilibrium and thus free considerable energy for either creative or destructive acts. (p. 14)

As universities struggled to manage such violence, student affairs officers relied upon the principle of *in loco parentis* (in place of parents) to dismiss students for violent conduct. Prior to the 1960s, this transference of parental authority to the university was viewed as necessary for the "moral, physical, mental, and moral development" of the student population (Grossi & Edwards, 1997, p. 832). Since the student affairs officer acted as the university "stand-in parent" (Barr & Desler, 2000, p. 630), it was this position which received "the delegation of a father's right to discipline" (Bickel & Lake, 1999, p. 19); however, students in the 1960s rejected this principle and began to demand their individual rights under the 14th amendment of the U.S. constitution. The *Dixon v. Alabama* case dealt with this very issue. It found in favor of the students and their constitutional rights to due process; thus, *Dixon* signaled the death of *in loco parentis* as a legitimate disciplinary concept (Bickel & Lake, 1999; Henning, 2007; Melear, 2003). From this point forward, student affairs administrators needed to craft disciplinary policy which treated students as "constitutional adults" (Bickel & Lake, 1999, p. 42).

Violence, Mental Illness, and Tragedies of the Modern Era

The decade of the 1960s also witnessed a new type of violence on the college campus—the student with mental illness who chooses murder and suicide as a response to their inner conflict. Such emotions plagued Charles Whitman as he carried out the first notorious mass shooting on an American college campus in August, 1966. Whitman shot and killed 16 people, including himself, using skills he had learned as a former United States marine (*Houston Chronicle*, 2001; Zdziarski, Dunkel & Rollo, 2007). Whereas previous campus violence may have been intentional and resulted in serious injury or death, the Whitman incident demonstrated mental illness as a significant factor in choosing violence as a response. After the shootings, *Time Magazine* (1966) displayed Whitman on their cover with the headline, "The Psychotic and Society." Americans were, quite possibly for the first time, exposed to the problem of serious mental illness and the possible danger it posed to campus communities. Unlike American society today which has experienced multiple school shootings, such was not the societal climate experienced in 1966. As Levin and Fox (1985) described it, "Americans today are virtually unshockable. When we hear of the latest school shooting, we are saddened, certainly, but not shocked…it happens so often that we've long since lost count of the shooters and their victims" (p. 12). Unlike the data presented in modern college shootings, which revealed multiple interactions with student affairs and campus mental health staff (Leavitt, Gonzalez & Spellings, 2007; Levin-Epstein, 2007; Massengill et al., 2007; Schuchman, 2007), Whitman had only experienced one interaction with a campus psychiatrist prior to the University of Texas tragedy. The psychiatrist's notes revealed

"great distress over the separation of his parents" and the verbal communication of a possible attack plan in which Whitman expressed his "thinking of going up in the tower with a deer rifle and start shooting at people" (Hicks, 2006, p. 16). In addition, unlike today's system of background checks used to regulate handgun purchases, in 1966, "the only requirements for the purchase of a handgun were a name, address, and age of buyer…mail order purchases of dangerous weapons were commonplace" (Lavergne, 1997, p. 260). By the 1990s, both secondary school and college shootings had grabbed the national spotlight. Calculated, deliberate murder seemed to come back with a vengeance. From 1990 to present, 13 school shootings have occurred in America's secondary schools (Bova, Cornell & Groth, 2007; O'Toole, 2000). During this same time frame, nine shootings have occurred at the nation's colleges and universities (Smith, 2007). While some of these cases may not have involved shooters with underlying mental health issues, several of them present documented proof of mental health concerns as a contributing factor (Chen, 1995; Cotliar, 1992; Gibson, 1999; Kahn, 2004; Oliphant, 2002; Rooney, 2002).

Post-Mortem Commissions and Their Resulting Research Studies: Commonalities and Insights into Red Flags of Concern

The immediate aftermath of the University of Texas shootings also witnessed the establishment of post-mortem commissions as a valuable research tool. Such research, usually commissioned by the governors of the state in which the incident occurred, became a standard in not only offering insight and analysis into the motives of the shooter, but also in providing recommendations to avoid a similar incident in the future

(Iscoe, Kluender & Sorenson, 1967; Lavergne, 1997). By establishing a group of experts who utilize qualitative research methods (i.e., numerous interviews and document analysis), the chief state executive has not only contributed to society's knowledge of violence, but has also offered some sense of reassurance (albeit true of false) that such an incident can be avoided in the future. Governor Connally demonstrated this latter point in a press conference where he announced the establishment of the Texas Tower commission in which he directed it "to examine every aspect of the tower incident" (Lavergne, 1997, p. 255). Amongst its findings, Iscoe, Kluender and Sorenson (1967) found Whitman to be "an intelligent, intense, and driven young man, but someone who has been encased in internal and external predicaments causing personal turmoil…a profound dissatisfaction and a poor self concept that resulted in an acute schizophrenic break" (p. 25). Scholarly research on campus shootings in the late 20th and early 21st centuries are also presented in the form of books and articles which examine four additional incidents. All of these incidents also share both murder and mental health issues at their core. Similar to past post-mortem commission which employed qualitative research methods to arrive at their conclusions (Angle et al., 2007; Iscoe, Kluender & Sorenson, 1967; Leavitt, Gonzalez & Spellings, 2007; Massengill et al., 2007), these studies also offered insight into similar patterns of behavior, also known as red flags, that have become evident in all of the current investigatory inquiries (Chen, 1995; Cotliar, 1992; Fox, 2007; Gibson, 1999; Kahn, 2004; Oliphant, 2002; Rooney, 2002; Smith, 2007). In chronological order, these incidents took place at: The University of Iowa (1991), Simon's Rock College (1992), Appalachian State University (2002) and the

University of Arizona (2002). The research presented several factors of personal behavior that should have raised five red flags of concern amongst university administrators, but failed to do so, resulting in tragic consequences. First, the assailants were ostracized by and exhibited strong anger and rage toward their peers. Such action culminated in peers deliberately avoiding social interaction with them (Chen, 1995; Cotliar, 1992; Gibson, 1999; Rasmussen & Johnson, 2008; Rooney, 2002). Second, they exhibited a strong sense of injustice or maltreatment that has beset them during their time at the college or university. As Chen (1995) described in the Lu murders at the University of Iowa, "this was just one more act of cowardly sabotage designed to block him" (p. 117). Third, the strong sense of perceived injustice culminated in a plan of revenge which, in almost all of the cases, had been communicated to someone prior to the actual attack. This is demonstrated in Gibson's (1999) study of the Simon's Rock College shootings which found that Lo had expressed interest in obtaining a gun for the purpose of "shooting up the dining hall" (p. 66). Fourth, the assailants suffered from paranoia and delusions which, as in the Odighizuwa murders at Appalachian State University, festered and manifested into the assailant personally developing into a "time bomb waiting to go off" (Oliphant, 2002, p. 16). Fifth, and probably most important from the perspective of possible prevention, university administrators, usually in the form of student affairs officers, had prior knowledge of the fore-mentioned behaviors and yet, failed to act in a manner which could have stopped the murders from occurring in the first place (Chen, 1995; Gibson, 1999; Kahn, 2004; Oliphant, 2002; Smith, 2007). A good example of such failure to act is demonstrated in the Lo murders whereas Lo had

received the gun he used via campus mail. Such a curiously-shaped package raised obvious concerns in the campus mail department. This suspicion was immediately communicated to the dean of students; yet, when the dean met with Lo and asked him to open the package in his presence, Lo refused and due to the dean's misinterpretation of student privacy law, he, in turn, did not require Lo to open the package and allowed him to leave his office with the wrapped item (Cotliar, 1992; Gibson, 1999). This last point, that being missed opportunities for intervening action, became a major focus of both national media attention and the post-mortem commission reports following the most recent incidents at both Virginia Tech and Northern Illinois University (Angle et al., 2007; Boudreau & Zamost, 2008; Davey, 2008; Leavitt, Gonzalez & Spellings, 2007; Rasmussen & Johnson, 2008; Massengill et al., 2007; Schuchman, 2007).

The Virginia Tech Incident: A Closer Look

Since the Virginia Tech incident, which represented the deadliest shooting in U.S. history, became the focus of a national dialogue concerning campus safety and mental health issues (Dunkle, Silverstein & Warner, 2008; Fiegel, 2007; Fischer & Wilson, 2007; Schuchman, 2007), and; whereas, specific post-mortem research offers further insight into the aforementioned red flags of concern, it is worthy of special analysis. The research literature on the Virginia Tech incident which, due in large part to its recent occurrence, continues to evolve and further informs our knowledge of behaviors which should raise red flags amongst student affairs administrators. While the research on previous campus shootings demonstrated isolated incidents of alarming behavior, studies of the Virginia Tech incident pointed to several years' worth of alarming behavior which

were not only tolerated and allowed in both academic and non-academic settings, but were also mismanaged in both of these arenas (Angle et al., 2007; Fischer, 2007; Leavitt, Gonzalez & Spellings, 2007; Massengill et al., 2007; Rasmussen & Johnson, 2008; Schuchman, 2007). On the academic side, several of Seung-Hui Cho's instructors had expressed their concerns regarding his odd behavior and disturbing class writings (Cable News Network, 2007; Chesbrough et al., 2008; Kleinfeld, 2007; Massengill et al., 2007). Several examples demonstrated such concerns. Dr. Linda Roy, a Virginia Tech English instructor, found Cho to be a depressed and angry young man in her classroom and she began to meet with him, urging him to utilize the university counseling center (Flynn & Heitzmann, 2008; Johnson, 2007). She was so concerned about meeting him alone that she arranged a code with her assistant in case of trouble. If she uttered the name of a dead professor, her assistant was to immediately contact campus security (Kleinfeld, 2007; Massengill et al., 2007). Poet Nikki Giovanni had Cho as a student in her creative writing class where Cho had become known amongst her students for his silent behavior and aloof manner. Half-way through her course, she learned that Cho had "been using his cell phone under his desk to inappropriately photograph female students" (Schuchman, 2007, p. 105). One tenured faculty member went as far as threatening to resign his position if Cho were allowed to enroll in his class (Massengill et al., 2007).

Cho also exhibited alarming behavior outside the classroom environment. Campus police met with Cho twice after they had received reports from female students who had become very uncomfortable with e-mail and instant message communications they had received from him (Kleinfeld, 2007; Massengill et al., 2007; Robinson, 2007).

These are just some of the accounts of behavior which, while not completely ignored, were tolerated and allowed to accumulate. As CBS News Anchor Bob Shieffer (2007) commented:

> This time, public officials reacted with despair, even resignation—despair that no one seems to know what to do, resignation that these things are going to happen from time to time as guns are available to the mentally deranged…there is just not much that can be done about it. (p. 1)

The research also shed light on a concern which falls outside of the educational arena—the failure of the psychiatric committal process and resulting lack of follow-up care (Angle et al., 2007; Goss, 2007; Knott, 2007; Schuchman, 2007). While the university did eventually seek a judge's order to have Cho committed for psychiatric hospitalization after he expressed suicidal ideation to other students (Angle et al., 2007; Leavitt, Gonzalez & Spellings, 2007; Massengill et al., 2007), he had been released a short time afterward and was allowed to re-enter the campus community with no follow-up care plan in place (Chesbrough et al., 2008; Leavitt, Gonzalez & Spellings, 2007; Massengill et al., 2007). As the report to President Bush stated, "Institutions must be prepared to both provide immediate and longer-term mental health support following an event, and evaluate events and the responses to them in order to gather lessons learned and implement corrective measures" (Leavitt, Gonzalez & Spelling, 2007, p. 18). There are several issues raised by the preliminary Virginia Tech research. First, mounting behavior cannot be ignored; rather, all faculty and staff should be encouraged to document such behavior and report it to a "campus response mechanism" (Chesbrough et al., 2008) Since this incident, this mechanism appears to be, at a minimum, the senior student affairs officer and, at its best, a threat assessment team which is lead by the student affairs

officer along with representatives from other university offices (Bova, Cornell & Groth, 2007; Cornell et al., 2004; Davies, 2008; Dunkle, Silverstein & Warner, 2008; Leavitt, Gonzalez & Spellings, 2007; Massengill et al., 2007; Sokolow, 2007). Second, while acknowledging the perception among university administrators that mental health issues may be increasing among campus populations and, in response, recommending more thorough campus psychological follow-up care (Leavitt, Gonzalez & Spellings, 2007; Massengill et al., 2007), the actual resources needed to accomplish such a task (i.e., financial and personnel), remain largely unavailable (Amada, 1994; Bishop, 2002, 2006; Cooper, 2005; Cooper & Archer, 1998; Flynn & Heitzman, 2008).

The Secondary School Shootings Literature: Lessons Which can be Applied to Higher Education Settings

The use of post-mortem commissions as a mode of research inquiry is well-documented in the secondary school literature, particularly in the period of the late 20th and early 21st centuries. This is most likely due to the larger number of school shootings which have unfortunately taken place in America's schools. Since 1990, 13 school shootings have taken place in both America's elementary and secondary schools, resulting in 323 deaths (Bova, Cornell & Groth, 2007; Fein, Vossekuil & Holden, 2002; McEvoy, 2000; O'Toole, 2000; Vossekuil, Fein, Reddy, Borum & Modzeleski, 2002). These figures do not include the plans of school shooters which have recently either been foiled, such as the 14 year-old Pennsylvania student who planned a "Columbine-type" event (Pontz, 2007), or have been carried out, such as the recent Cleveland school shootings, which resulted in three deaths, including the suicide of the 14 year-old gunman

(Bazar & Bello, 2007; Raymond, 2007), nor do they include international school shootings, such as the recent event which took place in Finland, resulting in the deaths of 10 students, which included the shooter (Cable News Network, 2008). The body of American post-mortem research, taken as whole, offered further insight into red flags of concern which can be generalized to higher education settings. All of the school shooting studies share one overriding element—their acknowledgement of the lack of reasons as to why these attacks occurred. As Vossekuil et al. (2002) stated, "It is clear that there is no simple explanation as to why these attacks occur, nor is there a simple solution to stop this problem" (p. 3). Additionally, the research falsified public assumptions that are held about school shooters. Those assumptions proven false included: school shootings are impulsive acts, other people did not know of the attacker's plan, most attackers threatened their targets prior to the shootings, and finally, there is a useful *profile* of students who carry out such attacks (Bova, Cornell & Groth, 2007; Fein & Holden, 1995; Fein et al., 2002; O'Toole, 2000; Verlinden, Hersen & Thomas, 2000; Vossekuil et al., 2002). Rather than providing concrete solutions which will guarantee avoidance of similar shootings in the future, the literature provided shared patterns of behavior and personal dynamics that are common. On an individual level, school shooters were loners who had few friends and experienced troubled family relationships; furthermore, they experienced bullying by their peers and often felt picked on or prosecuted (Fein et al., 2002; Fox, 2007; McEvoy, 2000; Verlinden, Hersen & Thomas, 2000). As Vossekuil et al. (2002) stated, "they tended to be the kid everyone teased" (p. 25); furthermore, while they had internalized their feelings of being tormented or prosecuted by others, they had,

at the same time, externalized these feelings in the form of communicating their plans to others (Bova, Cornell & Groth, 2007; Fein et al., 2002; McEvoy, 2000; O'Toole, 2000; Verlinden, Hersen & Thomas, 2000). While these findings offer consistency with red flags of concern found in the higher education post-mortem research, a mental health analysis of both bodies of literature revealed one significant difference. Documented mental health issues, prior to the shootings, was only present one-third of the time in the school shooting literature (Fein et al., 2002; McEvoy, 2000;Vossekuil et al., 2002; Verlinden, Hersen & Thomas, 2000). One possible explanation for this difference may be that younger school students have not had the sheer number of years to demonstrate mental health problems as compared to shooters who were older college students.

The Empirical Study of Violence: A Combination of Contributing Factors

What actually causes students to choose violence and why would some go as far mass murder in acting on violent impulses? This is a complex and perplexing question that has been studied and analyzed in many academic fields, including: psychology, psychiatry, education, and sociology. Since the study of *violence* is variably defined by scholars throughout the literature (Carr, 2005; Lurpi, Granin & Brikerhoff, 1994; Palmer, 1993; Pezza, 1995), it is important to give a definition to *violence* which is representative of the intentional violence that has underlying mental health concerns as a significant contributing factor; therefore, *violence* can be defined as "an act which is carried out with the intention of causing physical or serious injury to another person" (Lupri, Granin & Brikerhoff, 1994, p. 53). One can amend this definition to include the intentional death of another person as one of the intended outcomes. While violence may be defined,

its actual cause largely remains an enigma to the scholarly community. As Whitaker and Pollard (1993) pointed out, "there is no single cause of violence; rather, there are complex interrelated reasons why some individuals are violent and others are not…a violent response is not inevitable, it is chosen" (p. 13). Similar to the findings of post-mortem studies which found a combination of variables interacting with each other as the root cause for chosen acts of violence, an additional body of research, conducted primarily on adolescents, studied additional exposure variables which may have contributed to violence. These include exposure to: media violence (i.e., television, movies, and video games), violence within the community in which one lived, and violence within the immediate home environment (Anderson, Berkowitz, Donnerstein, Huesman, Johnson, Linz et al., 2003; Bushman & Huesman, 2001; Ciccheti & Lynch, 1993; Cook, Kestenbaum, Conaker & Anderson, 2000; Dodge & Schwartz, 1997; Garbarino & Kostelny, 1997; Gorman-Smith, Tolan & Henry, 1999; Scarpa, Fikretoglu & Luscher, 2000; Strauss & Sweet, 1992). Exposure to media violence has not only been studied, it has also received much media attention. Several studies concluded that, as a direct result of the violence portrayed in today's media, young adults had a greater likelihood of exhibiting aggressive behavior in their future adult lives (Anderson et al. 2003; Bushman & Huesman, 2001; Cook et al., 2000). As Bushman and Huesman stated, "through cumulative exposure to media violence, young adults may come to believe that world is hostile, aggression is normal and acceptable, and problems may be solved through aggression" (p. 230). Additional research pointed to a transformation of social information processing systems that occurred within youth and contributed to

aggressive behavior towards others (Dodge & Schwartz, 1997; Huesman, 1998). All of these studies utilized various scales of measurement in an attempt to "measure or count what is physically violent" (Webber, Bessant & Watts, 2003, p. 248). Brady (2007) was the only scholar who employed these various scales with a specific undergraduate student sample. He found that "greater lifetime violence exposure was associated with more favorable attitudes toward interpersonal violence" (p. 522). The effect of community violence exposure is also examined in several studies which arrived at the same conclusion of a demonstrable relationship between variables of community violence exposure and aggressive behavior (Bell & Jenkins, 1994; Kleiwer, Lepore & Oskin, 1998; Johnson, Kotch, Catellier & Dufort, 2002; Cook et al., 2000; Scwab-Stone, Ayers, Kasprow, Voyce, Barone & Schriver, 1995). As Cooley-Quille (1999) stated, "basic physiological processes may be influenced by community violence exposure and may themselves influence affect and behavior" (p. 418). Similarly, the research on family relationships and their effect on youth violence found family functioning to be a significant factor in the minimization of violence (Ciccheti & Lynch, 1993; Garbarino & Kostetny, 1997; O'Donnell, Schwab-Stone & Muyed, 2002). However, one finds both scholarly debate as well as methodological limitations to this research. First, two studies directly contradicted such findings (Gorman-Smith, Tolan & Henry, 1999; Scarpa, Fikretoglu & Luscher, 2000). As Gorman-Smith, Tolan and Henry stated, "The correlation between community violence exposure and symptomology are modest, at best" (p. 439). Second, one can argue that since the samples studied are mainly drawn from urban areas, which are more prone to both more crime and violence than non-urban

areas, the results are skewed and not generalizable to similar, non-urban populations. Both the violence exposure as well as the school shootings literature provided insight into the possible causes of violence as well as red flags which must be noticed and managed in order to minimize the possibility of violence.

The Study of Violence within Higher Education

An additional body of research studied various aspects of violence within higher education settings; however, it lacked the depth of study found in the school shooting literature. It can be divided into two broad groups: gun violence studies and college violence data analysis, which resulted in campus safety recommendations. The first group analyzed gun possession at college. As Miller, Hemenway and Weschler (2002) pointed out, "little is known about violence on campus and even less is known about the role that weapons play in preventing or exacerbating such violence" (p. 57). Their research indicated that less than five percent of students had a working firearm at college and that an even small number (less than two percent) revealed being threatened with a gun on campus. The latter group of the literature attempted to provide analysis and explanation of campus violence (Asmusen & Crestwell, 1995; Hoffmann, Shuh & Fenske, 1998; Palmer, 1993; Pezza & Bellotti, 1995). Similar to some of the findings presented in the violence exposure literature (Cooley-Quille, Boyd, Frantz & Walsh, 2001; Schwab-Stone et al., 1995) , Pezza and Belotti (1995) found that "current students' past exposure sets forth violence as a legitimate strategy for problem solving or as an outlet of self-expression" (p. 19). Palmer (1993) as well as Fenske and Hood (1998) concurred with the conclusion that students are increasingly shaped by violence exposure

which occurred prior to their campus arrival. "There is a dynamic picture of students coming to campus from school and societal settings that are increasingly steeped in a rising tide of crime and violence which pervades schools and neighborhoods across the nation" (Fenske & Hood, p. 34).

Since the inception of the Crime Awareness and Campus Security Act (1992), also known as the Clery Act, in memory of the murdered student and for whom the act is named (Carter, 1998), all higher education institutions have been required to annually report crime and safety data to the federal government (Baum & Klaus, 2002; Carr, 2005; Nicoletti, Spencer-Thomas & Bollinger, 2001). At first glance, these data demonstrated that homicidal violence on America's college campuses remains a rarity. Of the over 4,000 college campuses nationwide, home to 17.5 million students, there is a reported 15 murders each year (Frank, 2007). As Fox (2007) described it, "the chances of being murdered on campus are about as likely as being struck by lightning" (p. 11A). At the same time however, one finds a number of critics who not only questioned the validity of these reported statistics, but who also firmly believed that the true statistics of campus crime and violence remained significantly underreported (Carr, 2005; Crowe, 2008; Gramlich, 2007; Landford, 2007; Paulson, 2007; Sloan, Fisher & Cullen, 1997). In attempting to explain this underreporting, Carr hypothesized that "victims fear retaliation and they don't believe that anything productive will come from stepping forward" (p. 18). Whether such data are accurate or not, one thing is certain—violence has become part of the American college landscape. As Palmer (1993) noted, "acts of violence will undoubtedly continue to plague higher education, just as they plague larger society" (p.

277). “Violence is threaded through many aspects of American life, but it is perhaps most out of place in an institution devoted education and personal development” (Roark, 1995, p. 5). The myth that the *ivy tower* is immune from the violence that is part of our larger society is a proven fallacy.

Mental Disorder and Violence: Is There an Empirical Link Between the Two?

In the wake of shocking murders which are perpetrated by mentally ill individuals, the media often portray such people as extremely dangerous and violent (Fessenden, 2000; Griffin, 2007; Knott, 2007). Such inflammatory impressions beg for a more objective measure of such conclusions; therefore, it begs the question, is there actual empirical evidence which has demonstrated a link between mental illness and violence? The answer to this question may lie in several studies which followed former psychiatric hospital patients who had recently been treated for chronic mental illness conditions (i.e., bipolar disorder, schizophrenia). After being discharged, these same patients subsequently reentered greater society (Friedman, Hrouda, Hoffsinger, Resnick & Buckley, 2003; Link, Cullen & Andrews, 1992; Marzuk, 1996; Monahan, Steadman, Robbins, Appelbaum, Grisso, Heliburn et al., 2005; Swanson, Hozer, Canju & Jono, 1990; Swartz, Swanson, Hiday, Borum, Wagner & Burns, 1998). These studies, in combination with the post-mortem school shooting commissions (Fein et al., 2002; Leavitt, Gonzalez & Spellings, 2007; Massengill et al., 2007; Vossekuil et al., 2002), have created a body of research with both commonalities and differences. While they find evidence of a link between chronic mental illness and the likelihood of subsequent violent behavior in the cases they analyzed, they also cautioned against generalizing the

conclusions to all cases of mental illness. The same body of work also found three correlation variables which may contribute to the likelihood of violent behavior. First, patient non-compliance with prescribed psychiatric medication may contribute to violent behavior (Swartz et al., 1998). Second, evidence of violent behavioral episodes prior to an actual psychiatric hospitalization may be a significant factor (Link, Cullen & Andrew, 1992; Monahan et al., 2005). Third, the lack of an individual's awareness or acceptance of their own chronic mental health condition may also be a strong component in determining potential violent behavior (Friedman et al., 2003; Swartz et al., 1998). Based on these studies, Monahan et al. (2005) shared the beliefs of their professional colleagues when they stated " there may be a relationship between mental disorder and violent behavior, one that cannot be fobbed off as chance or explained away by other factors that may cause them both" (p. 812). Two significant limitations are also found in these same studies. First, they all arrived at their conclusions based on the study of populations represented in the general public and not of student-specific populations. Second, while the post-mortem research studied isolated acts of violence carried out by college students and arrived at similar conclusions, specific studies which not only follow students who have been discharged following a psychiatric episode, but also study their personal adjustment and re-entry into student communities prior to a violent episode, do not yet exist; therefore, it is extremely difficult to generalize these findings to all students have experienced a psychiatric hospitalization. Such an absence of research studies which follow college students after a psychiatric hospitalization represents a significant gap in the scholarly knowledge of college student mental health.

It should come as no great surprise that scholarly conclusions which link mental disorder to violent behavior are met by strong opposition in the form of both advocates for the mentally ill as well as a group of sociological and psychological researchers (Amada 1994, 2001; Flack, 2002; Hodgins, Mednick, Brennan, Schulsinger & Engberg, 1996; Pavela, 2007). As Monahan (1992) noted, "few questions in mental health law are as empirically complex or controversial" (p. 511). This opposition worries that sweeping societal generalizations will be made about all students with mental illness. They are further concerned that such beliefs have not only stigmatized such students, but have also added to, what they consider to be, a stereotype of perceived dangerousness. As Bower (2007) noted, "In the aftermath of incidents like Virginia Tech, people often look for quick solutions to reestablish a sense of safety" (p. 1). Such anxiousness may manifest in a societal overreaction which attributes dangerousness to all students with mental illness (Davies, 2008; Pavela, 2006, 2007). As one prominent advocate for the mentally ill stated, "will we go through the records of every American who has ever been to the doctor for anxiety or depression and then lock them up?, it's simply not the American way" (Griffin, 2007). As such debates continue to unfold, American society must now grapple with not only one, but two deadly campus shootings which have occurred in less than 10 months of each other. Society must balance individual rights (e.g., citizens with mental illness) with the safeguards needed to protect against future violence. Two issues become clear in this greater societal debate. First, there is a fine line between mental illness and possible violent behavior. This requires institutions to carefully and succinctly analyze behavior which may be the direct manifestation of mental illness.

Second, while college campus communities strongly desire an environment free from acts of violence, the guarantee that administrators will be able to both identify and stop such acts before they happen, is not always possible.

Trends in College Student Mental Health

College Student Mental Health: Millenial Dynamics of Concern or Sweeping Generalizations?

The literature consistently points to a combination of both external (i.e., family functioning and community violence exposure) as well as internal variables (i.e., mental health issues) as key factors in choosing violence (Asmusen & Crestwell, 1995; Hoffmann, Shuh & Fenske, 1998; Palmer, 1993; Pezza & Bellotti, 1995). As Fenske and Hood (1998) described it, “Data do not exist which absolutely link violent behavior to these same students once they arrive on campus; however, it is not a leap of faith to assume that their previous environmental exposure and resulting violence are linked” (p. 50). This previous exposure to violence prior to entering the college environment is only one factor in the overall portrait of the current generation of traditional-aged (18-25 years) college students. While several scholars have pointed to the transitional period, where students enter and adjust to college life, as one of significant instability and change exploration (Arnett, 2000; Benton & Benton, 2006; Kadison & DiGeronimo, 2004; Nelson & Barr, 2005; Sanfordt & Haworth, 2002), some also contend that the millennial generation presents dynamics of stress, anxiety, and mental health concerns that are unprecedented and unique to the millennial generation (Benton & Benton, 2006; Howe & Strauss, 2000, 2003; Kadison & DiGeronimo, 2004; Sax, 2003). In addition, some

scholars have suggested that both personal levels of stress as well as the pressure to succeed are at unprecedented levels for the current college student generation (Howe & Strauss, Luther & Becker, 2002; McGinn, Raymond & Henig, 2007; Twenge, 2006). The literature further substantiates such claims by suggesting that many college students are arriving on campus with both histories of mental health concerns as well as previous psychological and psychiatric treatment (Arehart-Treichel, 2002; Barry, 2002; Becker et al., 2002; Benton & Benton, 2006; Clemeston, 2006; Eudaly, 2003; Magna-Zito et al., 2007). This prior psychiatric treatment includes claims of the increased usage of psychotropic medication, leading to the conclusion that the millennial generation is "the most medicated generation" (Downing, 2006; Hollingsworth, 2004). Several recent studies demonstrate this assertion. Barry (2006), for example, claimed a three-to-five fold increase in the use of anti-depressant prescriptions by young adults has taken place since 1992. In a similar vein, One study demonstrated an eight percent rise in the youth suicide rate—representing the largest increase in more than 15 years (Carey, 2007), while another demonstrated a four-fold increase in the diagnosis of bipolar disorder in American youth since 1994 (Gellene, 2007). While these data concern young adults, they do not differentiate between college students and non-college adolescents. Specific data on the actual use of psychotropic medication amongst incoming college freshmen, however, remains scarce. The Higher Education Research Institute found that nearly six percent of entering freshmen were already taking psychiatric medication prior to their arrival at college (Sax, Gilmartin, Keip, DiCrissti & Bryant, 2000); unfortunately, these

data were only captured once with this annual instrument and no further studies have been conducted to either substantiate or invalidate such claims.

The other side of this debate is represented in a body of research which both negates millennial students' medication use as a form of overmedication, as well as which repudiates mental health claims based on significant sample and terminological limitations. Several scholars claim that the wide misdiagnosis of behavior problems (e.g., attention-deficit disorder) are resulting in the improper use of psychotropic medication (Begley, 2010; Harris, 2005; Hazell, Carr, Lewin, & Ketrina, 2003; Kim-Cohen, Caspi, Moffit, Harrington, Milne & Poulton, 2003; Tilman, Geller, Nickelsburg, Bolhofner, Craney, DelBello & Wigh, 2003); thus, the claims of skyrocketing psychotropic medication use by millennial students do not accurately reflect the corresponding claims of actual medical treatment for mental health problems. The other side of the debate also invalidates sweeping claims of rising mental health concerns amongst millennial students, based on several sample and terminological limitations (Fischer, 2007; Hattig & Steigerward, 2007; Hutz & Martin, 2007; Klein, 2007; Luther & Becker, 2002; Luther & Latendresse, 2005; Mayo & Christenfeld, 1999; Schmidt, 2007). First, minority students may be entering college with lower GPAs as well as having lower expectations of academic performance; therefore, they may not feel the pressure to achieve higher academic success (Fischer, 2007; Klein, 2007; Mayo & Christenfeld, 1999; Schmidt, 2007). Second, incoming freshmen from suburban populations may feel pressure to succeed in gaining entrance to a prestigious college on a much greater level than their inner-city counterparts (Luthar & Becker, 2002; Luther & Latendresse, 2005). Third, first

generation college students may not have the high levels of involvement from their parents, due, in part, to their parents' unfamiliarity with the college experience (Gibbs, 2009; Hattig & Steigerward, 2007). In consideration of these dynamics, strong skepticism is raised about the mental health characteristics which are made about millennial students. If, in fact, sweeping conclusions are being drawn from samples which are not representative of these groups, the resulting data may be misleading and not generalizable to *all* millennial students. In addition, while key terms such as *stress* and *pressure* are referred to frequently in the millennial literature, terminology which gives clear definitions to these words is, in some cases, not found (Howe & Strauss, 2000, 2003; Kadison & DiGeronimo, 2004; Twenge, 2006). Due to this conflicting research presented throughout the literature, it is left up to the reader to decide if the millennial conclusions drawn are truly accurate or not representative of higher levels of stress, pressure, and mental health concerns when compared to previous student generations.

College Mental Health Research: Anecdotal Impressions vs. Empirical Evidence

The existing college mental health literature can be broken into two broad categories: anecdotal impressions and empirical data. A third category, survey data, bridged the two and often served as the logic in forming conclusions. Anecdotal impression are presented in various articles and books that "assessed the landscape" by means of interviews, collegial conversations, and analysis of single campus reporting data; as a result, they have arrived at conclusions which described current college student mental health issues in increasing and even alarming terms. It is even described in

“epidemic” proportions such that college student mental health conditions are widespread and ever-growing (Arehart-Treichel, 2002; Kadison, 2004, 2006; Kadison & DiGeronino, 2004; Marano, 2008; MacDonald, 2007; Moran, 2005; Peterson, 2002; Rudd, 2004; Sharpe, Bruinicks, Blacklock, Benson & Johnson, 2004). As Kadison (2004) described it, “without question, concerns about the mental health of college students have risen substantially over the past decade” (p. B20). Some scholars reported huge increases in both the volume of students being seen at college counseling centers as well as dramatic increases in the use of psychiatric medications (Cooper & Archer, 2002; Boyd et al., 2000; Carter & Winesman, 2003; Levin-Epstein, 2007; Soet & Sevig, 2006; Voelker, 2006). In analyzing student health insurance provider data, Kadison and DiGeronimo (2004) shed light on the prevalence of college student antidepressant usage when they stated, “the number one prescribed drug for college students is not birth control or acne medication, it’s Prozac. In secondary place are anti-anxiety agents. The number three spot goes to all other anti-depressants combined” (p. 100). In an even more alarming trend, the frequency of student psychiatric hospitalizations appeared to also rise in increasing numbers (Ghallager, 2005, 2007). One study, whose methodology included counseling center director interviews, claimed a 35% increase in student hospitalizations over the past five years (Arehart-Treichel, 2002). Marano (2008) described such hospitalizations in commonplace terms when she stated, “on one 5,000 student campus where most students are commuters, three to six students are typically hospitalized each semester, primarily for suicidal gestures and psychotic breaks” (p. 9). In a related manner, the literature highlighted growing numbers of students who felt overwhelmed

and depressed to the point of having difficulty functioning, with an increasing number of students also having exhibited suicidal ideation (American College Health Association, 2005; Ghallager, 2007; Hurtado, Sax, Saenz, Harper, Oseguera, Curley et al., 2007). This is concerning, considering that death by suicide remains the third leading causing of death amongst college-aged Americans, only behind car accidents and homicides (McGinn, Raymond & Christenfeld, 2007; Silverman, 1993). In sum, the anecdotal evidence is, at its least, concerning, and its worst, extremely grim.

National and Single-Campus Survey Data: Compelling and Timely Empirical Evidence

Many of the previously-mentioned studies and articles drew their conclusions from survey data. These data can be divided into two groups: national, annually-produced surveys which utilized both counseling center director and student samples and single campus studies which replicated the methodology found in the national instruments. Three national surveys have formed the backbone of research on college student mental health for the past two decades and, it is primarily from these data which conclusions are drawn in the literature. The first is the First College Year Survey (FCYS) which reported nearly 40% of college students feeling "overwhelmed by all they had to do," with 13 % feeling depressed (Hurtado et al., 2007). These data represented a 10% rise in the eight years that the same instrument has been utilized. Two additional surveys, which are most cited in the literature, are the national survey of counseling center directors and the American College Health Association (ACHA) surveys. Prior to the arrival of these surveys in the 1990s, only two empirical studies were presented in the

literature (Bonner & Rush, 1988; Furr, Westfield, McConnell & Jenkins, 1988). Both of these surveys examined depression in the college student population and found that the majority of students had experienced depression. They both concluded that the prevalence of depression amongst the college student population was twice that of their same-aged peers who were not attending college (Bonner & Rush, 1988; Furr et al., 1988). By the late 1990s, a third had performed a meta-analysis of existing research studies and concluded that psychopathology was on the rise in the college student population (Cooper & Archer, 2002). In addition, Douglas, Collins, Warren, Kamon, Gold, Clayton, et al. (1997) conducted a one-time study in conjunction with the Centers for Disease Control (CDC). It attempted to build on an annual American youth health survey by adapting the instrument for a national college student sample. It arrived at conclusions similar to those of both the Bonner and Rush (1988) as well as Furr et al. (1988) research. By the 1990s, the annual counseling center and ACHA surveys had become the norm for national data collection and analysis.

Though cited widely in the literature as direct evidence for dramatic increases in college student mental health issues, these surveys described feelings of both hopelessness and depression as well as the use of both counseling center services and psychiatric medications in broad terms. They failed to shed light on the chronic and most severe mental health conditions which may or may have risen in the college student population. The American College Health Association survey has annually gathered broad health data from a national sample of nearly 20,000 students since 1998. Its purpose is to “assess and understand the health needs and capacities of college students”

(ACHA, 2006, p. 196). Of the 300 total questions, only four yielded data on mental health issues. It established a mental health cohort by first asking students if they had been diagnosed with depression during their lifetime. This group is then broken down into specific experiences which had taken place during the course of academic year. For example, the most recent survey found that nearly 15% of students reported this lifetime diagnosis of depression, up only two percentage points since 2003. Of this same cohort, nearly one-third reported being diagnosed during the past school year with “26% currently utilizing psychotherapy and 37% taking medications for depression” (ACHA, p. 204). There are three serious methodological limitations presented in the ACHA data. First, the statistics presented are nearly consistent with the 2003 and 2005 data sets and, therefore, do not demonstrate a rise in either category. Second, the same annual survey acknowledged its own methodological limitations when it stated that “due to the self-selection, rather than random sampling, the results cannot be generalized to college students nationally” (p. 204). Third, the term *depression* is solely defined by *diagnosis*. One can assume that this is a professional psychological diagnosis; however, this one, broad category offers very little depth or breadth of knowledge on chronic mental health data.

The National Survey of Counseling Center Directors (NSCCD), which has been performed annually since 1981, gathered data from specific counseling center directors. These data, and to a much lesser degree, the ACHA data, are referenced in nearly all of the anecdotal evidence referred to earlier in this section. As scholars gathered impressions conducting interviews of both college mental health practitioners and

professional colleagues, they also referenced the NSCCD data as a supplemental tool in providing validity to their assertions (Arehart-Treichel, 2002; Berger, 2002; Boyd et al., 2000; Cooper & Archer, 2002; Flynn & Heitzman, 2008; Kadison & DiGeronimo, 2004; Levin-Epstein, 2007; Marano, 2008; Pledge, Lapan, Happner, Kivlighan & Roehilke, 1998; Soet & Sevig, 2006; Voelker, 2003). The percentage of counseling center directors who believed that the "number of students with severe psychological problems has risen in recent years" (Ghallager, 2007, p. 3) has consistently risen to its current level of over 90%. These data are further defined by the perceived number of students with severe psychological problems who are actually being seen at college counseling centers which, not only found nearly half of directors reporting having such clients, but also concluded that eight percent of clients had "impairment so severe that they cannot remain in school or can only do so with extensive psychological or psychiatric help" (Ghallager, 2007, p. 5; Ghallager, 2005, p. 4).

Senior Student Affairs Officers and Student Mental Health Concerns

Survey data has also been obtained from senior student affairs administrators with regard to their perceptions of managing student mental health concerns. This marked a departure from the trend to gather such impressions solely from counseling center director or student samples. Belch and Marshak (2006) found that in a large, national sample of senior student affairs officers (SSAOs), the majority felt there had been a "sharp increase in the severity and frequency of student mental health problems" (p. 464). Their results also shed light on the high levels of frustration felt by the majority of SSAOs when it comes to managing the disruptive behavior of such students, particularly

when they “did not pose an imminent risk to the greater community” (p. 471). Two similar surveys validated Belch and Marshak’s data by finding similar SSAO perceptions (Rasmussen & Johnson, 2008; Stokes, 2007). As Stokes stated, “it is noteworthy that about 90% of SSAOs rated mental health as both a top challenge and priority even before the issues made national headlines” (p. 9). Kitzrow (2003) summarized the impressions of both senior student affairs and counseling center administrators when she stated, “the increased demand and severity of student mental health problems may have the most impact on student affairs and counseling staff, who are on the front lines of dealing with student behavioral issues” (p. 171).

Single Campus Studies and Multi-Campus Data Analysis

Beginning in the late 1990s and continuing to the present day, a handful of single campus studies attempted to replicate the fore-mentioned surveys with their own student populations, utilizing similar methodology. Bishop, Bauer and Trezise-Becker (1998) arrived at conclusions similar to those of the ACHA and NCCD surveys with regard to rates of both depression and suicidal ideation; similarly, Silverman, Meyer, Sloane, Raffel and Pratte (1997) analyzed data from big ten university counseling centers and not only concurred with Bishop, Bauer and Trezise-Becker (1998) results, but also highlighted dramatic increases in the number of students being seen at member institution counseling centers. In turn, Soet and Sevig (2006) conducted a longitudinal, singe campus study within one big ten university and concluded that “the results support the evidence from other colleges and universities that have been reporting an apparent rise in both the presence and severity of mental health issues among students” (p. 411). In a

similar vein, Kitzrow (2003) pointed to an apparent 50% increase in counseling center usage by students during the 1995-2003 time periods at several prominent national institutions, such as Columbia University and MIT. While these scholars made claims regarding rises in student usage of counseling centers, they also openly acknowledged the lack of knowledge of the total picture of campus mental health (Silverman et al., 1997; Kitzrow, 2003). As Soet and Sevig (2006) put it, "there is truly little known about the breadth and depth of mental health issues on college campuses" (p. 430).

Scholarly Debate Regarding Current Research and the Call for More Empirical Results

Several prominent scholars in the college mental health profession have raised serious concerns about, what they consider to be, the lack of empirical evidence that is presented in much of the existing research literature. They have pointed to several methodological limitations in national survey data, which include: lack of consistent, operational definitions for *depression* and more severe form of *psychopathology*, very little longitudinal research which follows a student cohort over an empirically-justified amount of time (10 years or more), and the arrival of conclusions that are based on practitioners' impressions rather than the utilization of objective data collection procedures which lend themselves to more empirical analysis (Bishop, 2006; Males, 2007; Schwartz, 2006; Sharkin, 1997; Sharkin & Coulter, 2005). Two issues of concern are apparent. First, practitioners may be confusing the rising rates of client usage with *actual* presentation of psychopathology. Second, student clients' presenting problems may, in fact, be normal developmental issues experienced by a student population, such

as development of autonomy and identity as well as achievement of personal intimacy (Kitzrow, 2003; Sharkin, 1997). In attempting to address some of these empirical limitations, Benton, Robertson, Tseng, Newton and Benton (2003) conducted a study on a single campus population over a 13-year period, comparing data obtained both at the start and conclusions of psychotherapy. Their dramatic results claimed the number of student clients with suicidal ideation had tripled and those with depression had doubled. The literature widely referenced this one study in watershed terms and claimed it as empirical evidence of such a trend; however, several scholars who have criticized additional previous research, also shared concerns of terminological limitations, which, in their view, invalidated the conclusions; more specifically, they argued that the terminology which was commonly accepted within the psychological community to define specific psychopathological conditions, was absent (Kitzrow, 2003; Schwartz, 2006; Sharkin, 2006; Sharkin & Coulter, 2005). According to Schwartz (2006), only two previous studies (Cornish, Kominars, Riva, McIntosh & Henderson, 2000; Pledge et al., 1998) had empirically addressed the issue of apparent rises in college student psychopathology in the past decade and, according to him, both of these longitudinal studies disproved the claims made by Benton et al. (2003). In order to prove his point, Schwartz (2006) replicated the Benton et al. study on a single campus student population and utilized the same methodology. He arrived at conclusions which also contradicted their findings. “The actuarial…indices of client psychopathology indicated that student clients did not become acutely distressed over the 10-year period of this study” (Schwartz, p. 335). While all of the previously mentioned studies yielded knowledge

which advanced our overall understanding of campus mental health issues, there are inherent limitations in their designs which greatly reduced their generalizability to the overall state of college student mental health issues. These limitations lent themselves to a national scholarly call for further empirical research that longitudinally studies a national student sample (Benton, Benton, Newton, Benton & Robertson, 2004; Kitzrow, 2003; Soet & Sevig, 2206; Sharkin, 1997, 2004; Sharkin & Coulter, 2005; Schwartz, 2006). In a possible effort to answer this call, Pennsylvania State University has recently established a Center for the Study of College Student Mental Health (CSCMH) (Flynn & Heitzman, 2008; Locke, 2008). This center represents the first "longitudinal, collaborative initiative to build a national mental health informatics infrastructure" (Locke, p. 20). Such a national effort may lend empirical validity to the impressions which are shared by both counseling center directors as well as senior student affairs administrators across the nation that the frequency and severity of student mental health problems is on the rise.

After Virginia Tech and NIU: Societal and Institutional Responses

As in many times of national crisis, American society inevitably turns to their elected representatives, both at the state and federal levels, to conduct thorough investigations of such violent acts as well as to produce systems of change in the forms of law and public policy in an attempt to protect them in the future. When such crises involve death by guns, American society enters into another cycle of heated national debate over the second amendment of the U.S. Constitution—the right to bear arms. While this long-standing societal issue remains too complex for the purpose of this

dissertation, the specific issue of gun control legislation which is designed to keep guns out of the hands of mentally ill citizens (Cochran, 2008; Griffin, 2007; Hebel, 2007; Luo, 2007) is very timely and worthy of discussion. Within individual states, several governors have established state review commissions (Griffin, 2007; Lewis, 2007; Rasmussen & Johnson, 2008) which have acted to "review their policies and campus practices related to guns, mental health, crisis planning, and emergency communications" (Hebel, 2007, p. 36A). At the federal level, the post-mortem Virginia Tech commission led by member of President Bush's cabinet highlighted a broken system of background checks in current gun control laws, when it states, "state laws and practices do not uniformly ensure that information on persons restricted from possessing firearms and are made available to the national criminal background check system" (Leavitt, Gonzalez & Spellings, 2007, p. 2); furthermore it also found that only 23 states provided sufficient mental health information to this national data base meant to keep guns out of the hands of mentally ill citizens (Jackson, 2007). In a direct response to this concern, Senator Charles Schumer and Representative Carolyn McCarthy, both of New York, introduced House Resolution 297 for legislative consideration by the U.S. Congress in June, 2007 (Associated Press, 2007; Cochran, 2008). The measure was signed into law by President Bush in January, 2008 and marked the first piece of national gun legislation in more than 13 years (Associated Press, 2008; Bansal, 2008; Simon, 2008). Amongst its provisions, the new law required both federal and state agencies to "update, correct, modify, or remove obsolete records and notify the U.S. Attorney General of such action to keep the National Criminal Background Check System (NICS) up to date" (Library of Congress,

2007). It also provided financial incentives of $ 1.3 billion to states which demonstrated improvements in their tracking of citizens with mental illness who are ineligible to purchase firearms (Bansal, 2008; Cochran, 2008).

Gun Control Legislation: Up Against Strong Odds

The fact that such national gun legislation was not arrived at for a period of 13 years, lends proof to the reluctance of many state and federal lawmakers to deal with such a hot-button political issue, which is only exacerbated in a presidential election year, such as one found in 2008. While republicans seem to have eluded further gun control legislation, the democrats, who now control both houses of Congress, have also shown reluctance to address such measures (Associated Press). As Schwartz (2008) stated:

> Democrats learned the perils of reviving the gun control issue during the 2000 presidential campaign when candidate Al Gore pledged to limit hand gun sales, crack down on gun sales, and support state registration of firearms. It was a liberal position that some think cost him the vote in a few, southern pro-gun states…for many democrats, the lesson was clear: gun control was a losing and consuming issue. (p. 1C)

This same point can be further demonstrated in state house debates across America. For example, in Illinois, where the NIU shootings took place, packages of gun proposal legislation have been introduced annually in the state legislator only to meet heavy opposition by guns rights advocacy groups (Washburn, 2008). In addition, there is also a current social reaction unfolding in various states which represents the polar opposite of further gun legislation (Riccardi, 2008). It is found in the form of campus gun advocacy groups which encourage concealed weapons as a means of protection to future shooting rampages (Erwin & Mills, 2009; Molina, 2008; Shackner, 2008). One such group, Concealed Carry on Campus, argued that “the impact of such incidents could

be prevented or minimized if students and faculty were allowed to carry guns on campus" (Rasmussen & Johnson, 2008, p. 26). This same group claims to have 17,000 members on more than 150 college campuses nationwide (Molina, 2008; Shackner, 2008). A national poll taken immediately after the Virginia Tech incident further demonstrated this particular viewpoint. It found that one in four Americans believed that allowing concealed weapons on college campuses would have reduced some of the deaths experienced at Virginia Tech (CBS News, 2007; Lewis, 2007). Regardless of which side of the gun control debate Americans find themselves aligned, many citizens felt a strong sense of fear in the face of random violence which had no apparent cause or motive.

Federal and State Case Law Interpretation: Legal Precedent Which Shapes University Responses

American society is governed by both state and federal laws which serve to protect individual rights and safeguard the American public; therefore, institutions must continually adapt their practices in managing students who present mental health concerns and who may pose a threat to campus communities. Recent case law can be divided into two distinct groups, those which concern suicidal ideation and self-harming behavior and those which concern legal challenges to institutional responses. The former category is represented by several examples in the literature. In both *Nott v. George Washington University* (2004) and *Hunter College* (2003), a student had presented thoughts of suicidal ideation which resulted in the student seeking hospitalization in an attempt to avoid self-harm (Baker, 2005; Blanchard, 2007; Hoover, 2006; Wolnick, 2007). In both cases, university officials responded by immediately removing them from

campus housing, citing concerns of dangerousness to self or others (Arenson, 2004; Pavela, 2006). Both students successfully challenged the mandatory eviction policies under federal and state antidiscrimination laws (Bower, 2007; Lipka, 2007; Smith & Fleming, 2007; Ulferts, 2007; Wolnick, 2007). An additional handful of cases have examined institutional liability. Courts have ruled both for and against institutions in cases where suicidal death unfortunately occurred (Belch & Marshak, 2006; Blanchard, 2007; Pavela, 2006; Wolnick, 2007). In both *Jain v. State of Iowa* (2000) and *Schiezler v. Ferrum College* (2002), courts determined that no *special relationship* existed between the respective college and the deceased student; therefore, there was not a *legal duty* to prevent the suicides (Baker, 2005; Blanchard, 1997; Wolnick, 2007). Both *legal duty* and *special relationship* are key legal, terminological concepts which can ultimately determine institutional responsibility. According to Baker (2005), these terms can be defined together as “a distinctive set of circumstances which has arisen that operates to place a legal obligation upon the university to undertake reasonable actions designed to protect the student from foreseeable harm” (p. 521). Such possible legal responsibility is demonstrated in the courts’ stance taken in *Shin v. MIT* (2005). Elizabeth Shin was a student who arrived at MIT with a documented history of chronic depression. Upon matriculation to the university, she sought and received treatment at the MIT counseling center; tragically, she lit herself on fire and subsequently died from her injuries (Baker, 2005; Blanchard, 1997; Smith & Fleming, 2007; Ulferts, 2007). Her family sued MIT and a court ruled that a *special relationship* was, in fact, established between Shin and the university; and thus, a *legal duty* to prevent harm was established (Baker, 2005;

Blanchard, 1997; Pavela, 2006; Wolnick, 2007). The legal cases taken as whole, offer three distinct "take-away" lessons for all universities. First, institutions cannot formulate policy which removes housing accommodations for students who have expressed suicidal ideation and/or sought professional help for such feelings. Second, despite the university's best efforts to offer psychological treatment to its current students who suffer from mental illness, legal duty may be unintentionally established and, as a result, the university may find itself paying out large sums of money to the affected families. Third, such legal duty may represent a return to, as some scholars have suggested, universities practicing *in loco parentis* as a principle which informs their policy decisions (Bickel & Lake, 1999; Edwards, 1994; Henning, 2007; Melear, 2003). Bickel and Lake (1999) further described this policy shift when they stated, "whereas the *in loco parentis* era was legally easy, the new *duty* era remains highly complex" (p. 65). Kitzrow (2003) concurred with this new reality when she stated, "these lawsuits appear to be challenging current standards of confidentiality and advocating that universities resume their role of acting *in loco parentis*" (p. 172). Melear (2003) argued that such cases signal a new type of *in loco parentis* where institutional responsibility has evolved into a contractual obligation in which the students represents the consumer and the university the provider.

The Americans with Disabilities Act (ADA) and Confusion over the Federal Educational Records Privacy Act (FERPA)

Besides the legal cases which set precedent in adaptation of existing institutional policies, two federal laws, previously mentioned in Chapter I, also serve to significantly affect how institutions craft policy in responding to students with mental illness. The

first, the Americans with Disabilities Act (ADA) of 1990, 42 U.S.C. Sec. 12101, protects students with a mental disability form discriminatory practices. The term *mental disability* can be defined as "a mental impairment that substantially limits one or more major life activities of the individual" (ADA, p. 4). The term "major life activities" received greater interpretation and clarification in the form of a long list of physical activities as part of the Americans with Disabilities Act Amendments of 2008 (ADAAA), which became federal law on January 1, 2009. This legislation not only requires accommodation for individuals with a documented disability, but also for those who may be "regarded as having an impairment" (U.S. Department of Labor, 2008). Currently, both the disclosure and accommodating record which documents the disability are the responsibilities of the individual student under ADA (Amada, 1994; Archer & Cooper, 1998; Noonan-Day & Jennings, 2007; Pavela, 2006). While ADA offers this protection, it does not prohibit an institution from holding the student accountable for conduct which violates the institutional code of student conduct and/or threatens the safety of the campus community in which the student is enrolled; rather, it expressly allows the institution to adjudicate conduct violations in the same manner it would do for a non-disabled student (Amada, 2001; Hoover, 2007; Noonan-Day & Jennings, 2007; Pavela, 2007; Wolnick, 2007). "Colleges and universities are not required to tolerate or excuse disruptive behavior caused by manifestations of mental disability or by behavior that otherwise violates school policy" (Munsch & Shapansky, 2003, p. 10). Despite federal legislation which expressly allows for such adjudication, the literature also points to empathy on the part of SSAOs in student conduct follow-up for students with mental

health concerns (Dunkle, Silverstein & Warner, 2008; Rowe, 2005). As Dunkle, Silverstein and Warner put it, “Be sure to consider how discipline of a student exhibiting mental health symptoms will be perceived and the impact discipline could have on a student in a precarious mental health state” (p. 27). The second federal law, FERPA (Federal Educational Rights and Privacy Act) of 1990, 20 U.S.C. 1232 (g), protects the confidentiality of student records. This particular federal regulation came under much scrutiny as a result of the Virginia Tech incident. University officials there seemed to operate within institutional silos when it came to sharing the disturbing behavior of Sueng-Hui Cho with each other (Fischer & Wilson, 2007; Massengill et al., 2007; Pavela, 2007; Schuchman, 2007). In openly acknowledging this issue, President Bush commented, “information sharing among health care, law enforcement, and education communities must improve” (Jackson, 2007, p. 4). All three subsequent post-mortem commissions found widespread confusion about when and how university officials may share student information with each other (Angle et al., 2007; Fischer & Wilson, 2007; Leavitt, Gonzalez & Spellings, 2007; Massengill et al., 2007; Moehlmann, 2007). As the federal commission report stated

> Critical information sharing faces substantial obstacles…university officials are not fully informed about when they can share critical information on persons who are likely to be a dangerous to themselves or others and the resulting confusion may chill legitimate information sharing. (Leavitt, Gonzalez & Spellings, 2007, p. 2)

Studies conducted amongst university judicial officers affirmed the issue of confusion with regard to interpretation of federal law (Bostic & Gonzalez, 1999; Rowe, 2005). “The task of implementing FERPA bedevils many higher education officials…there are

no national standards or requirements for FERPA training" (Bostic & Gonzalez, 1999, p. 499). As a direct result of their research, Leavitt, Gonzalez and Spellings (2007) directed the U.S. Department of Education to "develop additional guidance that clarifies how information can be shared legally under FERPA and disseminate it widely to the mental health, education, and law enforcement communities" (p. 8). In complying with this directive, the U.S. Department of Education provided written such written guidance, by late October, 2007, in the form of brochures. As U.S. Education Secretary Margaret Spellings wrote in the brochures' introduction, "In response to these comments (of the federal report), I am pleased to provide you with the enclosed brochures on FERPA as a timely refresher" (p. 1). While the brochures covered the fore-mentioned areas, it failed to provide specific examples of student situations which are exempt from confidentiality (U.S. Department of Education, 2007). In a further, more detailed response to the federal report to President Bush (Leavitt, Spellings & Gonzalez, 2008), new FERPA rules went into effect on January 8, 2008 (U.S. Department of Education, 2008). These rules, which were devised as the result of direct comments from university officials nationwide, are mean to "dispel the impression that college and university officials cannot share information about potentially troubled students with each other" (Lipka, 2008, p. A 18); rather, the new rules and accompanying guide are meant to strike a balance between privacy and safety in which "safety is paramount" (Bernstein, 2008). The new rules clearly state that "if there is an articuable and significant threat to the health and safety of the student or other individuals, an educational agency or institution may disclose information to appropriate parties" (U.S. Department of Education, 2008, p. 74837).

Four key issues regarding interpretation of FERPA have become evident. First, it only regulates the actual written content found in educational records and does not regulate behavioral observations made by faculty and staff, nor does it prohibit sharing these observations with other university officials. Second, a clear exception is made for sharing the contents of educational records when the purpose is for legitimate educational interest. Third, an additional exception is made in situations which pose a significant threat of harm to either the identified student and/or the greater university community. Fourth, student health emergencies allow the institution to make contact with parents (Bernstein, 2007; Moehlmann, 2007; Pavela, 2006; Tribensee & McDonald, 2007).

Prevention vs. Post-Intervention Models of Practice

Several models of practice are presented in the literature, which offer guidance in both the management of and policy development for student mental health. These models can be broadly categorized under two distinct groups. The first, is concentrated on *prevention*, that is, models of practice which provide deliberate intervention in an attempt to not only manage student mental health situations, but also to prevent violent behavior which can result in devastating consequences (Amada, 1994, 2001; Bova, Cornell & Dewey, 2007; Cornell et al., 2004; Fein et al., 2002; Hollingsworth, 2004; Howard et al., 2006; Sokolow, 2007; Stovall & Domino, 2003). The second, *post-intervention,* centers around activities which occur after a disruptive incident has already taken place due to the manifestation of a mental illness. Post-intervention models seek to develop policy which both manages the mental illness and minimizes further disruptive behavior (Boyd et al., 2003; Cooper, 2007; Dannells & Consolvo, 2000; Gilbert &

Sheilman, 1995; Joffe, 2003; Kiracoffe & Wells, 2007; Pollard, 1995, 2001; U.S. Department of Health and Human Services, 2004). It also considers development of both voluntary and involuntary student leave policies (Amada, 1994; 2001; Hollingsworth, 2004; Pavela, 1985, 2006, 2007). While these two larger scholarly groupings are separable by either incident prevention or post-incident stages, they also share two commonalities. First, they can be employed interchangeably in both stages, depending on the student situation that is being managed. Second, they are all derived from one model which, despite being introduced nearly 20 years ago, has stood the test of time as the being the standard in both the recognition and management of student mental health concerns. That model is Delworth's (1989) assessment and intervention of student problems (AISP). As Dunkle, Silverstein and Warner (2008) noted, "Delworth's model did not garner the attention it deserved at the time of its publication, but…it remains as relevant and useful as it did when it first appeared nearly twenty years ago" (p. 590). Delworth is the first to utilize the terms *disturbed* and *disturbing* to describe disruptive student conduct which may have accompanying mental health concerns as a root cause (Barr & Sandeen, 2006; Benton & Benton, 2006; Cooper & Archer, 1998). The AISP model defined a disturbed student is having both strong inward and outward focuses which are usually coupled with symptoms of depression. The *disturbed* student is defined as one who lacks maturity and social skills; whereas, the *disturbing* student chooses to repetitively engage in conduct that is disruptive to the greater university community (Delworth, 1989). Amada (2001) added further clinical definition to the term disruptive when he described it as "acting in a demonstrably bizarre manner that seems to

be inspired by hallucinatory, delusional, or paranoiac psychological processes” (p. 111). It is the combination of disturbed *and* disturbing which represents the most challenging situations for student affairs administrators to effectively manage. While the actual terms *disturbed* and *disturbing* may have evolved into more sensitive terminology (e.g., students with mental health concerns as opposed to disturbed students or disruptive as opposed to disturbing), the AISP model continues to inform scholars as they craft future theories and models which serve to guide practitioners in their management of student mental health concerns.

The prevention models presented in the literature can be divided into two groups: threat assessment and continual management. The common element found in both is the use of multi-disciplinary teams in providing leadership and making decisions (Amada, 1994, 2001; Bova, Cornell & Groth, 2007; Cornell et al., 2004; Fein et al., 2002; Hollingsworth, 2004; Howard et al., 2006; Sokolow, 2007; Stovall & Domino, 2003). Delworth (1989) recommended the use of such teams in the form of a Critical Incident Team (CIT), which is composed of personnel from: student affairs, mental health services, campus safety, and legal counsel. In the wake of the Virginia Tech and NIU shootings, the use of such teams in managing potential threats appears to have gained acceptance not only in scholarly circles, but also by state governments who are considering mandating this practice as part of their legislative practices (Boone & Eells, 2008; Office of the Governor of Illinois, 2008). Rasmussen and Johnson (2008) found the use of ‘care teams’ or similar groups that meet regularly to discuss troubled and potentially troubled students to be in place at more than half of their sample. Scholarly

threat assessment models recognize that many observations may be made by several administrators within a school setting; in addition, FERPA exceptions allow for such communication. Thus, the use of inter-disciplinary teams is highly encouraged as an effective tool in minimizing threatening behavior (Amada, 2001; Bova, Cornell & Groth, 2007; Boone & Eells, 2008; Cornell et al., 2004; Dunkle, Silverstein & Warner, 2008; Fein et al., 2002; Flynn & Heitzman, 2008; Sokolow, 2007; Stovall & Domino, 2003). There are two limitations to the use of such teams. First, while they may have the ability to *minimize* threatening behavior, they cannot completely *prevent* such incidents from ever happening. Second, while probably unobtainable, the institutional desire for complete prevention may be fostering the growth of a threat assessment industry, in the form of campus consultants, which, according to Flynn and Heitzman (2008), warranted a strong level of caution. “It is incumbent on our profession to assess the validity of these offerings and to ensure that scientific rigor has been associated with the development of each” (p. 487).

Post-Intervention Models: Behavioral Agreements, Mandated Assessment, and Mandated Psychotherapy

Post-intervention models place emphasis on the development of policy and practices which assist institutions in managing student behavior after a disruptive event has occurred. One commonly-held belief of all these models is that self-harm behaviors as well as those directed towards others are both given equal weight in causing disruptions to student communities (Belch & Marshak, 2006; Eells & Cook, 2008; Hollingsworth, 2004; Joffe, 2003; Kitzrow, 2003; Pavela, 2006). As Amada (2001)

stated, self-harming behavior "should be regarded as disruptive because the students' self-imperiling behaviors are eventually likely to traumatize and victimize their roommates, classmates, and the college personnel who must deal with them throughout the crisis" (p. 116). The use of mandated assessment, following either the expression of suicidal ideation or an actual attempt suicide attempt, formed the basis of not only one model within higher education, the Illinois Plan, so named since it was conceived at the University of Illinois (Joffe, 2003), but also one model from without—the U.S. Air Force's suicide prevention model (U.S. Health and Human Service, 2004). In both models, suicidal students are mandated, under student conduct policy, to four psychological assessment sessions. As a result, both studies have empirically demonstrated dramatic reductions in suicidal behavior (Joffe, 2003; U.S. Health and Human Services, 2004). In a similar vain, Cooper (2007) offered the Valpo Model which utilized both mandated psychological and psychiatric assessment and placed emphasis on the combined usage of psychotherapy and pharmacotherapy in an attempt to manage college student mental health. Cooper's study followed 87 students who had received this combination therapy. Similar to Joffe's (2003) results, Cooper (2007) utilized a specific index to measure improvements and found that "most students showed significant improvement on this index" (p. 133). These results are in agreement with the American Psychiatric Association's (2005) guidelines which adhere to combination therapy to treat severe forms of depressive disorder. "More severe forms of depression improve faster and better with a combination of psychotherapy and pharmacotherapy" (p. 3). Such mandated models have gained acceptance as appropriate institutional responses

as evidenced by annual survey data, which showed 40% of counseling center directors nationwide being in favor of "mandating a certain number of counseling sessions for students who mention suicidal thoughts' (Ghallager, 2006, p. 6).

While the use of *mandated assessment* for suicidal students may be have gained acceptance, the use of *mandated psychotherapy* as tool for managing disturbed and disturbing students remains a highly controversial topic and one of great debate amongst scholars. It finds them divided into two camps. One, composed of scholars who tend to also be psychologists, is strongly opposed to such a practice (Amada, 1999, 2001; Archer & Cooper, 1998; Boyd et al., 2003; Gilbert & Sheilman, 1995; Kiracoffe & Wells, 2007). The other, viewed it as an acceptable practice in managing behavior; however, it also openly acknowledged its controversial use (Dannells, 1990; Dannells & Consolvo, 2000; Kitzrow, 2003; Pollard, 1995, 2001; Stone & Archer, 1998; Stone & Lucas, 1994). As Stone and Lucas described it, "Counseling and discipline are not easily combined; rather, their association is controversial, if not contradictory, leading to role ambiguity and bias…the role of counseling centers in fostering a disciplined community remains ambiguous" (p. 234). The opposition has described four problematic issues. First, the psychological profession adheres to ethical standards and principles which view psychotherapy as a voluntary and confidential process (Amada, 1999, 2001; Pollard, 1995, 2001; Stone & Archer, 1998). In their view, when this process becomes involuntary and is used as a form of conduct management, it becomes unethical and is in direct violation of ethical standards. Second, the same professional standards recommended that campus psychologists be perceived as administratively neutral in the

eyes of its student clients (Boyd et al., 2003; Kiracoffe & Wells, 2007); thus, an abuse of supervisory power occurs when student affairs administrators, who in most organizations, directly supervise campus counseling services, require psychological staff to carry out mandated psychotherapy (Amada, 1999, 2001; Archer & Cooper, 1998; Gilbert & Sheilman, 1995; Kiracoffe & Wells, 2007). This power dynamic may result in "pressure to accept mandated referrals for psychological treatment" (Gilbert & Sheilman, p. 17). As Amada (2001) stated, "Some psychotherapists undertake mandated therapy…even when they have ethical objections to this practice…when administrators authoritatively insist that students be seen, the psychotherapist who refuses to comply may be placing him/herself and their program in jeopardy" (p. 111). Third, the use of mandated psychotherapy will result in limited student usage of psychological services (Amada, 1999, 2001; Gilbert & Sheilman, 1995; Kiracoffe & Wells, 2007; Stone & Archer, 1998). As Boyd et al. (2003) stated, "It can severely restrict the use of the (psychological) service" (p. 168). Fourth, the psychological profession considered informed consent, that is, the client's willingness to release information to a third party, as a completely voluntary action that is decided by the client who has "the freedom to give or withdraw consent at any time for any reason" (Kiracoffe & Wells, 2007, p. 262). Therefore, if a student affairs administrator included therapy as a required element of a behavioral agreement, knowledge of therapy attendance becomes necessary. If the student withdrew consent, such an agreement is proven ineffective.

Despite these objections, the use of mandated psychotherapy appears to be growing in usage (Ghallager, 2006; Kiracoffe & Wells, 2007). Kiracoffe and Wells

claimed that “it has increased considerably over the past 40 years” (p. 259). Data derived from counseling center directors attested to this point by finding nearly 40% of campus counseling centers accepting mandated referrals for both assessment and therapy sessions (Ghallager, 2006). While “not crazy about it,” 68% of director believed that “some students can be helped in this way” (p. 6). While the other side of the scholarly debate doesn’t necessarily give its unconditional support to the use of mandated psychotherapy as a management tool, it views it is an acceptable one in managing disturbed and disturbing students. Pollard (1995) and Deisinger et al. (2008) discussed the legal system’s wide-spread use of mandated psychotherapy as an educational alternative to incarceration. “The call to university officials, including counseling center personnel, is to simply make the same connection” (Pollard, p. 48). He further believed that psychological staff is the most qualified experts to help with managing disruptive student behavior when he stated, “who better to help them with interpersonal aggression than those trained to work with behavior?” (p. 47). Van Brunt (2009) echoes this sentiment in stating the college counseling staff need to “step up to the plate” as their professional colleagues have done within America’s legal system. Terminology became important as scholars proposed *disciplinary counseling* and *disciplinary education* as more appropriate terms to describe the utilization of psychological staff in managing behavior (Dannells, 1990; Dannells & Consolvo, 2000; Stone & Archer, 1998; Stone & Lucas, 1994). “Mandated disciplinary education is engaged in for the public good; whereas, psychotherapy is conduct primarily for the benefit of the individual student” (Stone & Lucas, p. 238). Dannells and Consolvo (2000) proposed that “rather than mandating the

treatment, perhaps the outcomes desired could be mandated, leaving the decision to arrive at that outcome up the counseling center staff" (p. 55). In moving in this same direction away from mandated psychotherapy, Van Brunt and Ebbeling (2009) suggest a model of *mandated educational programming* as a behavioral management option. In their model, university professional staff members, who possess "an understanding of student development theory and…the basics of working with college students through a developmental process" (p. 5), serve as mentors who conduct a series of required meetings with the student. During the course of these required meetings, students are "made aware of counseling as a potential treatment option" (p. 8). According to Van Brunt (2009), required meetings are broken down into three levels, ranging from short-term (2-3 sessions), which places emphasis on the assessment of risk factors, to long-term (7-10 sessions) which places emphasis on action steps to avoid relapse behavior (p. 3). While both the Van Brunt and Van Brunt and Ebbeling models deal with aggressive behavior, they do not concern themselves with chronic mental health issues which may also be contributing to disruptive or concerning student behavior. Nonetheless, it is this scholarly grouping (Dannells, 1990; Dannells & Consolvo, 2000; Stone & Archer, 1998; Stone & Lucas, 1994; Van Brunt, 2009; Van Brunt & Ebbeling, 2009) which, taken as a whole, may offer a workable compromise which satisfies both sides of the debate.

The psychosocial literature presented numerous examples of behavior theory which rely on stages of individual growth as a fundamental component to changing personal behavior (Chickering & Reisser, 1993; Kohlberg, Levine & Hewer, 1984; Prochaska, 1999; Prochaska & DiClemente, 1984; Prochaska & Norcross, 2001; Stone &

Archer, 1998; Wampold, 2001). Both sides of the mandated therapy debate agreed that, in order for disciplinary education to be effective, the student must exhibit both a readiness and commitment to behavior change. As Pollard (2001) warned, "Attempts to assist clients to change before they have successfully negotiated the appropriate stage for change to occur will result in failure" (p. 66). Building upon classic student development theories which hold that adult maturity is arrived at only after the negotiation and successful completion of both tasks and stages of growth (Chickering, 1969; Chickering & Reisser, 1993; Kohlberg, Levine & Hewer, 1984; Wampold, 2001), Prochaska and DiClemente (1984) introduced a transtheoretical model which, despite being introduced 24 years ago, has become the standard in behavior change psychotherapy practice. In this six-stage model of personal change, clients progress from an awareness of their disturbing behavior to the eventual stage of commitment to make and sustain behavior change (Prochaska & DiClemente, 1984; Prochaska, 1999). By completing such stages, clients "are more likely and able to…commit to a process of change" (Prochaska, p. 265). Thus, the successful use of mandated disciplinary counseling may be highly dependent on the student's readiness to change their disturbed and disturbing behavior.

Conclusion

This chapter has presented a historical perspective on campus violence which has resulted due to student mental health concerns. It has also reviewed the current research on college student mental health which forms the basis from which conclusions of rising student mental health concerns are drawn. These impressions of increasing mental health concerns are also the source of a continual scholarly debate. On one side, scholars

believe the current research lacks both empirical evidence and methodological consistency. The other believes that survey data, in combination with other anecdotal impressions of student affairs practitioners, empirically justifies impressions of dramatic increases in college student mental health concerns. While this debate as well as the call for further empirical research may continue, the use of behavioral agreements to manage such concerns and its common usage is well documented in the literature. A review of the research concerning the various methods used in crafting student behavioral agreements is reviewed and discussed. Finally, the societal and institutional responses which have resulted due to college student mental health concerns and violent behavior are presented and analyzed.

CHAPTER III

RESEARCH METHODOLOGY

While the empirical evidence which supports rising levels of college student mental health concerns may be debatable in scholarly circles, the overall impressions, taken as whole, support a "growing consensus that more students are arriving on the campuses of higher education institutions with increasingly complex psychological, emotional, and behavioral challenges" (Eells & Cook, 2008, p. 9). The recent incidents at Virginia Tech and Northern Illinois University have not only heightened national awareness of student mental health issues, but have also made the American public aware of the violent risks which, if not properly managed, may threaten campus communities. As previously discussed in the literature, senior student affairs officers and campus counseling center directors have a variety of options to manage such challenging situations. These options involving students include, but are not limited to: voluntary and involuntary leaves of absence, mandated psychological assessment and treatment recommendations, mandated psychotherapy, and behavioral agreements. While both SSAOs and CCDs may have numerous options at their disposal, the actual process of how and why they arrive at their decisions can be a daunting task. "These decisions are extremely difficult on many different levels since the rights and interests of individual students must constantly be balanced with those of the larger community" (Eells & Cook,

p. 10). Thus, an exploration of the many facets of this decision-making process is an important component of this research study.

Overall, the objective of this exploratory, qualitative study is to examine how and why senior student affairs officers (SSAOs) and counseling center directors (CCDs) manage potential threats to the campus community by students with mental health concerns through the specific use of behavioral agreements which include long-term psychotherapy. Both university officers will be asked to reflect upon the various factors that lead to the use of a behavioral agreement in managing such student situations. A comparison of these viewpoints will identify if an alignment of management outcomes exists or if a potential conflict exists between these officers. Furthermore, an exploration of the use of mandated psychotherapy as a behavioral management tool will serve to inform practitioners as they consider its use in the management of student mental health concerns. Though it may be gaining acceptance as a specific tool used within behavioral agreements (Ghallager, 2006, 2007; Rasmussen & Johnson, 2008) its use remains highly controversial in the literature (Amada, 1999, 2001; Archer & Cooper, 1998; Boyd et al., 2003; Gilbert & Sheilman, 1995; Kiracoffe & Wells, 2007); and is, worthy of specific investigation within the context of this study. The remaining sections of this chapter describe the methodologies that are employed to reach the goals of this study.

Introduction: A Professional Journey

Qualitative research openly acknowledges the researcher's perspective, in the form of personal sensitivity, in interpreting the overall meaning of a qualitative study. As Rosmann and Rallis (2003) state it, "this sensitivity is a simultaneous awareness of self

and other and the interplay between the two" (p. 10). In order to better understand my personal sensitivity to the topic of this qualitative research study, the following section describes the development of my interest in the topics of student mental health concerns and the use of behavioral agreements in managing such concerns.

As a senior student affairs officer myself, I have consistently dealt with rising numbers of student mental health situations on an annual basis. Each of these student situations requires me to work collaboratively with my counseling center director as well as my student affairs colleagues in devising plans which utilize behavioral agreements in our attempt to effectively manage such students and, at the same time, minimize behavioral threats which may pose risk to the greater campus community.

In my interactions with professional colleagues at other institutions, I find them dealing with similar situations on their respective campuses. I find the same colleagues supervising the counseling center and, in turn, working collaboratively with them in identifying options which can be effectively managed in the behavioral agreement process. The recent tragedies at Virginia Tech and NIU have made my colleagues and me very aware of the pressure that our institutions place on us (whether intentional or not) to manage students with mental health concerns in a manner that will, at best avoid a similar outcome or, at a minimum, reduce the possibility of violence in our respective campus communities.

As I continue to work in higher education, I find the specific role of conduct management to be both an essential skill for student affairs practitioners as well as an institutional expectation placed on student affairs officers. My interest in college student

mental health issues and the use of behavioral agreements in managing such issues converge in this qualitative study. An in-depth exploration of how and why senior student affairs officers and counseling center directors utilize mandated psychotherapy as a management tool will provide a greater understanding of its effectiveness in the behavioral agreement process. Conversations with SSAOs and CCDs will determine how each of these university officers views the process. These conversations may also shed light on the possible frustrations that may exist between the different levels regarding the effectiveness that each holds for this process. This study represents my interest in knowing if both SSAOs and CCDs share the perspective that behavioral agreements, and specifically mandated psychotherapy as a specific chosen method, can be used effectively in managing college student mental health issues. This chapter outlines the methods to be used in this qualitative study that will clarify how each officer employs behavioral agreements in their attempt to minimize threats to the campus community.

Research Design

Rossman and Rallis (2003) describe a phenomenological study as one in which "the lived experience of a small number of people is investigated" (p. 97). Furthermore, phenomenological research assumes that through the use of "dialogue and reflection…the quintessential meaning of the experience will be revealed" (p. 97). In such a genre, in-depth and intensive interviews are utilized as the primary research method in gaining knowledge of the study's purpose (Rossman & Rallis, 2003; Seidman, 1998). Since this study focuses on the perspectives of both senior student affairs officers (SSAOs) and counseling center directors (CCDs), interviewing, as a qualitative research method, is an

appropriate data collection tool for this study. As Seidman explains, "the root of in-depth interviewing is an interest in understanding the experience of other people and the meaning they made of that experience" (p. 3). Therefore, this study will be a phenomenological, qualitative study in its research design. By exploring the expectations and viewpoints of both SSAOs and CCDs, this study will allow for a better understanding of how these two university officers interpret the use of behavioral agreements in managing students with mental health concerns.

Sampling Criteria for Institutional Participation

Larger university structures may have highly complex bureaucratic structures in which many staff engage in management roles within both the division of student affairs as well as the university counseling center. Since the subject matter to be studied requires an in-depth knowledge of the implementation and active monitoring of behavioral agreements for students with mental health concerns, it is imperative that both the senior student affairs officer (SSAO) and the counseling center director (CCD) have direct responsibility in both framing student behavioral agreements as well as monitoring the continual compliance with the actual agreement. It is hypothesized that, due to the bureaucratic structures inherent at many large institutions (greater than 10,000 students), the SSAO and CCD may not be intimately involved in the actual construction and implementation of student behavioral agreements. Such responsibilities may lie with other student affairs officers who are part of the greater student affairs organization. Therefore, it is further hypothesized that small institutions (fewer than 7,000 students) will provide a sample of SSAOs and CCDs who, due to the nature of their smaller staff

size, directly engage in the construction and management of student behavioral agreements and, as such, have deep personal knowledge of this study's subject matter. As such, SSAOs and CCDs will be chosen from four-year institutions with a total student population of 1,000-7,000 students. Furthermore, since the public universities in the geographic sampling area have total student populations which are greater than 7,000 students, private universities will, by the nature of the institutional criteria, be the focus of this study. Both the SSAO and CCD will be chosen from the same institution. Six pairs of SSAOs and CCDs will comprise the participants involved in this research study. Since the researcher is located in a major metropolitan area which is comprised of a rich, diverse representation of small, private institutions which meet the sampling criteria, the metropolitan area will serve as the geographical sample. The private institutions chosen will be both religious and non-religious affiliated as well as representative of both urban (inner-city) and suburban locations. The geographical proximity of sample institutions chosen will further facilitate the in-depth and necessary follow-up interviews which will be conducted in the form of personal interviews.

Sampling Criteria for Senior Student Affairs Officers (SSAO) Participation

Several sampling criteria for SSAOs are necessary for participation in the study. First, the SSAO must directly supervise the counseling center director (CCD) as part of his or her direct supervisory responsibilities. Second, the counseling center must be an internal unit within the college or university. Third, the SSAO must have at least one year of experience in his or her role at the sample institution. Fourth, the SSAO must have direct responsibility for the management of the student conduct system and that

student conduct system must include a written code of student conduct. The adjudication of student conduct is embodied within the written policies and procedures of the institution, and will include a student conduct hearing process which may include both administrative and campus judicial board options.

Sampling Criteria for Counseling Center Directors (CCDs) Participation

Several sampling criteria will also be utilized for participating Counseling Center Directors (CCDs). First, the CCD must be an employee of the institution. Second, the CCD must report directly to the senior student affairs officer in the scope of his or her job responsibilities. Third, the CCD must have been in his or her current role at the institution for one year. Finally, the CCD and his or her operation (campus counseling center) must be utilized as an option in formulating student behavioral agreements. This option is represented as a spectrum in the behavioral agreement process which, at its minimum, is represented by psychological assessment and treatment recommendations and, at its maximum, is represented by enforced treatment expectations (e.g., mandated psychotherapy). The latter may be conducted internally (campus counseling center) or externally (outside provider who may be a psychologist and/or psychiatrist). In the case of an outside provider, the senior student affairs officer and/or the counseling center director require a signed consent (from the student) for release of information, as part of the student behavioral agreement process.

Gaining Access to Participants

I will contact the institutional research board of each selected university by stating my desire to conduct a study at the institution through a cooperating institution letter (see Appendix A). Once approved and with a commitment to ensure participant and institutional confidentiality, an invitation to participate will be sent to the institutional senior student affairs officer (SSAO) (see Appendix B) and counseling center director (CCD) (see Appendix C) via their university email account. In order to avoid supervisory concerns which could skew the research results, I will ask that invited participants not share knowledge of the study, nor a willingness to participate in it, with their participating institutional colleague, prior to the scheduled interview. A strong emphasis will be placed on confidentiality of participation in the study. Those indicating a willingness to participate will respond directly to me via email. Thus, SSAOs and CCDs from the same institution will not have knowledge of each other's participation in the study. Should I receive a willingness to participate from SSAOs or CCDs who do not meet the criteria or are no longer needed, I will send the participant a letter indicating my appreciation for his/her interest but explaining that his or her participation is not needed at this time (see Appendix E).

Obtaining Participant Consent

A complete understanding of the study and the level of personal commitment required to participate are essential in obtaining rich data. In alignment with the Loyola University Chicago Institutional Review Board's requirements for the study of human subjects, my study includes careful attention to obtaining participant consent. I will

initiate email to the potential participants in which I will fully explain the details of the study (conversation) and I will receive confirmation of participation from participants (confirmation) (Loyola University Chicago, 2008).

The approach to invite senior student affairs officers (SSAOs) and counseling center directors (CCDs) will be fully considered to adequately inform and prepare the participants. Once I obtain consent through the research ethics committee from each cooperating institution, I will then inform the potential participants of their institution's consent. The letters of invitation (see Appendices B and C) will be written in a manner that is appropriate for the represented populations, those being SSAOs and CCDs. For the CCD population, I will make clear the decision to participate will in no way impact their immediate supervisory relationship with their SSAO. The time commitment of the interview, approximately 60-90 minutes, will also be outlined. Confidentiality will be ensured as I will select aliases for all participants in a manner that will not allow for personal identification of the participants. I will secure an on-campus location which is not located in the supervisor's or supervisee's immediate location. This location will both ensure a level of privacy to conduct the interviews in a non-intimidating climate as well as ensuring that participants do not need to access transportation in order to fully participate in the study. I will communicate the times and locations of the interviews with the SSAO and CCD.

To further acquaint the senior student affairs officer (SSAO) and counseling center director (CCD) with the nature of the study, I will send a synopsis of the research study (see Appendix D) to all participants. This synopsis will be sent as a supplementary

document along with the invitation to participate letter. This will help the participants to better understand the nature of the study as well as to ensure that they are comfortable in granting consent to participate. A written informed request requiring a signature at the time of the interview will be required (see Appendix F). This document will insure the confidentiality of the information shared in the interviews as well as offer the opportunity for a participant to withdraw from the study at any point for any reason. Invited participants will be asked to contact me by e-mail or by phone. Both of these contact options will be personal in nature (e.g., student e-mail account and personal cell phone number). Once selection has been established through a personal phone call as well as e-mail confirmation, I will then send the senior student affairs officer an interview protocol for his or her review, prior to the actual interview (see Appendix G). The same will be done for selected counseling center directors (see Appendix H). In order to gather biographical information which adheres to the sample population guidelines, I will contact each participant (via phone call or e-mail) to gather all biographical information, which will include: supervisory responsibilities for the counseling center and student conduct process, as well as number of years in their current position at the institution (see Appendices G and H, Section A) for specific biographical questions. Such pre-interview data collection will not only save time during the interview process, it may also help to build a level of comfort between myself and the participant prior the personal interview. Through follow-up conversations and letters, I will ensure that SSAOs and CCDs have all the necessary information to make an informed decision that allows for voluntary participation in this qualitative study.

Final Make-Up of the Study Sample

As anticipated due to the student enrollment parameters (1,000-6,000 students) which were established for this study, the final institutional sample was composed of six private institutions. Of these six, four were religious-affiliated institutions, while two were not affiliated with a religious organization or order. Variance was found amongst the Senior Student Affairs Officers (SSAOs) as well as the Counseling Center Directors (CCDs) in both their years of experience in their current position as well as their degree credentials. The following table summarizes these details:

Table 1

Experience and Credentials of Study Sample

Institution	SSAO No. of Years Experience	SSAO Highest Degree	CCD No. of Years Experience	CCD Highest Degree
A	10+	MA, Higher Education Student Affairs	2	MS, Clinical Psychology
B	2	MA, Higher Education Student Affairs	10+	MS, Social Work
C	8	MA, Humanities	6	Psy.D., Clinical Psychology
D	3	Ph.D., Higher Education Student Affairs	8	Ph.D., Clinical Psychology
E	10+	Ph.D., Higher Education Student Affairs	7	Ph.D., Psychology
F	7	MA, Higher Education Student Affairs	8	MS, Social Work

Data Collection

A qualitative, phenomenological study utilizes interviews as a way to make sense of the experience which is lived by the study's participants. These in-depth interviews allow for a greater understanding of participants' feelings and experiences. Interviews as a research method are particularly appropriate for this study due to their deep and highly personal exploration of the lived experience. The open-ended nature of interview questions allows for a greater understanding of how both senior student affairs officers (SSAOs) and counseling center directors (CCDs) make meaning of the behavioral agreement process as well as how effective they feel it can be in actually managing students with mental health concerns.

Personal Interviews with Participants

Interviews which focus on both the identification and personal interpretation of expectations represent research which is based in phenomenological inquiry (Seidman, 1998). In this study, the identification of the senior student affairs officer and counseling center director and his/her interpretation of the behavioral agreement process is not merely descriptive; rather, the participants will be asked about their opinions regarding the behavioral agreement process itself, which includes: identification of student mental health concerns, construction of agreements, and their overall effectiveness. Rossman and Rallis (2003) describe personal reflections of experiences, in phenomenological research, as transformation experiences. Since the data generated from the participants are highly reflective in nature, the actual experience which is captured in writing is reported through the researcher's reflective lens (Seidman, 1998). Engagement of the

study's participants in questions which focus on reflection of practices in the behavioral agreement process will generate themes (both of commonality and difference) among participants.

The interview protocols for both senior student affairs officers and counseling center directors include a predominance of open-ended questions (see Appendices G and H). Such questions are considered to be the most revealing in terms of individual meaning that is both experienced and interpreted by the participants (Rossman & Rallis, 2003; Seidman, 1998). Furthermore, open-ended questions may limit researcher bias since the actual answers given may be difficult to predict (Rossman & Rallis, 2003; Seidman, 1998). Such unpredictability allows for new knowledge to be discovered and interpreted as part of the research study.

As part of the interview process, I will tape record interviews with participants. The tape-recordings will be transcribed by a contracted service into text for analysis. The transcriber will be asked to sign a confidentiality agreement (see Appendix I) to ensure that data are held in strict confidence.

Document Analysis

While in-depth interviews will serve as the primary method for data collection, documents containing policies and procedures that concern themselves with the use of behavioral agreements in the management of student mental health concerns will also be collected as a supplemental research method. Rossman and Rallis (2003) describe this qualitative research method as "gathering aspects of material culture, which include artifacts and written material that may be available in or about the setting or about

individuals" (p. 172). In consideration of the subject of this study, such material may include both written policies (e.g., code of student conduct and leave of absence policy) as well as World Wide Web documents which are available on the institutional website. In addition, sample letters which summarize a behavioral agreement between the institution and a non-identified student will also be examined. An analysis of such written documents will add depth of meaning to the data collected in the interview process with sample participants. The following questions will be considered when reviewing documents and will serve as a guideline to evaluate the gathered data:

1. In what format (written or on-line) is the policy or letter presented?
2. Is the specific use of a behavioral agreement mentioned within such a policy or letter?
3. Are the terms "mandated" or "required" used in describing student conduct procedures which also apply to behavioral agreements?
4. Does a specific written policy differ from the on-line version of the same or similar policy?
5. Is there any mention of "informed consent" or "release of information" (on the part of the student) in compliance with student conduct policy?
6. Are "failure to comply" consequences described in any of the documents analyzed?
7. If so, what are the described consequences to the particular student?

Reflective Journal

The final research tool to be utilized consistently throughout the study will be the use of an electronic journal to record data findings and my personal thoughts. The journal will include field notes. Rossman and Rallis (2003) describe such notes as a method "to record the flow of events in the research setting and are captured in detailed descriptive field notes" (p. 302). A reflective journal also places the emotional and analytical reactions of the researcher into the data gathering process. By keeping such written thoughts, the researcher adds another perspective that will assist in the coding stages of data analysis.

Data Analysis

The primary means of data analysis for this study is transcript coding. According to Rossman and Rallis (2003), coding is "formal representation of analytical thinking" (p. 286). Coding is a research method used for the purpose of identifying repeated patterns (Seidman, 1998; Strauss & Corbin, 1998). By identifying such patterns, researchers recognize relationships and connections among the data collected in the interview process.

Coding also provides a means of protecting the research from the personal bias of the researcher. By identification and establishment of codes, the researcher continually questions the findings of the research data (Strauss & Corbin, 1998). Analysis confirmed by findings which result from the coding process give researchers a level of confidence that their deductions are confirmable. Coding occurs throughout the study and begins with the identification of three or four emergent themes which are directly related to the

study's research questions (Rossman & Rallis, 2003). In addition, the literature review is expected to provide guidance in identifying categories for coding (Marshall & Rossman, 2006). In order to code the data from my interviews, I will begin by labeling categories related to the personal reactions and interpretations of the study participants. This same method will be utilized to analyze my interpretations as they relate to the personal electronic journal entries. This labeling of categories will generate overall themes and, in turn, these themes will serve as the outline for the results and discussion sections of the study. Further analysis of the data will identify additional sub-themes. The interview analysis coding will be compared to the document analysis coding. I will compare and contrast the interview data with those of written and on-line policies as they relate to the student behavioral agreement process.

Theoretical Framework

In order to further interpret the data found as the result of interviews and document analysis, I will utilize models of practice which are used in both the management of student mental health concerns as well as campus threat assessment. For analysis of mental health management, I will utilize two models of practice which, despite their inception nearly 20 years ago, continue to form the theoretical backbone within the current literature for the purpose of analysis. The first is Delworth's assessment and intervention of student problems (AISP) model (1989). This model presents a framework for the identification of specific student behavior which presents mental health concerns as well as degrees of disruption to campus communities. The

following questions will serve as a guideline for comparison and contrast between the obtained data (interviews and documents) and Delworth's AISP Model:

1. When students are identified as having mental health concerns, are they described in terms of inward focus (withdrawn, lack of social skills) and/or outward focus (engagement in repetitive misconduct?)
2. Is there an acknowledgement that the combination of both of these focuses is the most challenging situations to effectively manage?
3. Does the institution utilize some form of a campus care team to discuss and make recommendations for intervention?
4. Does the campus care team meet on a regular basis? If not, when is it formed?
5. Does this campus care team also serve in the determination of threat assessment?
6. If so, how does it arrive at the determination that a threat is credible?
7. Does the team consider the use of the behavioral agreement as an acceptable means of minimizing threats to the campus community?

In analyzing the use of mandated psychological assessment and/or psychotherapy sessions presented in the data, I will utilize Prochaska and DiClemente's transtheoretical model of change (1984) as well as subsequent additions to this model (Prochaska & Norcross, 2001) in order to analyze the process of behavioral management. This six-stage model specifically examines the process of behavioral change, on the part of the client, in the psychotherapy process. I will concentrate on the first three stages which

place emphasis on the self-awareness of a mental health condition and the willingness to engage in the process of psychotherapy as a means to address behavior which may result as a manifestation of such a condition. Thus, the following questions will be considered:

1. Does the treating psychologist assess the student client and does he/she make a determination that the client has accepted his or her mental health condition?
2. Does the treating psychologist make a determination that the student client is personally prepared to enter into the psychotherapy process?
3. At any point during the psychotherapy process, does the psychologist make a professional judgment about the client's ability to change his or her behavior?
4. If so, is there a determination made about the likelihood of such behavior change being a sustainable process for the client?

Both of the proceeding models serve as a means of comparison and analysis between grounded theory and actual practice.

Development of a New Theory of Practice

In further describing the possible outcomes of qualitative research, Rossman and Rallis (2003) discuss the hopes of the researcher in terms of primary goals of the study as well as possible contributions. As they describe it, the study's outcomes may "lead to theory building, improvements in practice, and/or policy change" (p. 13). The same authors further describe such research as action research which "takes actions to improve practices or programs to forecast what works and what does not work" (p. 15). While this study's purpose is earlier defined as an exploratory study, the nature of qualitative research, which may change in scope and focus as the direct result of field research,

remains fluid (Rossman & Rallis, 2003; Seidman, 1998); therefore, it is possible, though somewhat unknowable at the study's inception, that a new theory of practice could develop as a result of data analyses. If the development of a new theory or model is not a result of the research, the study will remain exploratory and descriptive in its context. Rossman and Rallis (2003) describe a descriptive study as "describing phenomena which…contribute to understanding about such phenomena" (p. 15).

Ethics and Trustworthiness

Research which utilizes human subjects as its participants must be prepared and carried out with the highest attention paid to ethical considerations. Ryen (2004) describes three fundamental ethical issues: consent, confidentiality, and trust. Ryen pays particular attention to the issue of informed consent when he states, "research subjects have the right to know that they are being researched, the right to be informed about the nature of the research and the right to withdraw at any time" (p. 231). In the case of this study, participants will have the right of refusal fully explained to them and will realize that their decision to withdraw from the study at any time will be fully honored. To ensure confidentiality, I will, both in writing and verbally, express to each participant that I will take all necessary steps to ensure the confidentiality of their individual responses by masking their identities. Real names will not be used when describing participants; rather, pseudonyms will be created for each study participant. In order for participants to feel comfortable in sharing student conduct letters which describe behavioral agreements, as part of the document analysis process, participants will omit all student identifiable information (e.g., name, address). To further ensure confidentiality, participating

institutions will also not be identified except for general geographical location (e.g., urban or suburban location).

Ryen (2004) describes trust as a relationship between the researcher and the study participants. He further describes the ethical role of the researcher when he states:

> The researcher's responsibility is not to 'spoil' the field for others in the sense that potential research subjects become reluctant to [participate in] research. In this way, trust also applies to the report of the discursive practices defining the standards for presenting both the researcher and the work as trustworthy. (p. 234)

The development of trust between me and the research participants is critical to the success of this study. Since the subject matter relies heavily on the data gathered during the interview process, it is imperative that the participants feel a level of comfort that will produce rich, informative descriptions of their experiences with the behavioral agreement process. I will establish this trust by making myself available for any questions that may arise about the research study. Since the participants are busy individuals with multiple demands on their time, I will honor all commitments for arranged interview times. I will also adhere to the time commitments described for each interview; therefore, no interview will exceed the 90-minute allocated time.

Credibility is also an important aspect of trustworthiness. When the researcher employs qualitative methods for a study's design, actual data collection is often represented through the forms of field notes, observations, and the written transcriptions produced as the result of taped interviews. At any point, the reader may pose the greater question of credibility to the actual research by asking—how does one know that these findings are true? Lincoln and Guba (1985) suggested that the researcher employ several

methods to fully answer a research question. In order to build such a foundation of credibility, I will utilize both a member check system and triangulation as methods to insure credibility. First, member checks allow each study participant (known as members) to review the data they have individually provided in order to insure their accuracy (Janeskick, 1998). Therefore, each participant will have an opportunity to review their own interview transcripts before I move forward with data analysis. This process will further insure the data's accuracy.

Second, triangulation will be utilized to insure research credibility. Patton (2002) describes triangulation as a combination of multiple data collection methods which are used to make data analysis and subsequent drawn conclusions more credible. While interviews will serve as the primary means of data collection in this study, I will also collect documents of participating institutions' student conduct policies and procedures and maintain a detailed journal of my own notes gathered in the field. Each of these methods will allow me to address my research questions from multiple points of reference and thus, triangulation of the data will occur as a result.

The credibility of the researcher is also an important element of consideration. Patton (2002) describes such credibility in terms of the researcher's credentials as well as the possible bias the researcher may hold and how such bias might influence the study's findings. As a senior student affairs officer (SSAO) with 20 years of career experience in the field who also currently works in the same field as my research participants, I personally interact with behavioral agreements and management of student mental health concerns, about which I am asking the participants to reflect, on a daily basis. In my role

as an SSAO, I understand the complexities of the various roles which make up a student affairs organization as well as the various responsibilities that such roles play in the student behavioral agreement process. My years of experience have also given me key insight into the pressures that are also felt by SSAOs with regard to safeguarding campus communities from the potential threats posed by some student mental health situations. This wealth of experience will provide both valuable insight and a contextual understanding as I meet with my participants.

While I present no preconceived hypotheses with regard to the findings of this research study, I admit to having utilized specific behavioral agreement methods with students, mainly, the use of mandated psychological assessment as well as mandated psychotherapy. Since I have found these methods to be both useful and ineffective in a variety of behavior situations, I am open to the concept of discovery as it relates to the experiences and viewpoints of my participants. As a practitioner, I can relate to the impressions of rising student mental health concerns as well as strongly empathize with my colleagues on the desire to minimize threats to campus communities. As I conduct my study, I will remember the objective role of researcher that I serve in these areas of inquiry. Finally, I hope this study will add to the current knowledge base on the use of student behavioral agreements. While the current quantitative data describes the use of and participation in such processes in numerical terms (Benton et al., 2004; Cornish et al., 2000; Eudaly, 2002), it is my hope that this qualitative study will provide rich stories from actual practitioners who choose such agreements on a daily basis. Thus, it will provide a human element to the numbers which exist in much of the national data. I

further hope that the reader is left with a depth of understanding about why such processes are chosen and how they are perceived by student affairs practitioners themselves.

Limitations of the Study

While researchers may go to great lengths to ensure credibility in their study preparations, no research study is without its limitations. For a qualitative research study, sample size is one of the most common limitations. While a combined total of 12 interviews represent a reasonable sample size from which one can draw conclusions, one can argue that sample size is not sufficient. In order to best address this limitation, I will use triangulation and document analysis as methods which complement the data gathered from participant interviews. I will further utilize thick descriptions when explaining and interpreting my study. Lincoln and Guba (1985) describe thickness as the "specification of everything a reader may need to know in order to understand the findings" (p. 126). Thick descriptions also "should include as much detail about the context as feasible" (Rossman & Rallis, 2003, p. 68).

Another limitation of the study is the selection of small institutions from which to draw participants. While behavioral agreements are utilized at both small and large institutions, this study will focus on one size of institution, that being the small institution and its student affairs officers. It is my intent to establish transferability through the use of the fore-mentioned thick descriptions. Lincoln and Guba (1985) as well as Seidman (1998) specify the use of thick descriptions as a key element in facilitating transferability. While quantitative research places emphasis on the generalizability of findings,

qualitative research relies on transferability as a primary research component. According to Lincoln and Guba (1985), transferability can be defined as "providing sufficient information about the (study's) context…so that anyone else interested in the subject matter may have a base of information appropriate to the judgment" (p. 125). Thus, a reader can decide for him or herself if the study's findings may be applicable to their specific institution. "The final judgment of the matter is, however, vested in the person seeking to make the transfer" (p. 217). Lincoln and Guba place strong emphasis on the reader when considering a study's transferability when they add:

> Thus, the researcher cannot specify the eternal validity of an inquiry, he or she can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be completed as a possibility. (p. 221)

While I will make every effort to make the findings of this study transferable to all readers, which include those who practice at larger universities, the study addresses only one segment of the national institutional profile.

Lastly, my experience as a professional practitioner in higher education, which is also noted as an aspect of credibility, may also represent a limitation. Even though I have worked as a practitioner who shares the same work roles as my study participants, I have not yet systematically explored their reflections of the student behavioral agreement process in an empirical manner. This new role of the researcher may be a limitation in how I gather and analyze the data of this study.

Conclusion

The purpose of this chapter was both to describe the research methods I will utilize as well as to address the ethical considerations needed to conduct a credible study. In this chapter, I have outlined the study's research design which includes data collection and analysis procedures. All research methods were chosen in order to enhance the trustworthiness of the study's findings. As researcher, it is my hope to do no harm in gathering comprehensive data for thoughtful analysis. I further hope that my study will provide a valuable addition to the current research literature in student mental health and threat assessment.

CHAPTER IV

RESULTS: THE MANAGEMENT OF STUDENT MENTAL HEALTH CONCERNS

Interpretation of the Results

The analysis of the data is organized around the eight original research questions which inform the inquiry of the study. The findings are further organized into two broad themes which are presented in two separate chapters. The first is the management of student mental health concerns. These findings are presented in Chapter IV. The second are the findings on efforts to minimize threats to campus communities. These findings are presented in Chapter V. The original eight research questions will form separate, broad sections under which sub-categories will be presented. These questions are organized in the following order within each chapter:

Chapter IV: The Management of Student Mental Health Concerns

1. Why do Senior Student Affairs Officers (SSAOs) and Counseling Center Directors (CCDs) choose behavioral agreements to manage students with mental health concerns?
2. How do SSAOs and CCDs create behavioral agreements and what are the most common elements found in these agreements?
3. What criteria are used to require disruptive students with mental health concerns to enter into behavioral agreements that may include psychotherapy?

4. To what extent do SSAOs and CCDs agree on the use of mandated psychological assessment or mandated psychotherapy as a management tool? If differences do exist, how are they addressed?
5. What role, if any, does the student conduct system serve in addressing students who may violate campus policies while exhibiting mental health concerns that may contribute to disruptive behavior?

Chapter V: The Minimization of Threats to Campus Communities

1. How do SSAOs and CCDs identify student mental health concerns that may pose a threat of harm to the campus community?
2. Who, both on and off campus, has the responsibility for identifying and addressing student mental health concerns that may result in harm and what role does each person serve in the process?
3. How are policies and procedures that address potential risks of harm by students evaluated for their effectiveness?

As I begin each major section within Chapter IV, I will present a summary of the key findings that address each research question. Though not part of the original research questions posed in this study, one consistent theme which permeated the data was the rising levels of mental health issues that are being experienced at small institutions. Since this dynamic greatly influences the methods that small institutions choose to manage student mental health concerns, which include behavioral agreements, I have chosen to begin the first section of Chapter IV with an overview of this very important theme.

The Rising Numbers of Students with Severe and

Complex Mental Health Concerns

The impressions of rising student mental health concerns on college and university campuses nationwide that have been described in the literature (American College Health Association, 2005, 2007; Arehart-Treichel, 2002; Benton, Robertson, Tseng, Newton, & Benton, 2004; Ghallager, 2007; Kadison, 2004, 2006; Kadsion & DiGeronimo, 2004) were profoundly experienced by all of the study participants. Across the entire sample, the Senior Student Affairs Officers (SSAOs) and Counseling Center Directors (CCDs) described both rising numbers of students who had mental health concerns on their respective campuses as well dramatic increases in the severity of student mental health issues. Senior Student Affairs Officer Katherine shared a perspective on the rising numbers that was common amongst all of the SSAOs when she said, “It’s a constant stream and it rises ever year.” Senior Student Affairs Officer Jane used her hands to demonstrate rising numbers that she has experienced in her role as she explained, “When I first got here, the concerns were a few a year, like here (places her hand at her waist), now they are way up here (places her hand above her head).” One SSAO, who had only been in her current role for a short time, described these rising numbers in terms that were overwhelming when she stated, “I’ve been here two years and in that time, I’ve seen our numbers rise by more than 50 percent each year.” Counseling Center Directors also shared these experiences. The CCD Donald also described such increases in quantitative terms when he stated, “Our usage has probably tripled in terms

of identification of students coming in here for counseling services." The CCD Colleen echoed this rise in usage at her campus counseling center:

> We're seeing more and more students coming in (to the campus counseling center)…I mean, just in the last year, we had a 20% increase and in the last two years, I think, we've had a 40% increase in the numbers of students coming in.

These dramatic increases in the numbers of students who were actually being seen at counseling centers were described in almost overwhelming terms by CCD Bruce as he described a direct correlation between his institution's growing enrollment numbers and the rising number of student mental health concerns:

> We're seeing tremendous increases…Here's the thing, we're a school that has grown in size, I'm not sure of the actual enrollment numbers, but it has to be close to more than 50% enrollment, compared to just 10 years ago, so our enrollment growth curve is on a steady incline and just based on that, we're going to see more and more students every year…in the past three years, we've seen a 118% increase in the demand for our clinical services…there just seems to be some kind of exponential growth going on.

Such rising numbers also seem to verify the anecdotal impressions, which describe such rises in almost epidemic proportions, in the literature (Franklin, 2009; Marano, 2008; Moran, 2005; Peterson, 2002; Sharpe et al., 2004). As Kadison (2004) describes it, "Without question, concerns about the mental health of college students have risen substantially over the past decade" (p. B20).

The sense of severity and complexity to these rising numbers of student mental health situations also became apparent. The SSAO Tanya gave clarification to such conditions:

> When I first began here six years ago, we might have had some students with depression or anxiety, now, it's common to have many students with

> severe disorders like bipolar disorder and even schizophrenia…sometimes it feels like we are a mental health clinic more than a college campus.

Tanya's CCD Donald reaffirmed these concerns of severity when he explained, "Even though we're small in size, we have a significant number of students who have pretty serious mental health issues." This impression was also shared by another CCD Colleen who stated, "We're just seeing more severity…we're seeing more and more psychotic people and suicidal people." She demonstrated this point further by offering evidence in the form of the increased student demand for her campus's contracted psychiatrist when she explained, "We just got a contracted psychiatrist last year...We've had to double her hours from three to six in just one year." Colleen's SSAO Barbara affirmed these continual rises when she revealed, "The trends we are all experiencing are real." The SSAO Sally probably best summarized the impressions of increases in and the severity of student mental health situations when she said, "We're certainly seeing an increase in the number of students with mental health issues that are consistent each year… I also think the nature of the severity, like bipolar disorder and schizophrenia continue to rise in numbers every year." These impressions confirm the findings in the literature which state that both the numbers of students who present with mental health conditions as well as the severity of those conditions continue to be experienced on college campuses at almost unprecedented levels (Benton et al., 2003; Franklin, 2009; Ghallager, 2005, 2006, 2007; Soet & Sevig, 2006).

As they reflected on their job responsibilities in their role as student affairs officers, some SSAOs openly acknowledged that student mental health was their greatest concern. This reflected the findings of both Ghallagher (2005, 2007) and Belch and

Marshak (2006) who had consistently captured such concerns amongst SSAOs. When asked if the management of student mental health concerns was a growing demand on her job, SSAO Tanya threw her hands up in the air and said:

> Oh Yeah!...you know, it really my number one concern…it (student mental health concerns) take up so much of my time, I haven't plotted the actual number of hours, but I know, by far that is the most time consuming task that I deal with in my job and I just see it growing in the future.

The SSAO Jane concurred with student mental health concerns being her number one priority when she shared, "Without a doubt, it's become my biggest concern…it (student mental health concerns) just grows and grows and it takes a lot out of me and my staff." The SSAO Sally concurred with her colleague when she revealed, "If I look back, let's say the last five years, managing student mental health has become my largest job responsibility." This acknowledgement of student mental health concerns being their number one job concern was also described in terms of bewilderment and surprise. As SSAO Barbara described it:

> When I entered this profession, I never thought I would be dealing with so much psychological stuff…I mean, I had read about increases in mental health, but I guess I didn't realize how much of a concern it would really be for me…it just takes up a ton of my time.

Both the prior mental health diagnosis and treatment that today's college students experience before they come to college (Barry, 2002; Becker et al., 2002; Clemetson, 2006; Eudaly, 2003; Magna-Zito et al., 2007) was also a factor that was consistently described by the study participants. As CCD Vicky described it:

> We're getting more students who have experienced some type of mental health breakdown or have been involved in some type of mental health service before they get to campus…A lot of our students have already

> started medication before they even get here…and five years ago, that was not the case.

Vicky's SSAO Lisa concurred with this impression of prior mental health experience; however, she also partially based such prior usage on millennial student dynamics which described more acceptance of and less stigma attached to mental health concerns (Arehart-Treichel, 2002; Barry, 2002; Howe & Strauss, 2002, 2003):

> I believe students are more forthcoming and transparent with psychological issues that they have…the millenials tend to be more forthcoming about their own inner-self…I don't want to call them inner-demons, but I don't know what else to call them, maybe their own inner conflicts…I find they are more sharing with us.

The SSAO Barbara discussed the presentation of mental health conditions as an expected dynamic that is part of the traditional-aged college student population (Belch & Marshak, 2006; Kadison & DiGeronimo, 2004; Kitzrow, 2003; Robinson, 2007) when she explained, "If you read any of the literature…it's telling you that college students are first going to present with mental illness when they are 18-23 years old and that's when they're with us." The SSAO Tanya echoed these thoughts on the millennial generation when she explained, "Many of them (millenials) have already been to a psychologist or psychiatrist before they even get to us…they don't have the same stigma that my generation had about mental illness, they just see it as part of life." The SSAO Barbara shared this sentiment with regard to the millennial generation and how they view mental health when she stated, "Today's students just don't show the stigma for mental health that existed ten years ago…for them, it's common to have been to a therapist or even to already be on meds." This latter point about the prior usage of psychotropic medication is one that is well documented in the literature when the millennial generation is

described as ‘the most medicated generation in our society’s history (Downing, 2006; Hollingsworth, 2004). The SSAO Jane describes this prior use of psychotropic medication in more alarming terms:

> When you overlay the fact that students are coming to campus with already-defined mental health issues and perhaps even years of either medication for their ADHD or anxiety disorder or manic depression, and add to that the other episodic things that are typical for college students, it just terrifies me.

The concerns of both the over-usage of psychotropic medications as well as the lack of proper monitoring of such medication is also widely presented in the literature (Harris, 2005; Hazell et al., 2003; Kim-Cohen et al., 2003; Sax et al., 2000; Tilman et al., 2003). The CCD Vicky expressed strong concerns about such usage when she shared, “Sure, let’s just put a band on it and that’s it…these drugs are serious stuff and students need proper follow-up, not just take a pill and that’s it.”

The acceptance and familiarity of mental health by today’s college students may also be a “window of opportunity” for university officers who must manage such situations in the context of their job responsibilities. This window allows for the initial conversation that will take place between the SSAO, as the chief conduct officer, and the student who is being considered for placement within a behavioral agreement. As SSAO Jane described it, “Today’s students are just willing to share more with us about their mental health…this allows me to get information to build a successful (behavioral) agreement that can really motivate them.”

The impressions of rising numbers of student mental health situations as well as the increased complexity and severity of these problems were consistent in the findings.

Not only are SSAOs and CCDs spending significant amounts of their time on managing such issues, they anticipate that student mental health will only increase in both size and scope in the years to come. This dynamic forms the foundation in which behavioral agreements are necessitated as a management tool. I will now turn to the specific findings that address each of the major research questions of the study.

Research Question: Why do Senior Student Affairs Officers and Counseling Center Directors Choose Behavioral Agreements to Manage Students with Mental Health Concerns?

In this section, I examine the specific reasons why SSAOs and CCDs choose behavioral agreements as a method to manage students with mental health concerns. Five themes arose that help explain the use of behavioral agreements:

1. To manage behavior that is disruptive to the campus community.
2. To establish clear limits on acceptable behavior within the campus community.
3. Since the student with mental health concerns is often one who is in denial, the agreement offers an option to address the student's lack of self-acceptance of their mental health condition.
4. To facilitate adult responsibility in young adults with mental health concerns.
5. To create a sense of safety and foster the student's personal success at the institution.

To manage behavior that is disruptive to the campus community. When underlying student mental health conditions manifest into behavior that is disruptive to

the greater campus community, the SSAO and CCD utilize the behavioral agreement as a tool to manage such behavior. Amada (1994) describes disruptive behavior as "behavior that persistently or grossly interferes with academic and administrative activities on campus" (p. 8). As Delworth (1989) described in her AISP model, it is the *disturbing* student, that is, the student who with mental health concerns who also engages in conduct that is disruptive to the greater community that the SSAO should consider for use in behavioral agreements. Without exception, all of the SSAOs viewed such behavior as needing to be managed. As SSAO Katherine explained, "When the student's behavior impacts others in a way that's aggressive or other students feel very uncomfortable or threatened by it, that's when a behavioral agreement may be appropriate." She gave further definition to what she considered to be appropriate uses for a behavioral agreement:

> If the misconduct is such that we feel it needs monitoring, but it's not severe enough that we're going to kick the student out, and we don't do that very often, then the use of the behavioral agreement is the way to go…we go the behavioral agreement route first.

The findings also revealed the specific acknowledgement that disruptive behavior is especially problematic within a residence hall community. Katherine's CCD Mary agreed with this statement about the appropriate use of behavioral agreements when she stated, "When there are harmful behaviors that disrupt a community, especially residential communities, we have a heightened sense of responsibility." The SSAO Barbara shed further light on the impact of disruptive behavior within a residence hall environment when she shared, "The second hand impact of the disruption that's occurring around them, in a residence hall, is huge." This emphasis on disruptive

behavior that directly agitates a residence hall community was described by CCD Donald when he explained, “When these behaviors take place on a residence hall floor, the community views it and greatly affects them.” These impressions of the unique and highly concerning impact that disruptive behavior can cause within campus residential communities is described by Amada (1994) when he stated, “Certain forms of disruptive behavior can actually be highly detrimental to some students who live in (campus) residential facilities” (p. 41).

Not only the acknowledgement of disruptive behavior, but patterns of repetitiveness and the urgency to address such behavior in the form of a behavioral agreement are also revealed in the findings. As CCD James described it, “When you have repeat performances of disruptive behavior or the behavior continues to escalate, something must be done to get it under control.” The SSAO Tanya shed further light on the issue of repeated behavior when she added, “When I see incident of disruptive behavior, like four in a row over a four-week period, that’s recurring behavior and it’s a highlight for me…something must be done to address it.” The CCD Colleen probably best summed up the reason why behavioral agreements are used when she shared, “It’s about disruptive behavior and managing it…period.” These observations on the need to address disruptive behavior also turned to the horrific events that took place at Virginia Tech (2007) and Northern Illinois University (2008). Three of the SSAOs make direct reference to the repeated, disruptive behaviors of the eventual gunman (Cho) and the mismanagement that occurred in addressing the behavior (Angle et al., 2007; Fischer, 2007; Leavitt, Gonzalez, & Spellings, 2007; Massengill et al., 2007; Rasmussen &

Johson, 2008). As SSAO Mary explained, "The events at Virginia Tech and Northern Illinois affected us all directly…it made us think about disruptive behavior that comes up all the time on our radar." Fellow SSAO Barbara expressed similar feelings when she shared, "I mean, look at Virginia Tech…there was clearly knowledge that this guy (Cho) was a mess and they just let it ride." She then tried to give broader definition to her comments:

> There are two things you need to keep in mind as a senior student affairs officer…foreseeability and risk…If I can foresee the risk then I must do something to mitigate that risk. Period…It is my responsibility as the Dean of Students.

The SSAO Sally also mentioned the Virginia Tech incident when she reflected on managing disruptive behavior when she stated, "You read all of the Virginia Tech reports and it's just so sad…You have to think to yourself, what if they had put him under a behavioral contract, would it have made a difference?" Both the SSAOs and CCDs expressed a consistent urgency in effectively addressing repetitive disruptive behavior. When patterns of disruptive behavior are linked to underlying mental health conditions, a management tool that is often chosen by the SSAO is the behavioral agreement. This agreement, which is often crafted between the SSAO and the student, both addresses the disruptive behavior and clarifies that such behavior will not be tolerated in the future. Furthermore, it lays out specific action steps that the student must take in order to address the behavior in a manner that allows him/her to remain enrolled at the institution. Deisinger et al. (2008) give definition to a behavioral agreement when they stated:

> This is an agreement that is established between an institutional representative and the person of concern… with the purpose of getting the person to stop performing certain behaviors…in exchange for something

> the person wants, such as a chance to continue enrollment or maintain a position. (p. 73)

To establish clear limits on acceptable behavior within the campus community. There are several reasons described as to why SSAOs and CCDs choose behavioral agreements as a method to manage student mental health concerns. Chief amongst these was its ability to set limits of acceptable behavior for the student. The CCDs consistently shared the perspective that setting limits was a critical reason why behavioral agreements are utilized. As CCD Mary explained it, "It (behavioral agreement) gives the student clear limits of their behavior…it keeps the lid on the pressure cooker." Her CCD colleague Bruce agreed with this perspective when he stated, "Putting things in writing is very effective…It's clear and concise. The agreement is saying this (behavior) is unacceptable and these are the steps you need to take to remain here as a student." This sense of the power of the behavioral agreement as a written tool was found consistently discussed amongst the CCDs. As CCD Amy expressed, "Setting limits, in writing, sends a very helpful message…it says that your behavior is not acceptable…we want you to stay here, but here's what you need to do." Her CCD colleague Vicky agreed with this perspective when she said, "The agreement is helpful because it creates a kind of structure, it says these are the next steps…and it makes it clear when it's in writing. " The importance of putting these steps into writing is a perspective also shared by CCD Bruce when he stated, "I think it makes it very explicit to the student…these are what our concerns are and this is what you need to do to address them within our community." The CCD James also agreed with the importance of the behavioral agreement being a written document that sets appropriate limits when he said:

> So, the written expectation is that you will comply and you will maintain your behavior and you will do what it takes to live up to your side of the behavioral agreement. We will show you what it takes or what we have to offer to maintain your behavior…if need some support, these are the services available.

The SSAOs agreed with the perspective that behavioral agreements both set appropriate behavioral limits and that their use as a written instrument is very helpful. When reflecting on the importance of the written agreement, SSAO Tanya explained:

> I would make the student read every word of the agreement a loud to me, it's very important to me…it made me feel that the student was really internalizing all of the elements of the agreement and that they understood what they were agreeing to do.

The SSAO Lisa not only agreed that behavioral agreements set limits, she also stated the importance of having them in writing when she shared: "The steps are made clear in the written agreement that if you do not follow these directives, your registration as a student can be jeopardized." The SSAO Barbara concurred with this perspective when she explained, "It makes it clear that if you (the student) want to continue here, you're going to need to do x, y, and z." It became clear that both the SSAOs and CCDs viewed written behavioral agreements as both a powerful and acceptable tool in the management of student mental health concerns and disruptive behavior.

To address student lack of self-awareness. Another reason given for the use of behavioral agreements was the dynamic of denial that was described as common amongst students who experience mental health conditions that may have manifested into disruptive behavior. As CCD Bruce explained:

> A truism, in terms of working with those that are mentally ill is that those with mental illness also tend to be in more denial of their own mental

> illness…they can be in the throes of the illness and they may be acting out in very inappropriate ways and they just don't think that they are sick.

He added that the use of the behavioral agreement, to some degree, acknowledged this dynamic by placing the student under clear parameters when he explained, "They (the students) don't appreciate the full extent of their illness…they need clearly defined expectations of what is expected." His CCD colleague Donald agreed with this judgment when he shared, "Many times students with mental health issues have a defense wall around them and they don't want to acknowledge their mental health condition…that can be a very difficult thing to come to terms with." The SSAO Lisa shared this perspective of why behavioral agreements are utilized:

> I don't know a better way to say it…I can't say it medically, because I'm not a counselor, but some students are very much in denial and when they're in denial and their behavior is of concern to me, they may need a behavioral agreement to really address their mental health issues.

Lisa's CCD Vicky agreed with her SSAO's perspective on denial when she shared, "Many times students with mental health conditions are in complete denial of their condition and their behavior." When considering this dynamic and use of the behavioral agreement, she added, "For many of them, a behavioral agreement gives them a place to start in addressing their mental health." The SSAO Sally expanded on the issue of denial when she stated, "I mean, think about, many of these kids may have never experienced a mental health condition until right now, it's scary and confusing…they may need a behavioral agreement to begin to accept their condition." These impressions of denial as a rationale for the use of a behavioral agreement are found, from a theoretical perspective, within the work presented by Prochaska and Norcross (2001). In their model

of behavioral change theory, they described individuals in the first stage, known as pre-contemplation, as “unaware or under-aware of their problems” (p. 443). They further stated, “Families, friends, neighbors, however, are often well aware that pre-contemplators have problems” (p. 443). In a similar vein, it is the university administrator, in the form of the SSAO or CCD, who is aware of such problems and who feels that the use of the behavioral agreement offers an opportunity to actively address mental health problems.

To facilitate adult responsibility in the young adult with mental health concerns. The sense of creating a level of adult responsibility for a student’s own behavior and mental health condition was also a rationale given for the use of behavioral agreements. By creating a behavioral agreement, several of the SSAOs and CCDs acknowledged a greater responsibility to nurture and offer guidance to students with mental health concerns. These reflections described traditional-aged college students in terms of being in a state of personal development that is in agreement with Arnett’s (2000) principle of “emerging adulthood.” That is, they are not yet fully independent adults; rather, they are in a state of flux between early adolescence and full adulthood. As CCD James explained it, “So, we want to bridge the gap between adulthood in a way that’s supportive, but also pushing them (students) towards selfhood.” He viewed the behavioral agreement as a means to achieve this goal:

> I think behavioral agreements afford us the opportunity to have a student take responsibility for themselves…now, it’s time to make some amends and make some changes or you can’t be here…I think it reinforces a certain level of adult responsibility that we’re supposed to be instilling in these students.

Fellow CCD Mary agreed with this perspective when she said, “we need to be supportive and developmental when we create behavioral agreements…we need to realize that these students are just experiencing adulthood and we have a responsibility to help them get there.” Several SSAOs also concurred with this recognition of the emerging adult and their responsibility to foster personal development through the use of a behavioral agreement. “There is a certain sense of responsibility that comes with adulthood…it’s collective and individual responsibility and behavioral agreements help to emphasize that responsibility,” stated SSAO Barbara. As SSAO Jane commented, “My focus is to figure out how to make this into a grown-up agreement that’s going to encourage their personal development.” Jane went further when she described behavioral agreements, in an almost uncomfortable manner, in terms of *in loco parentis*:

> I almost hate to say it, but it’s very *in loco parentis* in many ways…we know we have to hold them accountable and at the same time, we need to get them help…behavioral agreements let us do that…I guess, in a way, we are acting as campus parents to some degree.

This sense of *in loco parentis* being a concept that was almost feared when describing behavioral agreements was exhibited by SSAO Tanya when she explained, “Higher education is always going to have a parental-type responsibility to the student…call it what you will, but it’s still *in loco parentis* and when you use behavioral agreements, it’s rearing its ugly head again.” At the same time, Tanya also placed emphasis on the role of self-responsibility:

> When I create a behavioral agreement with a student, I’m implying that I believe the student actually has control over his or her own behaviors, that I think that in signing this contract, for me, they are taking a level of adult responsibility…they are saying that I’m an adult and I accept personal responsibility for my actions and I know what you expect of me.

To create a sense of safety and foster student personal success. The use of behavioral agreements was also cited as way to insure that students are both safe within the campus environment and that they are being given the structure necessary to be academically and personally successful at the institution. The CCD Donald explained the importance of behavioral agreements in facilitating such success:

> The goal is to keep the students in their academic institution…to give them the help that they need so they can succeed personally and academically and so that that they can grow…In my mind, I can help them deal with both personal issues and psychological issues that will get them to the end and keep them in school…so that's the goal…to assist them.

Donald also pointed to the behavioral agreement as a way to achieve such success when he stated, "I think these agreements have the possibility to turn out to be useful because the student experiences collaboration and cooperation…I think they're great for achieving personal and academic success for the student." Donald's SSAO Tanya also affirmed the use of the behavioral agreement to help with such success when she added, "When I've created agreements, I've looked right at the student and said, the only thing standing in the way of your success is right here…do you want to take a small step now or wait until it's too late." Such success seemed to focus on utilizing the behavioral agreement as a means to connect the student to the institutional services that are dedicated to assisting students in being successful at the institution. The SSAO Jane also acknowledged this connection when she said, "The agreement has to be individuated in a way that makes the student take advantage of our institutional resources so they can accomplish their personal goals and eventually graduate." The SSAO Barbara agreed with this responsibility to connect students to resources when she explained, "One of the

purposes of behavioral agreements is to make students aware of the services that are here to help them be successful." The CCD James agreed with this sense of resource connection:

> So, if you need some assistance, if you need some support, these are the services that are available to you…if you're going to manage your behavior, these resources are here to help you maintain your behavior and we're going to connect you to them so that you can be successful here.

There was also a shared perspective that behavioral agreements helped to create a sense of safety for the student in such a way that the SSAO and the CCD felt a level of confidence that the student was learning to function in a personally healthy manner within the campus environment. The SSAO Barbara described this concept as it related to behavioral agreements:

> I need to feel they're in a healthy place to continue here…I need to be somewhat assured about that…with a behavioral agreement, I feel more confident that their personal mental health is at a level where they can properly engage in the community.

The SSAO Jane shared a similar perspective on the need for creating safety when she shared, "When I put a student under a behavioral agreement, I feel I am doing my part in trying to keep them safe here."

The CCDs also shared this responsibility of safety as a rationale for the use of behavioral agreements. As CCD Mary revealed, "I think we sometimes forget that our objective is to keep students safe and to graduate them." Her counseling colleague CCD Vicky emphasized this sense of safety when she stated, "We're here because we care about you and we want to keep you safe…a behavioral agreement is going to help us keep you safe." Documents obtained from the institutions, in the form of sample

behavioral agreement letters, also revealed the institutional responsibilities of student safety and academic success. In its behavioral agreement template, Institution B utilized the introduction, "In order to ensure your safety and well-being…you will comply with the following…" Institution F placed emphasis on personal success in its behavioral agreement document when it stated, "In an effort to provide a supportive environment that enhances the educational and personal development of all students." In a similar vein, a sample behavioral agreement letter provided by Institution D began with the statement, "My primary concern continues to be your health and safety." The same letter ended with a very personal sentence of concern and self-responsibility when it stated, "This agreement gives you an opportunity for you to change your patterns of behavior, to make better choices and to create your own success. What you do with that opportunity is up to you."

The findings revealed that both SSAOs and CCDs viewed behavioral agreements as a method which instilled self-responsibility in a manner that recognized the unique stage of emerging adulthood that is common amongst the traditional college student-aged population. Both SSAOs and CCDs viewed the agreements as effective tools in both setting behavioral limits and establishing a level of accountability. They also shared the common need to feel that the student was safe within the campus environment. While they had no absolute level of confidence that such safety can be guaranteed, they viewed behavioral agreements as a method to insure that the student with mental health concerns will be safer within the campus environment. Finally, SSAOs and CCDs exhibited a strong sense of shared responsibility to the personal and academic success of the students

with mental health concerns. They viewed the behavioral agreement as a tool that helped to make such success possible.

Research Question: How do Senior Student Affairs Officers and Counseling Center Directors Create Behavioral Agreements and What are the Common Elements Found in Such Agreements?

In this section, I explore how SSAOs and CCDs create behavioral agreements by examining both common steps and unique approaches to creating such agreements at small institutions. Five steps were consistently revealed in the findings, they include:

1. The initial meeting between the SSAO and the student which relies heavily on the element of persuasion.
2. The establishment of behavioral limits and community expectations.
3. The use of mandated psychological assessment.
4. The use of a signed release of consent.
5. Consequences for non-compliance with the behavioral agreement.

In addition, the findings also revealed that those SSAOs with longevity in their positions, described that the common elements in past and present behavioral agreements have evolved from a mandated approach to one that is now more cautious in the face of state and federal laws. This concept will be presented before an examination of the unique approaches found in behavioral agreements at small institutions. The two unique approaches found within behavioral agreements included: the commitment to treatment or care approach as an alternative to the traditional behavioral agreement and the use of a

check-in person who meets regularly with the student and provides active follow-up to the behavioral agreement process.

Regardless of whether the small institution utilized common or unique elements in their behavioral agreement process, I found an element of commonality that predicates all steps—the strong suspicion held by the SSAO and CCD, that the student's disruptive behavior may be a direct manifestation of a mental health condition. Since this dynamic is an essential foundation for the establishment of a behavioral agreement, I will first explore this concept before I actually present the common and unique elements found in behavioral agreements at small institutions.

Indicators that Mental Health Concerns May Contribute to Student Misconduct

While student conduct management, in the form of follow-up found in misconduct documentation, is a common element found in the job responsibilities of most SSAOs (Belch & Marshak, 2006; Rasmussen & Johnson, 2008; Stokes, 2007), the realization that such behavior that may be indicate a student may have underlying mental health concerns caused the SSAOs to take careful consideration in how they proceed. The SSAO Jane described how she arrived at the conclusion that underlying mental health concerns may be a mitigating variable in a student's behavior when she commented, "When a student's conduct is really inappropriate, my intuition takes over, to some degree…there's probably a psychological connect here and it's going to affect how I proceed." Her SSAO colleague Tanya shared a similar approach when she stated, "Our approach was we started getting reports about something that we thought was disruptive,

but the behavior told us there was more here…I'd have them (the student) come and see and we would have a conversation."

When SSAOs had the suspicion that mental health concerns were a strong variable contributing to disruptive conduct, they consistently expressed the need to consult with their CCD. As SSAO Katherine shared, "When I see behavior that I think has mental health involved, I am going to pass it by counseling center director and get their opinion…does she think there could be a psychological issue here?" The SSAO Sally agreed with this approach, but went further when she described such a review as almost a necessity:

> I'm not a psychologist or a psychiatrist…I have a trained licensed psychological professional who can look at this conduct and help me decide if there's a real mental health problem here…I just can't imagine any good conduct person not passing this by their psychological person first.

The SSAO Lisa agreed with the approach of first consulting with the CCD before consideration of a behavioral agreement when she stated, "I don't have the professional background or the skills to say that this is also a psychological problem…I lean to her (CCD) for that knowledge." She went further by viewing such a review as a job necessity for a conduct officer:

> You can't just decided on your own that there's some psych issue going on here when you don't have the professional training to make that kind of a decision…I really don't think you should do that…it's just not the right way to decide what to do.

The SSAO Jane also strongly agreed with this perspective. As she began to share her opinion, she purposefully used her hands to place emphasis on the importance on this approach when she explained, "Oh, absolutely! ... I'm not the clinical professional

here…he is!...I can't just make judgments about a person's state of mind, he's got to give me his opinion first."

When the SSAO and CCD mutually determine that there is "more at play" in a particular situation of disruptive behavior, their conclusions often lead them to the creation of a behavioral agreement to manage both conduct as well as the student's mental health condition. I will now present the five common elements found in behavioral agreements at small institutions, as well as three unique approaches which were revealed by the data.

Common Elements Found in Behavioral Agreements

Element #1: The initial meeting and the power of persuasion. When the analysis of disruptive conduct indicated mental health issues, the first common step is the initial meeting that takes place between the SSAO, as the institutional conduct officer, and the student. Every agreement, between two parties, requires a place to start. The behavioral agreement process finds this initial meeting, in the form of a very personal conversation between the SSAO and the student, to be a very important first step. Overwhelmingly, the SSAOs viewed this initial meeting as a way to connect with the student in a caring and empathetic way. The SSAO Katherine shared a story of one initial meeting:

> I had one student who was very disruptive in class and when I first met with her to discuss these reports, she was just very, very angry. I needed to take the time and really try and connect with her, I mean, try and develop a personal relationship with her. I needed her to feel that we cared about…I wanted to explore the cause of her anger and I needed her to realize that her anger might be a personal issue also, a psychological issue…I needed her to understand that she couldn't continue to do this…that we could get her help.

Katherine's SSAO Colleague, Tanya, emphasized the importance of taking the time to make this personal connect with the student:

> For me, it's about taking that extra twenty minutes to get a little context about what the student is really going through, what's go on with them personally…I think it contributes to a lot of my success in setting up behavioral agreements.

The SSAO Barbara also shared her perspective on the importance of establishing a personal connection as part of the initial student meeting:

> When you take the time, you realize there are a lot of other issues here, like complex family issues that are sometime a hindrance for disruptive students or triggers that may lead to conduct problems…I need them to realize there's an element of control to their behavior and that I can get them to a place where they can cope with these kinds of triggers.

The CCDs also agreed on the importance of the exploration of mental health and the personal connection that is made as part of this initial meeting between the SSAO and the student. As CCD Mary explained, "Some of these kids are dealing with severe psychological problems…so instead of making that first meeting, you need to connect with them and give them a chance to work on their issues and their behavior." The CCD James agreed on the importance of the initial meeting in establishing a personal rapport:

> The initial intervention is critical…they (the SSAO) need to make that first step in making the student aware of their mental health condition, they need to get to a point where the student feels he or she can begin taking control of their own life and that they can begin to make things happen for themselves.

When CCD Colleen reflected on how her SSAO colleague successfully conducted these meetings, she placed an importance on the role of the SSAO in making the behavioral agreement into an initial success:

> Honestly, I think the role of the dean (of students) is huge…It's really about that first meeting when she sits down with the student and she's giving that message that we care about you and that we want you to be successful here, but she's also making it clear that your disruptive behavior isn't working here...she's telling them that she's worried about them. She's telling them, 'let's work on this together…I think that's the biggest thing and she's really good at it.

The personal connections made between the SSAO and the student with mental health concerns also relied on one common skill--persuasion. Persuasion was necessary to get the student to realize that not only was their disruptive behavior unacceptable, but it also contributed to the initial realization on the student's part that he/she may need psychological help. The SSAO played a key role in persuading the student to come to this realization for help. As SSAO Sally explained it, "When we know that student has mental health issues, we really rely on the persuasion, you know, conveying to the student that we really, really think you should consider therapy…we really think you need this." A sample letter, summarizing the initial meeting between Sally and a student demonstrated this point, when it stated, "I strongly urge you to follow treatment recommendations with Dr. XXX in our counseling center." SSAO Lisa emphasized the importance of persuasion when she shared, "I need to make the student come to the realization that they need." She explained this concept further:

> If I can persuade them that look, your behavior is one thing, but your mental health is also something you need to address and here's what we have to help you…If I can convince them that they need professional help, then I can create a behavioral agreement that can work for both of us.

The inflection in SSAO Tanya's voice rose dramatically when she described the issue of persuasion in her initial meeting with the student with mental health concerns:

> Oh, It's huge! I need to build a level of trust so they trust me when I tell them, hey, you've got these issues and I don't view them as a fault, I believe you can work on these issues and we have a counseling center and it's free, it's part of your tuition, so take advantage of it, do it now.

The SSAO Jane also agreed with the importance of persuasion in creating successful behavioral agreements when she stated:

> There's all kinds of debate right now about forcing students into therapy and if we can really do that…If I can persuade them, to convince them that they need help and they believe me, I am so much more confident that they will actually go to therapy and be productive when they go.

The CCDs also agreed with the important role that persuasion played in establishing successful behavioral agreements. As CCD James described it:

> We can't require a student to go to therapy, but we can require them to maintain their behavior…if she (his SSAO), can make that connection with the student, to make him realize that we have this support in the counseling center and these services are available to you, then we can have a behavioral agreement that makes therapy work for the student.

Element #2: Behavioral limits and community expectations. A common second element of behavioral agreements revealed in the findings was the expectation that certain behaviors must be maintained in order to remain a member of the campus community. As SSAO Jane described it, "The student is acknowledging that the way they are behaving is affecting people and that is unacceptable here." She demonstrated this point by sharing a story:

> I had this one student who was really freaking out the people on his floor. He was very isolated and he seldom interacted with anyone on the floor, but he was self-harming and using razor blades to mutilate himself…he's a cutter and it got everyone worked up…when I contracted with him, as long as you keep these things to yourself and others don't have a problem, that's your business, but when your roommates and others on the floor are really disturbed by your behavior, then that's my business.

Jane's CCD James described the importance of framing the behavioral agreement around disruptive community behavior when he stated, "When students are experiencing psychotic symptoms, their community often becomes disrupted…the community reacts to the behavior…it's important to lay out expectations of community behavior." The SSAO Barbara emphasized the issue of community disruption when she explained, "The second hand impact of the disruption to the community is huge, it's not just one student that's impacted…it's essentially the community that's disrupted around them." Her colleague, SSAO Lisa, agreed with this point when she shared, "I find that in many of these situations, the behavioral agreement is making it clear that this behavior is not acceptable and it will not be tolerated…it's disrupting a community and we will not tolerate it." This sense of the institution calling attention to the student's concerning behavior and making it known that such behavior will not be tolerated in the future was a common element found within the second step of the behavioral agreement. As SSAO Katherine revealed:

> When you have a student whose behavior is impacting others and it's a clear violation of the code of (student) conduct, the behavioral agreement needs to make it clear that the behavior is unacceptable and that we're not going to put up with it in the future…the student should know that they need to address their behavior so that this doesn't happen again.

Documents, in the form of sample behavioral agreement letters, also further revealed written reference to community expectations. As Institution D stated, "As a member of the Institution D community, it is expected that you adhere to a certain set of basic expectations for community membership." Institution C placed emphasis on the self-responsibility of the student when it stated, "I accept responsibility for my personal

and psychological issues that at times can be disruptive to the learning community… I accept responsibility for…my behaviors and actions." Institution C also provided an internal document, labeled "Disruptive Behavioral Protocol," which was intended to provide guidance to faculty and staff on disruptive student behavior. In it, direct reference is made to community expectations when it stated:

> Institution C believes it is important to foster an environment that encourages students to maintain a standard of responsibility and self-care…some students who are distressed engage in behavior that impact their self-welfare and the welfare of our community. (p. 4)

When she reflected on placing community expectations within the written behavioral agreement, SSAO Barbara described this element in terms of action steps required by the student, when she stated, "I need the student understand that if you want to continue here, then you're going to have to do the following…" By putting behavior parameters and expectations within the written behavioral agreement, the SSAO established clear boundaries on acceptable behavior within the campus community.

Element #3: Mandated psychological assessments. The third step which was found to be common in how SSAOs and CCDs created behavioral agreements was the use of mandated psychological assessment. Before I discuss these findings, it is first important to note that *mandated* psychological assessment differs from *mandated* psychological treatment with the latter representing a form of required, continual psychotherapy that I will discuss later in this dissertation. When the SSAO and CCD have determined that the disruptive student may also have mental health concerns, the mandated psychological assessment served as a tool to determine both the psychological issues and provide recommendations for treatment. All of the SSAOs and CCDs utilized

this tool as part of their behavioral agreement processes. The CCD James described this step in the behavioral agreement process:

> That's when the mandated intervention of counseling services might be suggested and we say, okay, you need go down for an assessment and then, based on the assessment, we'll determine your mental health needs…if you need to go for further treatment.

His CCD colleague, Donald, expressed a similar strategy with regard to mandated psychological assessment:

> We do the mandated assessments here in the counseling center…we require a student to come in for a general psychological assessment…we'll spend a good hour to an hour and a half with the student and try to get an understanding of all the issues that are impinging on the student at the time, to understand that and then come up with a treatment plan that is specific to each student and their presenting issues.

The CCD Colleen described a similar approach as she explained the role of her office in carrying out mandated psychological assessments as part of a behavioral agreement when she shared, "In the agreement, we have them do a psychological assessment for a diagnosis and we determine our treatment recommendations." She then added, "It's almost always that our recommendation is going to be that we think you can benefit from therapy." CCD Bruce was very emphatic in his belief that mandated psychological assessments have become a necessary part of any behavioral agreement when he stated:

> I don't know how an institution in this day and age would function without mandating a student to seek an assessment with a mental health professional when they present with the kind of behavior that we've been discussing…its absolutely critical.

These observations of mandated psychological assessment for the student with mental health concerns is a concept which has also gained national acceptance as a

management tool (American Psychiatric Association, 2005; Cooper, 2007; Ghallager, 2005, 2006). In particular, the use of mandated assessment was viewed as a necessity when it came to self-harming or suicidal behavior. I will discuss the particular aspect of mandated psychological assessment later in this dissertation when I examine the specific criteria that are utilized for students who enter into behavioral agreements.

The SSAOs also discussed the use of mandated psychological assessments as a common element of the behavioral agreement. They also described the mandated assessment in terms of student accountability and the fulfillment of psychological treatment recommendations. As SSAO Jane explained:

> The typical approach is that they're required to through an assessment and they can decide the provider of the assessment…they're responsible to the terms of whatever the assessment recommends...they usually have to meet with somebody monthly and meet their campus obligations, like going to class and whatever.

Element #4: Signed consent for release of information. Another common element found in the behavioral agreement process was the use of a signed release, signed by the student, which allowed the SSAO to speak with the psychological professional who is completing the assessment. While Kiracoffe and Wells (2007) have described this waiver as a completely voluntary process in which the student has "the freedom to give or withdraw consent at any time for any reason" (p. 262), the SSAOs viewed the signed release as a necessary action in the behavioral agreement process. While SSAOs viewed the signed release as essential, they also placed limited parameters within the release, such that, they only needed to know that the student was actually completing the assessment. Thus, these parameters did not reveal the details of the conversations

between student and psychologist. SSAO Tanya described the signed release in very specific terms:

> In a case where we had an outside provider do the assessment, I would have the student sign a release to let Donald (her CCD) talk to their provider. If the assessment is done here, I'll have them sign the release for me, so that I can talk to Donald…I always make it very clear to them that I don't want to know what you are talking about…I'm not qualified to assess what it means, but, I want to know if you're not going and if you're not in compliance…all I want is to know that you're going….as long as you're going, I'm not gonna get further involved.

This dynamic of not needing to know specific details revealed in the therapeutic process was a common theme revealed in the findings. As SSAO Barbara described it:

> I always have the student sign a release for me…I need to know that they are going to the appointments that are part of the assessment, but I also make the releases very limited, I mean, I make it clear that I am only going to verify that they are going and I'm not going to dive into the things that they talked about with the psychologist…I want them to know that, hey, you are signing this and it only allows me to know that you are going, that's it.

The SSAO Lisa described a similar approach with signed releases:

> Once the release is signed by the student, there are levels of release that we allow the student to have…one level is for me…it's a check to make sure they are attending. The other would be if they are going to an outside provider and Vicky (her CCD) would be able to talk to the therapist about what's going on in the sessions and what the diagnosis is…for my part, I want the student to be comfortable when they sign the release and if they know that I'm just going to know they are going, I think they are more inclined to sign it (the release) because we are safeguarding the actual therapy…we're acknowledging the importance of the confidentiality of the sessions…that's between you and your therapist…I don't need to know the details.

This limited knowledge was continually expressed by the SSAOS in their attempt to have students both sign the release as well as to be comfortable with the main objective--the verification that they are going to the assessment sessions. As SSAO Sally

explained, "It's not useful for me to know all the details, there's no sense in telling everybody...the student needs to know that the content of the sessions are confidential…I just need to know that they completed the assessment."

The signed release as an element of the behavioral agreement was also described in several documents. While the signing of a release should be a voluntary action on the part of the student client within the psychologist-client process (Amada, 1994, 2001; Kiracoffe & Wells, 2007), sample behavioral agreement letters described it in terms of required action. In its behavioral agreement letter, Institution D listed several elements which included the requirement of the signed release. The document stated, "You must sign a release with Colleen, The Director of the Counseling Center, or the psychologist of your choice so that that person can communicate with me, as the Dean of Students, regarding your well being" (p. 1). Institution C took a similar approach in its behavioral agreement letter; however, it utilized wording which personalized the required action onto the student when it stated, "I will also sign a release of information permitting the evaluator (psychologist) with XXX, The Associate Dean of Students and Donald, Director of the Counseling Center, regarding assessment and treatment recommendations" (p. 1). The specific access granted revealed information being shared beyond the SSAO and CCD. Institution C's release granted access to a third party, the Assistant Dean of Students. This broader level of access is further demonstrated in the sample behavioral agreement letter provided by Institution B, when it stated:

> You must sign releases to all your treating professionals, including Dr. (Psychiatrist) and Dr. (Psychologist) to consult with Mary, Director of the Counseling Center, or other designated Institution B staff, such as: Katherine, Dean of Students, XXX, Assistant Vice-President of Student

> Affairs, and XXX, Vice-President of Student Affairs. These releases need to be active during the entire time you are enrolled at Institution B. (p. 1)

Not only was the release of information described in terms of broader access by several university officials, such access was stated in ambiguous language, which gave access to unnamed university officials. This ambiguity is described within Institution A's code of student conduct and its specific section which described mandated psychological assessment when it stated:

> A student who fails to complete the evaluation in accordance with these standards and procedures, or who fails to give permission for the results to be shared with appropriate administrators may be withdrawn on an interim basis, or referred to conduct action, or both. (p. 32)

This latter point of consequences that could result (e.g., withdrawal) for failing to sign a release of information was also revealed within the behavioral agreement letter provided by Institution F. Similar to the list of expectations utilized by Institution D, which formed a task list as the main written structure of the behavioral agreement, Institution F listed a directive to the student which stated that he/she must:

> Provide a signed release no later than February 20, 2009 for the Director of Student Care and the counseling center staff to communicate with the identified licensed counselor and psychiatrist specifically regarding compliance to the treatment plan and medication developed and prescribed for you…if you do not comply with each commitment, your status as a student at Institution F will be jeopardized. (p. 2)

The signed release was clearly an element of the behavioral agreement that was viewed as necessary by all the SSAOs. Its use both allowed the SSAO and CCD to speak to each other about the one follow-up element that all SSAOs viewed as critical in the behavioral agreement process—attendance at the required appointments with the psychologist. While the findings revealed the release process as having variations in the

access granted to university officials, they further revealed that the SSAOs consistently placed themselves under parameters within the signed release; such that, the content of sessions (between the student and the psychologist) were not revealed to them. This is consistent with the recommendations found in the literature which place great emphasis on confidentiality in the psychotherapy process (Amada, 1994, 2001; Pollard, 2001; Stone & Archer, 1998). This self-imposed parameter was primarily used to insure the student of the confidentiality of their sessions with the respective psychologist.

Element #5: Consequences for non-compliance. The final common element found in the behavioral agreement process was consequences. These consequences are experienced by students if they failed to comply with the three common elements: the initial meeting with the SSAO, a mandated psychological assessment, and a signed release of information. The findings revealed the actual accountability found in the enforcement of such expectations varied from institution to institution. The enforcement of the behavioral agreement expectations centered on whether the SSAO and the CCD viewed treatment recommendations as just that, meaning *recommendations* or if they viewed the treatment recommendations as leading to an enforceable plan of continued psychological follow-up. These variances in approach represented a continuum. On one end, I found SSAOs and CCDs who expected that treatment recommendations will be followed by the student. On the other end, SSAOs and CCDs utilized the previously-mentioned element of the power of persuasion to urge the student to consider on-going psychological treatment.

While all agreed that the mandated assessment must be completed as directed, some of the SSAOs believed that the treatment recommendations of continued psychotherapy and/or regular visits with a psychiatrist must be enforced and added to the behavioral agreement. SSAO Lisa explained this perspective:

> We would move forward with the treatment recommendations and make them part of the behavioral agreement because we want to give the student the opportunity to come to the realization that they need help…we need to enforce those recommendations...we need to have some meat behind our decision.

In a similar fashion, her SSAO colleague, Tanya, described how her institution viewed enforcement of the treatment recommendations as essential to the behavioral agreement process:

> We make it clear to the student that they are acknowledging the need for continued treatment by saying that I (the student) understand that in order to be able to stay at Institution C, I have to commit to this treatment plan…and then, if they didn't follow the treatment, we can intervene.

While Tanya was quick to point out the enforcement of treatment recommendations, she also provided clarification to her comments which placed emphasis on the personal care toward the student:

> We sort of outlined what the treatment was that he (her counseling center director) recommended and then I would say, now, it's really important that you go through with this treatment because if you don't go into treatment, I can't be confident that you're going to be safe and that the people in the community are going to be safe.

The SSAO Jane also viewed treatment recommendations as an enforceable element of the behavioral agreement. As she counted down the elements of her behavioral agreement process, she arrived on treatment recommendations that she enforced and then explained:

> And the second thing would be that they're responsible to the terms of whatever the assessment recommends…they usually have to meet with a psychologist weekly or monthly…I'm going to expect you (the student) to be responsible to the assessor and if you don't, there are going to be consequences.

While SSAO Jane's approach seemed very precise with regard to adherence to treatment recommendations and resulting consequences, her SSAO colleague Mary placed emphasis both on situational variables which are unique to each student case as well as on the use of enforcement as a student conduct policy matter:

> It really depends on the student and the treatment recommendations…if we believe that receiving appropriate mental health care, like continued therapy, is going to benefit the student, then we will make it part of the sanction…I mean, it really comes down to does it require an informal conversation or is it a formal hearing? If it's an informal conversation, then it's a recommendation and I don't think that's enforceable, but if it's a formal sanction, that's a different matter.

While Mary's comments seemed to distinguish recommendations from required treatment, her next comment represented a contradiction in this approach when she stated, "We will go into a behavioral agreement based on the recommendations for care…we need to make the appropriate care system work for the student."

It is in this "gray area," whether to take the behavioral agreement one step further by expanding its action items to include continued treatment, that I found some SSAOs and CCDs took an approach which placed the follow-up of such treatment directly onto the student and not onto the institution as an enforceable expectation. CCD James demonstrated this viewpoint when he discussed student responsibility:

> I don't think we can force someone to go to therapy…we can mandate that they change their behavior, not how they go about changing it…we can't tell you that you need to go to continued therapy, all we can tell you is that you need to stop acting this way…We have these treatment

> recommendations and we really think you should do them, but it's your choice…it's your responsibility to make some amends ad some changes…I think it affords us the opportunity to have a student take responsibility for themselves.

James' CCD colleague Colleen shared this same view about treatment recommendations:

> Counseling should be a personal choice, not like, we need you to continue to the counseling center to get fixed…this is about your behavior and it's inappropriate …the treatment recommendations are that you continue in therapy and we would really like to see you get treatment, but you shouldn't put a student through the discipline process just because they don't want to get treatment…that's not right.

Her fellow CCD colleague Bruce described a similar approach to the non-enforcement of treatment recommendations when he explained, "I don't think we should mandate treatment…it's more that we're setting up a set of recommendations for the student to follow…its' up to the student to agree and follow or not." The resounding recommendation of the CCDs was not to make treatment recommendations into an enforceable element of the behavioral agreement; rather, they wished to convey the need for treatment to the student and let him/her decide on whether to act on such recommendations.

Nostalgic Reflection on the Past: "The Good Old Days"

As the SSAOs who had longevity in their positions reflected on the enforcement element of behavioral agreements, they described an evolution that had taken place over the past several years. This evolution was described in nostalgic terms of "the good old days" versus the modern age of what behavioral agreements have become in the face of both national and state laws regarding mental health. As SSAO Sally described it:

> One of the biggest disagreements we've had is over mandating treatment after we get the treatment recommendations…so, what I talk about it in the good old days and they're getting kind of tired of hearing it…what I mean is that we used to use the student hearing process and if it was determined that a student had to follow the recommended treatment plan, then that would be in the letter and if they didn't follow the treatment plans, they couldn't be at the institution.

Sally went further by describing the evolution of behavioral agreement in legal terms:

> Now, we cannot mandate treatment per the law, which I can understand…the laws have changed...now, we really rely much more on persuasion, you know, we really, really think you should continue in counseling or we really, really think you should take a voluntary withdrawal and here's why. So, we don't say anymore that you must follow the treatment plan…we can mandate assessments, but we can't mandate continued treatment.

While she did not describe such past practices in the formation of behavioral agreements in legal terms, Sally's SSAO colleague Lisa reflected on how such agreements have evolved:

> It used to be very different, even up to five years ago, we would have what we called mandate letters and they would be saying that the treatment recommendations say you should be in therapy once a week or something like that or they would go the other route by saying that you had a psychological break and you are suspended from the university…it was very cut and dry back then.

Lisa summarized the differences between behavioral agreements "in the good old days," versus now when she shared, "We don't give mandates anymore, we give directives." The SSAO Barbara shared a similar perspective, but framed her comments around the past practice of her predecessor:

> When I got here, there were a lot of feelings on the part of the counseling center staff. They really felt that she (her predecessor) was mandating any treatment recommendations that came her way…they felt this was wrong,

> but they were afraid to speak up about it….I think behavioral agreements need to be about a partnership between myself and the counseling center…I think that's a change from the past.

While she acknowledged a change in how treatment recommendations are now enforced, Barbara differed from her SSAO colleagues by not completely "closing the door" on enforcing such recommendations when she shared, "I might tell a student that they have to continue with therapy, but it really depends…I mean, technically, it's mandated, but yeah…" The findings revealed a spectrum of opinions regarding the enforcement of treatment recommendations as part of the behavioral agreement. While the CCDs viewed such recommendations as best achieved on a voluntary level, the SSAOs viewed them as an important element to the agreement; however, the consistent enforcement of treatment recommendations was not established as a standard practice amongst the SSAOs.

Unique Elements Found in Behavioral Agreements

Unique Element #1: Commitment to treatment and to care. While common elements were found in how SSAOs and CCDs actually created and implemented behavioral agreements, three institutions within the sample described unique approaches to how they craft such agreements. Two institutions described philosophical differences in their behavioral agreement process which was reflected in the actual terminology chosen to describe such agreements. The SSAO Tanya's institution (Institution C) described a process called "the commitment to treatment." This process placed emphasis on the student to accept both their mental health condition as well as action steps that

he/she must take both to manage such a condition and minimize disruptive behavior. As she explained:

> What we do is a commitment to treatment; so, it isn't a behavioral agreement…it isn't that I promise not to do this…it's about the personal commitment that the student is taking…they are saying that I acknowledge that my life is important and that my disruptive behavior cannot only affect my life, but the people around me…I understand that in order to be able to stay at Institution C, I have to commit to this treatment plan…that I know that I have to make a commitment to health…I have to make a commitment to life.

Tanya felt strongly that this approach represented a description that was much better than a traditional *behavioral agreement.* As she described it, "We've chosen to call it something different and I think the language is very important…it's transferring the ownership directly to the student, not to us." As she described the *commitment to treatment* concept further, she talked about the importance of conveying a personal understanding to the student in which they clearly understood the process into which they were entering:

> I want to make absolutely sure that they understand what I'm saying in this agreement…they had to read every single world aloud to me and I need to believe they were buying it…that's the way we administer it here.

Tanya further clarified the importance of the student reading the *commitment to treatment* plan aloud when she stated:

> Even if they're reading it and it doesn't sound to me like they're really listening to themselves, I'll say, wait a minute, read that sentence again…do you really understand that?...so, it's very important to me that we get the student to really internalize what he or she was agreeing to.

Tanya's CCD Donald shared her enthusiasm for this different approach to traditional behavioral agreements when he shared:

> The commitment to treatment works better than behavioral contracting …and so, philosophically, I feel like this commitment to treatment is a true partnership between the institution and the student, it's putting responsibility where it belongs…with the student and I really want that.

In a similar vein, Institution F also described a process that it viewed as different than the traditional behavioral agreement. Institution F's SSAO Lisa and CCD Vicky described *the commitment to care* letter as their alternative to the behavioral agreement. As SSAO Lisa revealed:

> We have commitment to care letters and our letters say that we care for you as long as you commit to care for yourself…we purposefully changed our language to reflect not only our sense of care, but also our expectation that the student is going to take personal responsibility for their own care.

Lisa's CCD Vickie also echoed this same viewpoint when she stated, "We used to call it a mandate letter, but now we call it a commitment to care letter…it will outline what the students needs to do to remain here. " She further clarified the importance of the language used in this different approach:

> We wanted to change our langue to be more positive…to create a more optimistic approach in working with the student and just letting them know that the reason we go after them is because we care about them and we really want them to succeed…so, we really worked on the language piece and we approach the student.

While the findings consistently revealed the SSAO to be the institutional author of the behavioral agreement, Institution F took a unique approach. It created a *Wellness Board* as a standing body, composed of the SSAO and CCD as well as other student affairs staff members, who both created and enforced the *commitment to care* letter. As SSAO Lisa described it, "So, I developed a *Wellness Board* which is a group made of myself and other staff who actually analyze the situation and create the *commitment to*

care letter." Lisa described how the rising mental health situations on her campus became very problematic and almost burdensome to her within the scope of her job responsibilities. This led her to create a student mental health case manager whose title is the Director of Student Care. While a case manager position is still in its infancy on a national level, at Lisa's institution, this position has been in place for the past four years. This student affairs staff member played a pivotal role in not only managing student mental health situations, but also served as a member of Institution F's *Wellness Board.* Lisa described how she arrived at the need for this position on her campus:

> We were all doing triage and I needed a person who would write the *commitment to care* letters and who was there when we would tell a student that you're going to stay on campus, but you need to be referred out to have counseling…I needed someone who would make sure that the releases were signed and they would follow-up with the counselor to make sure the student was doing what they were supposed to do and following our directives.

Lisa's corresponding CCD Vicky viewed the director of student care position as a great asset to their efforts in managing student mental health concerns. As she reflected on this position, she shared:

> The Director of Student Care has a lot of contact with our students, especially those who have kind of made themselves known with mental health issues or because of their behavior…I just love having this position….my first year here there was no Director of Student Care and so I was involved in everything which did not leave me enough time to meet with students who actually would be dealing with other mental health issues…The Director of Student Care now does that and she is primarily in charge of the education on mental health that goes on around campus.

Institution F's *commitment to care* letter also not only clarified the use of the Director of Student Care as the author of such an agreement, it described the authority of the *Wellness Board* as the body which stands behind such an agreement, when it stated,

"It is the decision of the Wellness Board that to maintain your status as a student at Institution F, you will be required to commit to your own care by demonstrating compliance to the following set of directives" (p. 1). The letter also gave authorship as well as the direction of follow-up care to the Director of Student Care when it explained, "If you have any questions concerning the listed directives please contact the Director of Student Care as soon as possible" (p. 1).

By purposefully using different language to describe the behavioral agreement, Institutions C and F have developed a different philosophy toward the traditional behavioral agreement. The key terminology found in their respective approaches are *commitment* and *I* statement; thus, the university officers felt they have both created a greater sense of care for students with mental health concerns and at the same time, have shifted the ownership of mental health treatment directly to the student.

Unique Element #2: Check-in person to facilitate follow-up. One additional unique element within the creation of behavioral agreements was found to be practiced formally by one institution (Institution D). There, the SSAO and CCD created weekly or semi-monthly meetings between the student in the agreement and a designated "check-in" staff member. This staff member was always a professional staff member within Institution F's Division of Student Affairs. Similar to the mandated structure of continued psychotherapy sessions that could result from treatment recommendations; the student is required to meet with the designated staff member on regular intervals. This approach, known as *disciplinary education* (Dannells, 1990; Dannells & Consolvo, 2000; Stone & Archer, 1998; Stone & Lucas, 1994) or most recently as *mandated educational*

programming (Van Brunt & Ebbeling, 2009) advocates for frequent meetings between the student with mental health concerns and a designated staff member who is not a psychologist or counselor within the campus counseling center. Van Brunt and Ebbeling explain the purpose of such meetings as "to review developmentally relevant concepts and campus resources without being in 'counseling' or 'therapy'" (p. 3).

Institution F's SSAO Barbara expressed great enthusiasm in her voice when she described this concept as part of her behavioral agreement process. As she reflected on students who may not be at a stage of awareness or acceptance of their mental health condition, she said: "Sometimes, you have students who are really causing problems and they just don't understand that their mental health issues, which to us, seem so obvious, are a big contributing factor here." She then began to discuss the role of, as she described it, the *check-in* person in the behavioral agreement process:

> When I realize that this student is not ready to go to counseling, but at the same time, I need to do something to connect with them…I have the student meet with a check-in person, I mean, one of my staff who already has a relationship with the student or someone who I feel would be a great mentor to this particular student.

Like other required elements within its behavioral agreement, Institution F gave further description to these meetings in its letter:

> Given that I believe that you would benefit from one-on-one mentoring, you are to make an appointment with Joe, Associate Dean of Students. You must meet with Joe twice monthly (written in bold) during the spring semester or until which time you graduate…you will also work with Joe to become involved in some way on campus, as I believe that involvement will contribute to your success and persistence to graduation. (p. 2)

The SSAO Barbara gave further definition to this mentoring role when she shared, "When a student is open to talking to someone, but not necessarily a psychologist

and they need to figure why they are doing these things…that's where I'm going to use a check-in person." While the purpose of these meetings is described in terms of both establishing personal connections and addressing disturbing behavior (Van Brunt & Ebbeling, 2009; Wilcox, 2010), Van Brunt and Ebbeling also acknowledged that psychological counseling may be a topic of discussion when they stated that these meetings may "set the stage for therapy 'choice' later" (p. 5). Barbara echoed this sentiment as she explained, "When Joe is meeting regularly with this student, he can talk about therapy and get the student comfortable with the idea…if he can get the student to choose to go to therapy on their own, that's a big step!" Barbara's CCD Colleen became very animated with excitement as she talked about the *check-in* role:

> I just love it!...I think it's nice because it takes the onus off of counseling ...they (the check-in person) can be more like a friend, a mentor type person which isn't really what a counseling role…they can talk about things that a counselor can't do because it's a different relationship…it's just a different role.

Colleen also acknowledged how this mentoring relationship could lead to a student deciding to act on psychological treatment within the campus counseling center:

> If Joe or someone else is really making a connection with the student, I think them talking about therapy as a good option, I mean, an option that the student has be comfortable with, is really a good thing…If we can get the student to realize that, hey, you can really benefit from therapy and here's how you make an appointment, I'm all for it!...that' s what you really want…students choosing to be in therapy because they are ready to do the work with the counselor…they're personally investing in the process.

This concept of a *check-in* person was viewed in very positive terms by the SSAOs and CCDs. When this topic was raised with SSAO Sally, she reacted by saying, "Oh, I think that's a great idea…many of my staff have good counseling skills even

though they're not licensed counselors…I could see them playing that role." Her SSAO colleague Katherine also viewed this role as a valuable tool:

> I think a check-in person would be great…it would give me some confidence that someone is meeting with student that I'm concerned about…they might get to place where they would realize that counseling is something they want to engage in.

The CCD Donald also agreed that not only was such a role a good idea, he felt it would further protect the sanctity of the counseling relationship when he stated, "If we could have some of the student affairs staff serve in that role, it would be great for my staff…students would be coming to us because they wanted to, not because they had to." Fellow CCD Bruce also viewed this role in positive terms when he shared, "If the check-in person can establish a close relationship and make the student realize that counseling is a good thing, that it's something that can benefit them, that's a win-win for everybody." While these impressions of the *check-in* person role may have been viewed as a positive idea, none of the other sample institutions had yet implemented it as part of their behavioral agreement process. However, when the concept was raised during the course of the interviews, there appeared to be serious consideration to this concept as a future element for inclusion in the behavioral agreement. The SSAO Jane presented a very contemplative look on her face and then spoke in terms of great enthusiasm, "You know…that is really a good idea…I can see how that role could easily be done here…I have staff who really connect with students on a very personal level…why not take advantage of it?!" Jane's SSAO colleague Tanya also shared these same sentiments, "You know, you've really given me something to think about…mandated counseling is

just problematic and this could be a really good alternative…they could maybe get the student to choose to go to therapy…I like it."

While all of the sample institutions utilized behavioral agreements, document analysis further revealed that this process was only described within internal documents, such as division of student affairs protocols. Furthermore, the description of the behavioral agreement process is absent from nearly all of the codes of student conduct at the sample institutions. Institution C was the only university to describe the behavioral agreement process within its code of conduct. It listed this process under a section labeled, "Code of Student Conduct System Procedures/Terms Defined." It gave the behavioral agreement the title of a "behavioral contract" and it described it as:

> A behavioral contract is issued by the Office of Student Affairs when a student's behavior poses a significant disruption to the community, threat to self or others and follows a psychiatric evaluation as described in the Medical/Compassionate Withdrawal Policy. A behavioral contract is an agreement by the student to adhere to specified conditions. Failure to comply with the behavioral contract may result in judicial or administrative proceedings. (p. 27)

While the findings revealed both commonalities as well as unique approaches to how CCDS and SSAOs create and implement behavioral agreements, their use represented a concept that has become commonplace for small institutions. Behavioral agreements are viewed as a tool to manage student mental health concerns in a manner that both demonstrated a strong sense of personal care as well as provided structure to the student.

Research Question: What Criteria are Used to Require Disruptive Students with Mental Health Conditions to Enter into Behavioral Agreements that May Include Psychotherapy?

The data revealed three specific criteria which were utilized by the SSAOs and CCDs to require students to enter into behavioral agreements, they were:

1. The psychiatric hospitalization of a student and their return to the campus community.
2. The exhibition of self-harming behavior.
3. The student's acceptance of their mental health condition and their willingness to change their behavior.

In all three cases, the SSAOs and CCDs not only required the student to enter into a behavioral agreement, they also framed this requirement around the condition of continued enrollment at the institution.

Psychiatric hospitalizations. The SSAOs and CCDs consistently utilized mandated psychotherapy as an element of behavioral agreements for students who had been hospitalized for psychiatric concerns. Such a psychiatric hospitalization was viewed as a very serious event that caught the attention of both the SSAO and the CCD. Of even greater concern to them both was the follow-up needed after the student had been released from a psychiatric ward. Whereas a student with mental health concerns who may enter into a behavioral agreement, which may or may not include mandating psychological treatment recommendations, the student who has experienced a psychological episode so severe that he or she requires hospitalization represented an

entirely different criterion as it related to a behavioral agreement. The SSAOs and CCDs viewed continued psychotherapy and/or on-going monitoring by a psychiatrist as essential in these types of student situations.

The SSAO Sally expressed her expectation of a follow-up plan, in the form of a behavioral agreement, for a student who has just been released:

> Once they are released, I want to insure that they are seen by one of my staff…they cannot reenter our community without someone seeing one of us first. When we do meet with them, we make sure they have a follow-up plan…usually, their follow-up is with a psychologist and maybe a psychiatrist. I will then make those appointments part of the behavioral agreement.

Sally gave further clarification to these expectations for the student when she explained:

> I think it's appropriate for me to expect that they are going to remain in therapy and that they are going to keep their appointments…after all, they just experienced a major psychotic episode…I need to know that they are getting the help they need so that they can remain enrolled here.

While Sally's CCD Bruce concurred with his SSAO's comments, he focused on the behavioral agreement as a condition which must be met before the student can come back to the institution:

> We act on the treatment recommendations of the inpatient unit where the student was hospitalized…if they are recommending continued therapy, we are going to enforce it…the same goes for continued appointment with a psychiatrist for meds management…we will say you need to follow these recommendations and we're going to make it part of the agreement or we are not going to allow you back in school…we will involuntarily withdraw you.

Another institutional SSAO-CCD pair, Tanya and Donald, also shared a similar perspective on the post-hospitalized student. Tanya's face expressed an adamant look when she began to talk about this subject:

> You better believe I'm going to have them under an agreement!...when someone goes to a psych hospital, you know it's a serious situation, they can't just walk back onto campus and act like everything is ok, I'm fine...no!.. Donald and I need to meet with that student right away and find out what the hospital has recommended for their treatment.

Tanya went further by clarifying her expectations of the treatment recommendations when she shared, "I create an agreement that mandates the recommendations…when they have been in the hospital, it's serious…the mandated steps tell them that you need to do this or I am going to withdraw you." Her CCD Donald agreed with this perspective when he explained, "When a student goes to the hospital, it's usually a more serious form of psychological concern…it makes sense for us to uphold the recommendations of the hospital staff as they reenter our community." Donald then provided further clarification on the importance of creating the behavioral agreement before the student returns to the campus:

> We usually go to the unit and meet with the hospital staff and the student, sometimes, with the parents also. By meeting them at the unit, you are saying we are very concerned about you and you need to know that we are going to enforce these recommendations…we need to do this so that you get the help you need while you are going to school.

An analysis of Tanya and Donald's post-psychiatric hospitalization behavioral agreement attested to their unified stance on how they mandated follow-up with the affected student. While the common behavioral agreement steps of an initial meeting as

well as requiring signed releases are found, the language then changed to a very direct tone:

> If Dr. Bruce and I, in consultation with the staff from Hospital X, agree that you are healthy enough and safe to return to your studies at Institution F, you will be required to follow any and all recommendations for further treatment while you are a student here. (p. 1)

Institution B, on the other hand, utilized a template which "plugged in" different categories of behavior ranging from an initial meeting with staff to a hospitalization in a mental health unit, to describe its mandated treatment expectations. The template letter stated, "You will attend your scheduled sessions with Dr. X (Psychiatrist) and Dr. Y (Counselor) and follow all treatment recommendations and medication plan" (p. 2).

Two institutions utilized approaches to hospitalized students which were unique to the sample. These elements involved required laboratory testing for psychiatric medication compliance and involuntary leave after a hospitalization of three days or more. On the latter point, Institution F's SSAO Lisa expressed clear parameters of when a hospitalized student could actually remain at the institution under the terms of a behavioral agreement. According to her, these parameters were defined by the number of days spent in the psychiatric unit:

> If they are committed (to the psychiatric hospital unit) and they're there for three days…I mean if they are admitted and the psychiatrist there indicates that they need to stay for three days or more, they are not going to return here…if they keep the student for three days, they usually will keep them for seven days or more and at that point, they need to leave.

When this particular point was raised with Lisa's CCD Vicky, she expressed a blank look on her face and paused as she searched for a response:

> I can't say that I'm familiar with coming to a decision based on three days or four or five days plus. I know that we discuss the students who have been hospitalized and about them coming back to campus…we talk about what the follow-up issues are…

Vicky then paused and continued to have a look of bewilderment on her face. As she adjusts her posture in her chair, she added:

> It concerns me when we're talking about three days as opposed to five days. That does concern me because someone who is in the hospital for three days could be as much as an endangerment to themselves as they are to the community and someone who's been in the hospital five days doesn't necessarily mean that you can't survive, you can't succeed on campus…we've never had this discussion about the number of days.

This point of confusion with regard to the number of days spent in the hospital as a "benchmark" policy which, either established a behavioral agreement or facilitated an involuntary leave of withdrawal from the institution, was unique to Institution F's SSAO-CCD pair. Institution B had a policy which not only required hospitalized students to enter into mandated treatment; it also required students to allow for laboratory testing to insure compliance with psychiatric medication. In its behavioral agreement template, Institution B stated, "You will follow all treatment recommendations and medication plan, including but not limited to possible laboratory testing to confirm compliance" (p. 1). When asked about this requirement, Institution B's SSAO Katherine stated, "I know we have it listed in our agreement, but I don't think we have ever used it." Katherine's CCD Mary also expressed a similar viewpoint:

> I know that it's in the form letter that we utilize for all of our behavioral agreements, but I can't remember any time when we've actually made a student go for blood draws to test for medication in their bloodstream…I just don't see us doing that.

While these approaches may be unique to two of the sample institutions, the commonality found in post-hospitalization follow-up treatment, as a mandated requirement of the behavioral agreement, was consistent in the findings. Moreover, commonality was also established in *how* the institutions actually delivered mandated psychological and/or psychiatric treatment. In every case, delivery of continued psychotherapy or psychiatric care was arranged with outside providers and not the campus counseling center. The sheer volume of students being seen in a campus counseling center for a variety of both short-term and chronic psychological conditions has forced institutions "to utilize short-term or brief treatment methods" (Kitzrow, 2003, p. 26). The use of short-term treatment models has become a national standard with most institutions delivering an average of 3-4 sessions for each student (Cooper, 2005). Thus, in order to provide the long-term psychological care needed for students who have just been released from a psychiatric unit, institutions must cultivate and maintain relationships with off-campus providers (Benton & Benton, 2006; Cooper, 2005; Kitzrow, 2003; Mowbray, Megivern, Mandilberg, Strauss, Stein, Collins, et al., 2006). Several of the SSAOs and CCDs spoke to the necessity of utilizing outside providers for behavioral agreements which involved post-hospitalized students. As SSAO Sally explained:

> Every year we are seeing more and more students who experience an episode and end up in the hospital…these students have profound, long-term care needs and we only have five therapists on our staff and our psychiatrist only comes in two days a week and her appointments are always booked in advance…we have to use outside providers to care for that student…we have no choice. We are not set up to be a community clinic…the outside providers are giving that long-term care.

Sally's CCD Bruce concurred with her impressions and he further expressed the rising numbers of students who must be placed under behavioral agreements after being released from the hospital:

> We have a psych hospitalization rate that is at least four or five times the rate of most other schools. Two years ago, we had 33 hospitalizations with a population under 3600 students. That was a record for us. So, we have a lot of students who get hospitalized for a school our size.

Bruce then utilized these rising hospitalization rates to demonstrate the necessity for outside providers in being part of behavioral agreements:

> Since 2001, we've seen an increase of 118% in the demand for our clinical services here at the counseling center…when you consider students who have just been released from the hospital and who have significant long-term care needs, there's just no way that we can give them that kind of care…we need to have a network of outside providers who can really care for these students.

SSAO Barbara echoed the need for outside providers to for post-hospitalized students:

> We are not set up to be a long-term care counseling center….when we have students who have been hospitalized, we have to use a private psychologist or psychiatrist for follow-up…we just don't have the staff in our counseling center to give them weekly sessions they probably need…we do have a psychiatrist here two days a week but her schedule is always full and I'm trying to get here another day each week right now.

Barbara's CCD Colleen agreed with the necessity of outside providers for post-hospitalized students:

> Yeah, we just don't have the staff to care for those students…we are a campus of 3,200 students with a small counseling staff and we are not a mental health facility…I know that Barbara has used some outside providers when she has written the behavioral agreements for those students…I think that we have to do it out of necessity.

The use of outside providers as part of the behavioral agreement also raised frustrations for some of the SSAOs and CCDs. These frustrations centered on perceptions that some outside providers seemed to make quick judgments when attesting to a student's ability to function at the university. These quick judgments seemed almost "rushed" in some instances and they caused some of the SSAOs to have both great anxiety and to rely on the professional judgment of their CCDs to establish a level of confidence in the student's ability to remain at the institution. As SSAO Jane explained:

> We have some good relationships with some psychologists and psychiatrists in the neighborhood, but sometimes I have to work with some that I really don't know and there have been some real issues…I mean, we have this one case recently where the psychiatrist was telling me that the student didn't need to see him anymore , that she had stabilized and I was like, she is being very manipulative and we are very concerned about her behavior and he was arguing with me and saying, well, I'm a doctor and I can attest to her being ok…I mean, I have a responsibility here and I just don't buy what he's saying to me…it just seemed very rushed, very dismissive to me.

Jane's CCD James also agreed with these impressions of some outside providers:

> Working with outside providers can be tricky. You're dealing with very busy people who probably have very full caseloads and sometimes, they tend to rush patients through and they make judgments that cause us great concern…if we are going to have the student remain here, we need to feel a level of confidence in their treatment…if you have providers that just seem to rush them through and just kind of certify them and say it's all ok, that's not a good situation.

SSAO Tanya shared similar experiences with outside providers and related her confidence in her CCD Donald to give her advice on how to proceed:

> It's very common the student's own doctor will say that they're ready to be here because it's really what the kid wants them to say or the doctor believes that any other possibility, like withdrawal, is not going to be good for the student and that really frustrates me…that's when I turn to Donald

> (her CCD) to take a look at the situation and give me his opinion…I always go with my internal person's opinion.

Tanya's CCD, Donald, attested to this review when he stated:

> We have had some situations where a psychiatrist or a psychologist just seemed to be saying whatever the student wanted…Tanya will ask me to review the case and give my opinion and she has always went with my judgment…she has met with the student when she felt that the provider was just not giving us a solid judgment and she will adjust the agreement if she thinks it needs to happen.

Another institutional SSAO-CCD pair also expressed frustrations with outside providers as part of behavioral agreements. The SSAO Barbara shared this perspective:

> In general, it works well, but I can think of a few situations where a psychiatrist and a psychologist really made me frustrated…it just seemed like they wanted to move the student through really quickly, like well I've seen him now for a few sessions and he's fine…I just didn't feel that confident that he really was ok…I felt he needed more help.

While the practice of utilizing outside providers may be commonplace for many SSAOs and CCDs, the findings revealed that such usage may come with a price--the potential frustrations with the diagnoses that such professionals provide. The findings further revealed that the SSAO relied on the professional judgment of their CCD colleague to give an informed opinion. Such an opinion may then result in the SSAO adjusting the mandated treatment requirements of the original behavioral agreement. This approach may also prove to be problematic since the SSAO may have the campus counseling center at his or her disposal, due in part, to the short-term psychotherapy models that are necessitated with a small number of counselors who must serve the entire student population.

Self-harming behavior. Earlier in this dissertation, I discussed the use of mandated assessment as part of behavioral agreements. The particular behavior of self-harm was used as a criterion for requiring students to enter into mandated psychotherapy. This specific criterion straddles the line between assessment and continued therapy in that it is both used as an assessment tool *and* as form of mandated therapy. All of the sample institutions required students with documented self-harming behavior to enter into four sessions of psychotherapy. Documents provided by the institutions also revealed this stance to be a clear written policy which was found in both the codes of student conduct as well as internal protocol documents. For example, Institution D had a Self-Harm Policy as its own complete section of its code of conduct which stated:

> When a student has threatened or attempted suicide, engaged in efforts to prepare to commit suicide, or expressed preoccupation with suicide, the college requires that the student attend four sessions of professional assessment beginning within one week of the incident. (p. 3)

Institution F further gave justification for this policy when it stated, “The purpose of this assessment is to provide the student with resources to adhere to this standard in the future and to monitor the student’s willingness and ability to adhere to this standard” (p. 3). While the policy required a signed release for the Dean of Students, it also allowed the student to choose whether to have the four required sessions conducted at the campus counseling center or a private practitioner. Institution C listed its similar policy in an internal protocol document labeled, “Suicide Gesture or Attempt.” It took a much stricter stance by first discussing suspension for self-harming behavior:

> Students who are treated at a hospital due to suicidal behavior will be summarily suspended, effective immediately, by the Dean of Students (DOS) or his/her designee, pending a psychological assessment by the

> Director of Counseling Services (DOCS) and a follow-up meeting with the DOCS and DOS. (p. 2)

Institution F's policy then placed emphasis on the four required sessions : "If the student is permitted to return to campus, the Dean of Students will then require that the student attend four sessions of professional assessment" (p. 2). In a similar vein, Institution A also had a "Suicide Policy" as part of both its code of conduct and internal protocol within its division of student affairs. It also utilized the exact same wording as Institutions C and D in its rationale for required psychotherapy sessions. The policy of mandating four therapy sessions for self-harming behavior is based on Joffe's (2003) "Illinois Plan," which empirically demonstrated dramatic decreases in both suicidal ideation and actions on the part of students who participated in such a mandated policy. Furthermore, the use of such mandated therapy sessions has actually gained wide acceptance on a national level (Belch & Marshak, 2006; Eells & Cook, 2008; Hollingsworth, 2004; Kitzrow, 2003; Pavela, 2006). As Amada (2001) stated, self-harming behavior "should be regarded as disruptive because the students' self-harming behaviors are eventually likely to traumatize and victimize their roommates, classmates, and the college personnel who must deal with them throughout the crisis" (p. 161).

Amada's recognition of self-harming behavior being the cause of serious disruption in communities was discussed by several of the SSAOs and CCDs. As CCD Donald described:

> It's very common to have suicidal students be the source of, I'm not sure how to say it, of sucking other people in…like how many people are on the hook with this student and that tells you something about the community dynamics that are going on for that person and the community itself.

Donald’s CCD colleague Colleen agreed with this perspective on suicidal students:

> You have this one student who all these other people are worried about, especially in the residence halls and they all feel like they have to attend to this person…these are students and they’re not professionals…I think they can experience a lot of guilt, but they have to recognize their limits…I think a self-harm policy is good for this reason…we’ll get the student the help they need and I think, the community gets a break and it can begin to heal itself.

Colleen’s SSAO Barbara concurred with these thoughts:

> Suicidal students can be highly manipulative and they tend to get a lot of people really worked up….those other students feel a sense of responsibility for that student that just isn’t healthy for anyone.

When Barbara reflected on the use of the policy as a form of mandated therapy, she commented:

> We talk about it as an assessment, but it does involve four required sessions with a psychologist; so, I guess you could say it’s mandated therapy, I guess…I know that all of the other deans of students that I know use it and we all seem comfortable with it…we have to be concerned about liability, I mean, what if this student took their own life on the campus, then you would have a real problem!

SSAO Sally agreed with Barbara’s perspective on the need for mandated therapy sessions for suicidal students as a tool against possible litigation:

> Look at the *Shin* case at MIT…their counseling center was doing a lot to help her and she still took her own life and the family sued and won big time!...I think you need to take suicidal gestures very seriously…it’s not worth a law suit…if you are concerned about your job, you better have mandated sessions for suicidal behavior.

Sally’s SSAO colleague Lisa also described her institution’s mandated therapy policy for suicidal behavior in litigation terms:

> I know there was that case at MIT recently…from what I've read about it, they had her in therapy and she still ended up killing herself…I guess you can never be too careful…you need to have a policy that requires students who are suicidal to get the four sessions…it just makes sense.

While the four mandated therapy sessions may be labeled as *assessment,* I would argue that four sessions with a licensed professional could also be described as mandated *therapy*, since such sessions are conducted within the context of a therapeutic setting. Regardless, the findings reveal these criteria to be common in practice across the entire sample. Several of the SSAOs viewed this policy as necessary to minimize disruptions within campus communities. In addition, they also considered its use as a method to avoid possible litigation, should a student actually attempt suicide while on their campus.

Student acceptance of their condition and willingness to change behavior. The final criterion which was utilized by SSAOs and CCDs for behavioral agreements was the elements of self-awareness and the ability to change on the part of the student. If the disruptive student with mental health concerns had a sense of self-awareness of his or her mental health condition to the point where he or she was open to therapy as an option that would assist in making a change in their disruptive behavior, the SSAO and CCD viewed this as a "window of opportunity" for both them and the student. As I will discuss in further detail later in this dissertation, the act of personal engagement in therapy, that is, the willingness to address behavioral change and make a personal commitment to that change, is viewed as highly desirable by both the CCD and the SSAO since such engagement may result in a sustained change in behavior that minimizes further concern for the student and the community-at-large. The act of psychotherapy is a relationship process between the student and the psychological professional; and thus, the

effectiveness of this relationship requires active participation on both parts (Amada, 1994; Pollard, 1995; Stone & Archer, 1998). Both the SSAOs and the CCDs regarded the student who is both self-aware of his or her condition and ready to address behavioral change as the ideal combination for continued therapy within the behavioral agreement.

The SSAO Jane gave further definition to the self-aware student as it related to continued therapy:

> We always want the counseling to be outside of the conduct process…if the student has a strong sense of what's really going on with them and that they are willing to get help, that's a good situation to have…I feel a lot more comfortable mandating therapy when I know the student is ready to commit to the process and I know my counseling center staff like it too.

Jane's CCD James verified this perspective as he reflected on students who exhibit strong self-awareness of their mental health condition:

> As a practitioner, I'm always going to support people's self-awareness of their own mental health…the student who is more self aware and has some insight into what they're doing what they're doing, I think they are already four or five steps ahead in making some sort of behavioral change because they now have some insight into why they're doing it…I'm going to support their therapy a lot more.

Another institutional pair, SSAO Barbara and CCD Colleen also agreed with this perspective. As Barbara explained:

> If a student gets it, what I mean is if they understand why they're acting this way and they understand it may be related to their own mental health issues, I feel a lot more comfortable mandating therapy because I think they have a good chance of being successful in it.

Barbara's CCD Colleen agreed with this perspective as she reflected on mandating therapy for self-aware students:

> If they want to be there (in psychotherapy), if they're open to it, that's totally different that the kid who's like I don't want to be here, I'm here

> for part of the mandate, that's just not a good therapy situation…the student who wants to engage in therapy and really address what they're doing, that's what you really want.

The SSAO Tanya and her CCD Donald also shared similar perspectives on the issues of self-awareness and the willingness to address change criteria which create a level of confidence. Tanya clarified her perspective:

> If the kid said he wouldn't go to therapy, then I might say okay, you don't want regular counseling sessions…I don't want to waste my counselor's time with that student…but, I would try and persuade them and make them try to realize that, after some point, you have to start to wonder what your part is in all of this…it's by developing a relationship with a counselor where the student is willing to actually do the work in therapy…that is helpful.

When he was asked if the student's own sense of self-awareness and readiness to change were important to mandating therapy, Tanya's CCD Donald responded very enthusiastically:

> Oh, a lot! I mean, if people have some focus and are open to therapy and have an understanding of what their issues are, then you've got something to work with; so, the question is are you willing to do something about it or not? The situation is just problematic if the student is not willing to engage in therapy…there's a defensive wall around them…so, absolutely!...if students are willing to work on their issues, they're developing awareness…then I will gladly work with them as much as possible.

The findings revealed an overwhelmingly positive reaction on the part of both SSAOs and CCDs in utilizing mandated therapy for students who exhibit both levels of self-awareness of their own mental health condition as well as a personal commitment to change behavior. This perspective is represented in the literature by the work of Prochaska and DiClemente (1984) which, despite being introduced 26 years ago, has become the standard in behavior change psychotherapy practice. In their six-stage model

of personal change, clients progress from an awareness of their condition and behavior to the eventual stage of personal commitment both to make and sustain behavioral change (Prochaska, 1999; Prochaska & Norcross, 2001). In order to best assure the use of psychotherapy its effectiveness appears to rely heavily on the student client's willingness to actively engage in the therapeutic process. Pollard (2001) probably best summarized the importance of such self-acceptance when he stated, "Attempts to assist clients to change before they have successfully negotiated the appropriate stage for change to occur will result in failure" (p. 66). Thus, the successful use of mandated therapy may be highly dependent on the student's readiness to change his or her disturbing behavior as well as the therapist's understanding of this willingness to produce a successful relationship.

Research Question: To What Extent do Senior Student Affairs Officers and Counseling Center Directors Agree on the Use of Mandated Psychological Assessment or Mandated Psychotherapy as a Management Tool? If Differences Exist, How are They Addressed?

The findings revealed sharp contrasts between the SSAOs and CCDs with regard to the use of mandated psychotherapy. While these differences were much less pronounced when it came to the use of mandated psychological assessment, the CCDs held firm to the ethical principles of the psychology profession which adhere to psychotherapy as a voluntary process. The SSAOs, on the other hand, viewed mandated psychotherapy as an acceptable tool both to manage student mental health and minimize threatening behavior. While the findings revealed that these differences in opinion were

openly addressed between the SSAOs and CCDs in a manner which demonstrated mutual respect, they also demonstrated that the CCDs reluctantly accepted the use of mandated psychotherapy as the direct result of a power dynamic between supervisor and supervisee.

Mandated Psychological Assessment Versus Mandated Psychotherapy

I have previously discussed how mandated assessment (both in situations where students are disruptive and perhaps due to underlying mental health conditions as well as in cases of suicidal ideation and/or actions) is utilized within behavioral agreements. The findings revealed that in either case, treatment recommendations resulted from the therapist's professional assessment and the actual implementation of those recommendations varied from institution to institution. The SSAOs and the CCDs viewed *mandated assessment* and *mandated therapy* as very different elements within behavioral agreements.

The CCDs strongly adhered to the ethical principles of the psychology profession which view psychotherapy as a voluntary and highly confidential process (Amada, 1994, 2001; Pollard, 1995, 2001; Stone & Archer, 1998). However, they viewed assessment, which included several sessions of therapy, as an acceptable practice in addressing some forms of concerning behavior. This included disruptive behavior with underlying mental health concerns and suicidal ideation or actions. The CCD James clarified his position on mandated assessment as an acceptable practice within his campus counseling center:

> Most of our mandated assessments are with students who are in need of help, they're struggling and their behavior has a lot of people concerned …that's when the mandated assessment with counseling services might be suggested…I think that's okay…I understand why she (his SSAO) wants

> our professional opinion. She wants our recommendations on whether we think this student should be in therapy.

Fellow CCD Donald offered a similar openness to the practice of mandated assessments. He also differentiated between assessment and therapy:

> If there are behavioral issues, the Dean will sometimes mandate that they come over here and we participate in doing a mandated assessment…in those situations, I try to differentiate how that's different from counseling …I let them know that we are just doing an assessment and that we are going to provide recommendations to the Dean….I want them to know that we are not going to mandate therapy.

His CCD colleague Colleen concurred with these views on assessment, but framed it in terms of its use as a method to influence the student's decision to choose therapy:

> When we do the mandated assessments, our recommendation is almost gonna be we think you could benefit from therapy...we're asking the student do you want it though?, Because we're not going to force you to go and some of them do choose therapy because they've made the connection…when that happens, it makes me feel that the mandates can actually work to get the student to realize that therapy is something they want to do.

While her CCD colleague Mary agreed with Colleen's perspective that mandated assessments can sometimes lead to student choosing therapy for themselves, she took a stance which was not neither as supportive as her CCD colleague, nor did she view *mandated assessment* as different than *mandated therapy*:

> Okay, with the mandated assessments they agree to come and see a counselor. They usually come in and they'll sit here because they have to. It's really a waste of everybody's time and we're not getting anywhere. I can't say that's always the case, maybe one or two times where it felt like the student was open to talking about why they were there in the first place.

While the SSAOs viewed *mandated assessment* as different from *mandated therapy,* the findings revealed unique views that they also presented as a group. For example, The SSAO Jane described the mandated assessment in terms of predictions of dangerousness:

> We'll mandate assessment if we feel there are some mental health issues there…it might be as simple as one counseling session or maybe a few and the counselor usually says they're ok, but you know, it's a crapshoot to some degree, I mean, I'm taking their opinion and saying that they're right, but who knows if this student could be dangerous or needs further help?

Jane's perspective on the mandated assessment as a tool to predict dangerousness was unique to the SSAO group. This prediction variable in the form of a psychological evaluation of whether a person is dangerous or not, has been discussed as a fallacy in the literature (Amada, 1994, 2001; Davies, 2008; Pavela, 2006, 2007). Amada (1994) strongly advocated against the use of psychological assessments for the purpose of determining dangerousness:

> The relative inability of psychotherapists to predict dangerousness is an important fact for lay and professional persons to recognize so that they can deal effectively and realistically with individuals who post the risk of manifesting violent behavior.

On the other hand, SSAO Lisa viewed the assessment and its resulting treatment recommendations as a mandate which allowed her to move forward to implement mandated therapy as a requirement of the behavioral agreement:

> The assessment is going to tell me however often the counselor determines the student should be seeing them. I'm going to then tell the student that you need to go these therapy appointments and you cannot miss any appointments…I'll work with the counselor to determine whether or not they're going to be seen by her or referred out, but I will mandate the recommendations.

When asked if this was then a form of mandated therapy, Lisa presented a view which revolved around this requirement as a personal choice which had consequences to the student, "If they decide not to have the therapy, we can't force them into therapy, but as an institution, we do have the right to say whether or not they can attend the institution."

Lisa's SSAO colleague Mary expressed a view on mandated assessment as a predictor of mandated therapy which should only be carried out with outside providers:

> We don't mandate counseling normally with our own staff here, but we do mandate assessment with them, and, if they determine that therapy is needed, we go into a behavioral agreement which is based on those recommendations for care and we'll use an outside provider to make the appropriate care system work.

Finally, SSAO Tanya presented a contradictory view when it came to mandated assessments which seemed to revolve around terminology when she stated:

> I never mandate psychotherapy unless the psychotherapy came as a requirement, from the psychological assessor of the recommendation….if Donald (her CCD) is strongly recommending further treatment, I see it as not just therapy, but really as a structured program for the student…In that case, I am very comfortable mandating therapy.

Psychotherapy Should Not Be Mandated

As eluded to earlier in this section, the CCDs expressed strong opposition to *mandated therapy* as a requirement of a behavioral agreement. While they viewed therapy as a voluntary process which had no place in a student behavioral agreement, the findings revealed both consistency as well as contradictions. When examining consistency, the CCDs expressed unity in their stance on therapy as a voluntary process. Their views seemed very much in alignment with the ethical principles of the psychology

profession which viewed therapy as a voluntary and confidential process (Amada, 1994, 2001; Pollard, 1995, 2001; Stone & Archer, 1998). CCD Colleen expressed this viewpoint:

> It sort of goes against what I do believe in terms of therapy being a voluntary process…counseling should be a personal choice and if you force them to be in therapy, I feel it often leaves a bad taste in their mouth about counseling, which is too bad…you want them to voluntarily come into counseling, you don't want them to be like ugh!, I was forced to go because of x or y behavior, they just don't want to be there.

She further expanded on this view and expressed frustrations when her SSAO chose mandated therapy as an element of a behavioral agreement:

> I really don't think you can force someone to be in and be productive in therapy…my wish is that we never mandate the counseling, but sometime the Dean is saying it's mandated…it's sort of annoying that she is mandating counseling every now and then.

Her CCD colleague Mary shared a similar viewpoint:

> I find generally mandated counseling to be, I have to be honest a waste of my time…and I think my whole staff feels the same way, you know, 'Oh God, here's a mandated one'…and with the student, it's like let's get this over with, what do you want to talk about?

Mary further expanded on the uncomfortable feeling that she and her staff experience when conducting therapy with mandated clients: "We get a lot of hostile people here when it comes down the pike that way…I can't say they like and they don't resist it, but do they really get anything out of it?"

The CCD James concurred with his psychological colleagues:

> I'm not fan of mandated therapy. I don't think it works. I think it muddies the waters and makes things just too complicated. Somebody has to want to be in therapy in order for it to be useful and productive…we should mandate that they change their behavior, not how they go about changing it.

While the CCDs consistently expressed their opposition to mandated therapy, the findings also revealed contradictions to their stance. In some cases, these contradictions were presented in terms of explaining what was or wasn't *mandated therapy.* The CCD Bruce demonstrated this point:

> I don't know that we ever call it mandated therapy…I think those students who require mandated therapy have mental health problems that are usually so significant that you want them to be set up in the right treatment, and the treatment for those students is usually going to be something that lasts beyond three or four months…so, it's not so much that, technically we are mandating therapy, it's more that we're setting up a set of recommendations for the student to follow.

As he reflected on his views further, Bruce commented, "So, we're not saying it's mandated therapy, but if they don't participate in the therapy, as directed by the Dean, then they might be involuntary withdrawn."

While CCD Vicky had previously expressed her strong opposition to mandated therapy, she acknowledged its use at her institution. She also regarded mandated therapy as a reality of a college counseling center when she stated:

> We normally have the mandated therapy conducted with private providers, but when we do get them here, I don't assign them to my interns…they really question if mandated students are really where we need to be spending our time…when I have assigned them, I take the approach that it's part of the learning process for them, that if you work in a counseling center at a university, you are going to have some mandated therapy…I'm the one who goes to the board and presents that.

Similar to Vicky, CCD Colleen also acknowledged the use of mandated therapy on her campus and while she personally was opposed to the practice, she did acknowledge that it had, on occasion, produced some good results, "The Dean has given

us some students for mandated therapy and, I must admit, some of them have come around and have benefited from therapy; so, I guess I can't say it's not all bad."

Psychological Assessments Which Recommend Continued Treatment

The SSAOs viewed the psychological assessment as a vital tool in creating behavioral agreements. While their CCD colleagues frequently conducted such assessments, they viewed mandating therapy as a result of the assessment as unethical. The SSAOs, on the other hand, took the results of the assessment very seriously as a means to inform their decision to modify the behavioral agreement to include continued therapy as an added requirement. The SSAO Jane described this strategy in terms of a two-tier approach:

> The first step might be that the student is required to go through an assessment and they can decide who the provider of the assessment will be, like a private psychologist or someone in our counseling center, and the second step would be that they're going to be held responsible for the terms of whatever the assessment recommends…I am going to mandate the therapy in the behavioral agreement…they usually have to meet with a therapist monthly.

Jane's SSAO colleague Katherine took a similar stance with regard to assessment recommendations translating into expectations of continued therapy, but she placed emphasis on the use of outside providers to carry out such a mandate:

> We don't mandate counseling normally with our own staff here. I think its gets very messy if the counseling center has a lot of mandated therapy…I almost try and make that happen with an outside provider that the student chooses…when we go into a behavioral agreement, I want to make sure the student is going to attend therapy, it's about making the appropriate care system work.

While SSAO Tanya also mandated treatment recommendations, she presented contradictions in whether such recommendations were actually mandated or were arrived at, based on her own personal persuasion with the student:

> We sort of outline what the treatment is that Donald (her CCD) recommends and then I say to the student, now, it's really important that you go through with this treatment because if you don't go into treatment, I can't be confident that you're going to be safe and that the people in the community are going to be safe.

When asked if she is then mandating treatment or allowing the student to choose therapy for themselves, Tanya stated, "I never mandated psychotherapy unless the psychotherapy came as a requirement of the assessment." She then framed her response around the conditions of very concerning behavior when she explained, "I would say I'm very comfortable mandating psychotherapy if the student's behavior is extreme…I need to feel that we are doing something to help them."

Tanya's SSAO colleague Barbara also framed her use of mandated therapy as part of a behavioral agreement in confidence terms:

> I do think there are some situations where the assessment is telling me that this student really needs to be in therapy and , in those cases, I do think it's appropriate to mandate the treatment…so, for us, I need to feel that they're in a healthy place to continue here…I need to be somewhat assured about that.

The findings revealed very different viewpoints are held by the CCDS and SSAOs, as distinctive groups, regarding the use of mandated psychotherapy as a requirement of the behavioral agreement. While the CCDs held to ethical principles within the psychological profession, which viewed therapy as a voluntary process, the SSAOs viewed mandated therapy as a tool which created a level of confidence in which

something was actually being done to help the student. Since such viewpoints clearly demonstrate significant differences on the use of mandated therapy, how then are such differences addressed between the SSAO and CCD within the work environment?

Senior Student Affairs Officers and Counseling Center Directors: Mutual Respect and Working Out Differences

When exploring the question of how such differences, regarding the use of mandated psychotherapy, are addressed between the SSAO and CCD, the findings revealed several approaches which represented a continuum. On one end, I found a level of reciprocal respect as well as the use of dialogue to address such differences. On the other end, I found perceived power dynamics and pressure leading to reluctant acceptance, on the part of the CCD, to the use of mandated psychotherapy.

With regard to the former, several of the SSAO and CCD pairs expressed a level of respect for each other which represented an understanding of their respective roles within their student affairs units. In particular, the SSAOs acknowledged their limitations in arriving at conclusions which required licensed psychological professionals, who had the appropriate credentials, to make such judgments. SSAO Lisa made it clear that she did not have the capacity to make clinical judgments:

> I really don't have the professional background or the skills to make a clinical decision, I don't think any student affairs officer should do that…she's (her CCD) the psychological professional, not me. I lean to her judgment about how to proceed.

Lisa's CCD colleague Vicky agreed that her professional opinion mattered greatly when it came to mandated therapy:

> Lisa is very good about taking my recommendations seriously…very early on, when we first started working together, she told me, 'I don't know much about mental health and I don't do psychology, so, I really dependant on your expertise to guide us.

When Vicky reflected on this role in making decisions on mandated therapy, she smiled and enthusiastically said, "So far, so good!"

The SSAO Tanya spoke to this limitation in terms of respect for her institutional colleague (Donald):

> I mean, I'm not a psychologist or a psychiatrist, that' why I have Donald. His opinion is invaluable to me and I know that he respects my role…he gets that I have to create some kind of a plan for this student and he is honest with me about the best way to address my concerns…we have a great respect for each other and we make a good team.

Tanya's CCD Donald expressed a similar viewpoint, but framed it around respect for Tanya's role as the chief conduct officer at their institution:

> Tanya is the chief conduct person and she's the dean, so she and I really work as a team…we keep her separate in the whole behavioral agreement process so that if some disciplinary action needs to be taken via the judicial process, like mandating therapy, it would just be cleaner…her role is not easy and I understand that she's got to have plans in place for some of these students.

Donald gave further clarification to their relationship when he said:

> I think it's a very tricky position to be in institutionally where you have your professional psychologist in your institution making recommendations and then you have the dean, who is your boss, disagreeing with them. Tanya and I have always been able to work things out…we just get together and decide on a plan that we are both comfortable with…I think we do that very well.

Another institutional pair, SSAO Barbara and CCD Colleen also expressed similar views on their working relationship. Similar to her SSAO colleague, Barbara expressed respect for Colleen's clinical expertise when she stated:

> I certainly rely on her expertise, I recognize it. She's the clinical expert, not me. I don't have the psychological credentials and her opinion really matters to me when I create these behavioral agreements.

Barbara further clarified the importance of Colleen's opinion and how it affected her judgment in mandated therapy:

> So, I think there's mutual respect for each other…Colleen is very vocal and I think it's helped me in role to understand when my instinct is to just mandate. She's not afraid to tell me when she thinks mandating therapy is not going to work, that the student just won't engage in therapy…So, I'll work with her in terms of the language of the behavioral agreement letter…I always talk with her and get her professional opinion before I meet with the student…I always make sure that she's kind of comfortable where I am and, if she's not, she'll give me cause to maybe rethink some things…it's always good dialogue.

Colleen agreed with her colleague's perspective on their respectful relationship and she framed her thoughts around her consulting role for SSAO Barbara:

> I think a good leader recognizes that you have good people who are experts in certain areas and that you need to listen to them. You may not always agree, but you have to listen to them…Barbara's gonna listen and she looks to me to be a consultant and I'm happy to have that be my role.

While she accepted this consulting role, Colleen's comments also acknowledged Barbara's ultimate authority to arrive at final decisions when she stated:

> Barbara is the ultimate decision maker, as she should be…so, I would say that everybody gives their recommendations and feedback, including me, but ultimately, it's going to be Barbara doing the final agreement, she's going to be looking at us and saying ok, here's what we're going to do.

Another institutional pair, SSAO Jane and CCD James, also expressed respect for each other and while they discussed how they actively addressed differences through dialogue, they also acknowledged that they were still learning how to navigate through this process with each other. As SSAO Jane described it:

> Yeah, James and I have only worked together now for a little over two years and, when it comes to mandating therapy, I think we're still dancing…I mean, I respect his opinion as a psychological professional and I think he understands that there might be times when I think a student has to have therapy…we talk about it and we generally come to a mutual understanding, but sometimes I think there's some tension there on his part.

While James agreed that his clinical judgment was viewed as important to Jane when deciding on mandated therapy as a requirement within the behavioral agreement, he framed his response in authority terms:

> When there's a difference of opinion between myself and the dean of students, the dean ultimately is the sole gatekeeper for conduct….I think she needs to be the ultimate authority on that, so, if she and I disagree, ultimately it's her decision on who is going to be mandated for therapy, now, I will argue my point professionally and I'll always try and help her understand where I'm coming from as best I can, but when we have gotten all of the issues on the table and I feel she truly understands my perspective, but she still doesn't agree with me, then it's her call, she's the one who has to live with that….she's the one who has to bear the responsibility to the president, the parents, and all of those people…I understand.

Counseling Center Directors and Their Reluctant Acceptance of Mandated Psychotherapy

While one end of the continuum represented mutual respect and a willingness to try and work out differences in opinions about mandated therapy through the use of dialogue, the findings also revealed a possible power dynamic that existed in the SSAO-CCD relationship which may represent a sense of reluctant acceptance on the part of the subordinate party, that being the CCD. While each institutional pair expressed gratitude for the respect they had for each other, the findings further revealed that such a respect level may also revolve around the supervisory issue of the CCD reporting directly to the

SSAO within their role at the institution. While the findings revealed that the SSAOs respected their CCD colleagues' opinions, they did not speak to the power differential that may exist within their supervisory relationship. However, the CCDs were quite candid about this dynamic. As CCD Mary explained:

> I know my place in the pecking order of hierarchy around here. I will say my piece and I will voice my objection and it's happened…I always keep in mind that I have a different perspective, the clinical perspective and I see the world in those terms, especially when it comes to mandated therapy…so, sometimes I explain the way I think it would be better to do this and sometimes maybe not this and then there's Katherine's (her SSAO call) call.

Mary provided further details on what she did when such disagreements arose with regard to mandated therapy:

> I put everything in writing. I believe that when I don't agree with something, I mean, when I don't feel good about it, I want to have it documented that I didn't agree with it, but I always acquiesce and I really don't have a problem with that…it's Barbara's call and I have to respect that…I mean, what choice do I really have?

The CCD Bruce reflected on his role within the contexts of the supervisory relationship in terms of authority:

> Sally (his SSAO) and I do have disagreements every now and then when it comes to mandated anything, but I think it's to be expected…I do feel that she respects my opinion, that she does consider what I am saying, but I think it's understood that the VP (SSAO) has the authority to make the final call and we need to respect her authority and then just move on.

While CCD Colleen felt that her current supervisor took her opinion on matters of mandated therapy very seriously, she exhibited strong feelings with regard to the former dean, who had just vacated her position at Colleen's institution two years prior. She expressed strong power dynamics within this relationship:

> The former dean, the one who was just here before Barbara, she's the type who if you didn't do what she wanted, she'd threaten your job and I wanted my job so I did what I was told…I guess a truly ethical person would have said, if we don't do it this way, I'll quit, but I didn't do that.

Colleen's face showed great stress when she reflected on that former supervisory relationship and she had a look of sadness on her face when she added, "The power differential was huge." While the findings revealed some power differential dynamics between the SSAOs and CCDs, it appeared that the CCDs accepted the fact that the decisions of whether to mandate therapy or to recognize it as a completely voluntary process, resides fully with the SSAO. In addition, while they may have expressed frustrations with this stance, they seemed to reluctantly accept it as the reality of being a psychological professional within an organizational structure in which they reported to the SSAO. The findings further revealed both a strong sense of attempting to address such differences through continued dialogue as well as the recognition on the part of the SSAO of the psychological expertise of the CCD. This expertise significantly influenced their decision to mandate psychotherapy as part of a behavioral agreement.

Research Question: What Role, if Any, Does the Student Conduct System Serve in Addressing Students Who May Violate Campus Policies While Exhibiting Mental Health Concerns that May Contribute to Disruptive Behavior?

The findings revealed two distinct approaches when it came to addressing disruptive behavior that may be a manifestation of student mental health concerns. The first viewed behavior as a stand-alone issue. In this particular approach, the SSAO and CCDs believed that behavior should be adjudicated through the student conduct process, regardless of the presence of mental health concerns. The second found both SSAOs and

CCDs demonstrating empathy and compassion when considering the use of the student conduct process. They were concerned that by invoking the conduct process, one runs the risk of exacerbating the underlying mental health condition. In addition, the findings revealed caution when it came to the issue of mental health as a disability. Regardless of their approach to the use of the student conduct process, both SSAOs and CCDs exhibited strong hesitation with its use if the mental health condition had been documented as a disability.

Approach #1: Behavior must be addressed, regardless of mental health concerns. The findings revealed the use of the student conduct system in holding students accountable for their behavior as a primary issue for many of the SSAOs and CCDs. While the manifestation of mental health conditions may be a contributing variable to behavioral infractions, the majority of the SSAOs and CCDs expressed the viewpoint that such conditions do not justify, nor nullify, behavior which goes against established behavioral standards within the campus code of student conduct. The SSAO Jane expressed this viewpoint when she explained, "When there is behavior that clearly violates our code (of student conduct), we have to consider it as a judicial violation…we need to hold all students accountable, regardless of mental health or not." Jane's CCD James agreed with this perspective and framed his thoughts around adult responsibility:

> When the conduct is such that it is hurtful to other people we fall very much on the conduct side, I mean, we have to address it as a judicial issue…it reinforces a certain level of adult responsibility that we're supposed to be instilling in our students…we have a code of conduct for a reason and students need to be held accountable to the greater community for their behavior.

The SSAO Tanya agreed in the importance of accountability for behavior, but she also went further in framing her thoughts around the variable of mental health concerns:

> I focus on the behavior…I respond to the behavior…For me, mental health issues doesn't mitigate the behavior. If there's a violation of our code of conduct, it doesn't matter if there's mental health there or not, it's still a violation…I mean, this is an extreme example, but think about crimes that happen in society, there are all sorts of different reasons why that guy murdered that guy, but the guy is still a murderer, and I can't have any faith that he is going to murder again just because he was abused as a child or some other issue, so, I have to be sensitive to the reasons behind the behavior, but to me, what's important is the behavior and we need to respond to the behavior. Period.

Tanya's CCD Donald also agreed with the importance of holding students with mental health concerns accountable for their behavior:

> Just because a person has mental health issues, doesn't mean that they can necessarily act in any way that they want in our community…I don't philosophically agree with that. If you've got mental health issues, then you have to be personally responsible for managing it…we have to be consistent when it comes to student conduct. Behavior is a choice and if that choice goes against our standards as a community, there has to be a response to the behavior. If you make the behavior about conduct, it's just cleaner.

Tanya's CCD Colleague Donald also agreed with this perspective and she gave compliments to her SSAO for invoking the conduct process for inappropriate behavior:

> It needs to be about behavior and I think she (SSAO Barbara) is really good about that, like this behavior is not appropriate, it's really out of control and inappropriate and it can't continue…she's going to hold the student accountable through our judicial process and I think that's the right way to go.

The SSAO Sally offered a differentiation between behavior and mental health concerns, which she signaled by the use of her hands in creating categories for behavior and mental health:

> I think you first have to look at the mental health issues that might be there and move that to one side, and then look at the behavior that has actually occurred and move that over here. If it's a conduct issue, I make use of our judicial process, and, I must tell you, that approach never fails and maybe that's just my personal thing, but I find the clear separation of the two to be the best method.

Sally's CCD Bruce viewed the decision to pursue the conduct process as a matter to be decided by student conduct staff. He expressed his viewpoint in terms of the examination of mental health variables:

> When there are conduct violations, that's something for the conduct people to decide. If there's conduct that they have become aware of, there's probably some value in the conduct people responding to the behavior. I think good conduct people will go over the greater background and that might include the student's mental health issues. Good conduct people will use tact and empathy in deciding how to hold the student accountable.

These perspectives reflect two findings presented in the literature with regard to student conduct and student mental health concerns. First, the manifestation of student mental health concerns is not an excuse for the toleration of behavior which goes against established standards of conduct (Amada, 1994, 2001; Pollard, 1995, 2001; Stone & Archer, 1998). As Munch and Shapansky (2003) summarized, “Colleges and universities are not required to tolerate or excuse disruptive behavior caused by manifestations of mental disability” (p. 10). Second, while violations of conduct should be addressed, regardless of mental health concerns as a possible contributing variable, levels of sensitivity and empathy may be necessary in order to arrive at an appropriate response (Belch & Marshak, 2006; Van Brunt & Ebbeling, 2009). A violation of the behavioral regulations may become more a “gray area” if, as Belch and Marshak (2006) described it, such violation is “a manifestation of an illness rather than willful misconduct” (p. 472).

Approach #2: The manifestation of mental health concerns requires careful consideration in the student conduct process. The dynamics of sensitivity and empathy as they pertained to the consideration of mental health concerns and behavioral infractions were also revealed in the findings. While the SSAOs and CCDs were very much in agreement on holding students accountable for their behavior, some of them also expressed the need for sensitivity in creating appropriate responses to inappropriate behavior. Such responses often took mental health concerns into account when making the decision on how best to proceed. As SSAO Katherine shared this view:

> It really depends on the situation. We really look at the behavior and the mental health issues that the student is presenting. We ask ourselves, does this require a formal judicial hearing or does it require an informal conversation? If it does require an informal conversation, there are some times when we discover some serious mental health issues and we may go the counseling route to address the behavior….I think that's an appropriate response and I also think it demonstrates sensitivity to what's really going on with that student.

Katherine's CCD Mary also agreed with this sensitivity in the consideration of utilization of the student conduct process:

> Sometimes, behavior has to rest on itself, but there are some conduct situations where inappropriate behavior is really indicative of a psychological disorder and then, I'd say no to the conduct process and instead, I'd say let's try and work with him or her…so, instead of being punitive, we give the student a chance to really work on their psychological condition.

The SSAO Jane agreed to some degree with the consideration of mental health issues in deciding on appropriate action:

> So, if a student has really been inappropriate and they might not even realize there's a pathological connection to the inappropriateness, I think the counseling route is the first step, not the conduct process…I do think we need to be sensitive to the student who may have some serious mental

> health stuff going on…we can deal with the conduct issue later or maybe not at all…if putting the student through a judicial hearing is going to only exacerbate their mental health condition, I just don't think it makes sense to go that way.

Jane's CCD James shared a similar perspective on the consideration of mental health concerns when he stated:

> Sometimes, the intervention with the student is the most important thing and in situations where we've had really serious mental health issues which may have also contributed to conduct issues, we've made behavioral interventions that are respectful of those things…I think it's important to demonstrate a level of sensitivity.

The SSAO Tanya expressed the consideration of mental health concerns as simply that—a consideration:

> If there are mental health reasons for the behavior, I'm certainly not going to discount those…there have been some rare occasions where we address the behavior through counseling and we hold off on the judicial process, but those situations are rare….you have to think about consistency with conduct, I mean, can you justify that this student is all about counseling and not hold them accountable for their behavior?...that's a tough call.

Tanya's CCD Donald expressed his views in terms of behavior as an unfolding story to which an appropriate response is created:

> There are some students who are very psychotic and their behavior is really telling us a story…we have to find the words for the story to get us to make sense of it. If they're acting out in our community, we have to respond in understanding whatever they're trying to tell us…so, sometimes, that story is about some serious mental health concerns and I think our response has to take that into account…if we make it just about conduct, we need to consider if it will make the student's condition worse...like, if someone is exhibiting psychotic behavior that may be indicative of a serious psychological disorder, putting them through a conduct process could only make matters worse for that student…Tanya is very good about understanding that and at least, considering it in deciding how to move forward.

While SSAO Lisa felt very strongly that violations of conduct needed to be adjudicated in a consistent manner, regardless of mental health conditions or not, she did express sensitivity to such decisions:

> There are times when we dig deeper and we realize there's some serious mental health things going on and, if it the student is really not in control of their behavior because of some mental health condition, we do consider it when we think about the conduct process.

Lisa's CCD Vicky echoed Lisa's sentiments on sensitivity in certain conduct situations:

> When you're deciding on conduct follow-up, I think it helps to gather as much information as possible on the student and, if we find out that this student has a really serious psychological condition, we do give it consideration…I do think there are some genuine situations where a student may be so advanced in their condition that they may not even be aware of their own behavior and, in those situations we really do discuss it before we just invoke the conduct process.

The findings revealed that while both SSAOs and CCDs advocated for accountability of student behavior, levels of sensitivity and empathy were demonstrated in the consideration of whether to pursue misconduct through traditional student conduct processes or to create a plan which placed emphasis on psychological care. While both approaches may differ greatly in the degrees to which they are either punitive or therapeutic in addressing behavior, they are both represented within the textual context of the behavioral agreement.

Mental health, student conduct, and the issue of disability. The findings also revealed the additional consideration of a student's mental health condition, as a disability issue, as a strong element of consideration when deciding on student conduct follow-up. Similar to the literature's findings with regard to mental health and student

conduct (Amada, 1994, 2001; Pollard, 1995, 2001; Stone & Archer, 1998), the Americans with Disabilities Act (2008) does not prohibit an institution from holding a student with a disability accountable for behavioral infractions (Hoover, 2007; Noonan-Day & Jennings, 2007; Wolnick, 2007). While such precedent may legally shape the actions which institutions take with regard to mental health disability, the findings revealed disability as an additional item of sensitivity with regard to responding to student behavior. CCD Bruce elaborated on the disability issue as a consideration with student conduct and expressed this issue in terms of confusion:

> From my perspective, it's gotten a bit more confusing. I think we used to be much clearer on the behavior and responded specifically to the behavior that was disruptive to the community. Now, what I observe is that there's more of a process of sorting through whether or not we go with a behavioral process or disability-based process…it's just not as clear.

Bruce's SSAO Sally also expanded on the issue of disability as a strong consideration in the student process and framed her thoughts around legal issues:

> I do think you have to consider a mental health condition as a possible disability condition. When you're talking about disability, I worry about a possible complaint being filed with OCR (The Office of Civil Rights) and I think it's important that our response considers the legal implications of our decision…I just think it's an additional factor in this whole legal climate that we all work in.

The SSAO Jane expressed both the similar consideration of disability as an additional factor in pursuing student behavior as well as frustrations over legal issues:

> We look at the situation and if we know that a student's mental health condition is a documented disability, we know that we may have to intervene in a different way, you know, like involving the Disability Office as a way to address the behavior…I mean this whole legal climate with ADA and HIPPA, all the legal stuff just seems to mount every year

> and it can make student conduct decisions very tricky…it's just not very cut and dry anymore.

Jane's CCD James also expressed caution with regard to disability legal issues:

> If we determine that it's a mental health issue, I think you have to be really careful because then you have to be respectful of ADA issues as well and how do those play in with our decision, like what you can require or what you can't require or what do you have to do to be accommodating to or not.

While James discussed the legal precedent involved with disability, he also acknowledged his understanding of ADA not infringing on his institution's ability to move forward with the student conduct process:

> I think for the most part though any behavior issues that threatens the safety and integrity of other students, then there's not accommodations that need to be made for that. Regardless of the mental health issues, the student isn't allowed to hurt or threaten other students; so, if the mental health issue is one where the student is safe from hurting themselves or anyone else, I think we can have a lot of latitude in terms of accommodating them and helping them to maintain in this environment.

The SSAO Tanya expressed her consideration of the disability issue as simply another factor in arriving at a decision:

> Sure, sometimes you have a student with a mental health condition who may also have the condition registered with our Disability Office, but it doesn't negate their behavior, I just think you have to think about legal issues and make sure that your decision doesn't come back to haunt you in a lawsuit or some other legal action.

Similar to his CCD colleagues, Tanya's CCD Donald also expressed mental health disability as a strong legal issue:

> I can see potentially changing how we respond, as far as the student conduct process, because of some of the legal issues that sort of come up…we need to be concerned about the legality of all of this and making sure that we're operating within the laws that protect people with disabilities….On a national level, we need to be aware of how that

> unfolds…I don't want to leave myself or the institution vulnerable in any way.

While each sample institution discussed disability policies in their respective student handbooks, several specific conditions were also revealed through document analysis. First, legal language is utilized to describe compliance with federal law. Institution B, for example, employed language which was also found in the other sample institutions' disability policies when it stated:

> Institution B's policies comply with Section 504 of the Rehabilitation Act of 1973, which states that 'no otherwise qualified individual with disabilities in the United States…shall, solely by reason of disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. (p. 41)

The same policy then went further by both localizing this compliance to the institution's policies as well as reassuring such compliance when it stated, "Institution B is committed to providing equal access to programs for our diverse student body" (p. 41). While Institutions A and B also utilized similar language in its disability policy, its student handbooks created a separate section for grievance procedures as it related to "disability related matters." As an example, Institution B urged the student to first work the campus disability office as a first step to address such matters when it stated:

> The student should attempt to work with the Disability Services Coordinator informally to resolve the complaint. This attempt may serve to minimize the problem's impact on the student's current academic situation. (p. 41)

The second issue revealed through document analysis was the consistent absence of mental health as a sub-issue within the disability process. Rather than providing any special mention of mental health as a disability issue, many of the sample institutions

chose to utilize the legal language found within Section 504 of the Rehabilitation Act of 1973 as it official definition of disability. Only Institution C mentioned “mental health disability” as part of the spectrum of conditions which would be applicable under its disability policy.

The findings also revealed the student conduct process to be a very viable option that was utilized by the sample institutions to address disruptive behavior. Furthermore, the SSAOs and CCDs advocated for the importance of holding students accountable for their disruptive behavior, regardless of mental health conditions which may be a contributing variable to the manifestation of such behavior. The SSAOs and the CCDs exhibited a strong sense of empathy in their consideration of the student conduct process for such situations. While they exhibited a clear understanding of federal and state law which allowed them to hold students accountable for disruptive behavior, despite their mental health condition (Dunkle, Silverstein, & Warner, 2008; Rowe, 2005), they expressed confusion and concerns over disability law as it related to mental health and disruptive behavior.

CHAPTER V

RESULTS: THE MINIMIZATION OF THREATS TO CAMPUS COMMUNITIES

In this chapter, I present the findings of the three research questions which explore efforts to minimize threats to campus communities. As in Chapter IV, each research question will be identified and specific themes that arose from the findings will be presented.

Research Question: How Do SSAOs and CCDs Identify Students with Mental Health Concerns that May Pose a Threat of Harm to the Campus Community?

In this section, I explore how SSAOs and CCDs identify those students who may actually pose a threat to the greater campus community. These findings are divided into two categories. The first is the concern for the isolated student who may not pose a blatant threat. The second is the blatant threat which may include the communication of a plan for violence and/or have access to weapons to carry out such a plan. In both cases, the SSAOs and CCDs exhibited a heightened sense of concern and a plan for immediate action to minimize the potential of harm to their campus communities.

More than Just Blatant Threats: The Isolated Student

The SSAOs viewed observable and documented behavior that poses direct threats to others as the first clue in the identification of students who pose a serious threat to their respective campus community. As SSAO Katherine explained:

> When I get reports on students whose behavior is angry or aggressive toward others, or that students are feeling threatened by another student's behavior, then I get very concerned…I feel like I may have a real threat on my hands and I need to take it seriously.

Katherine's SSAO colleague Tanya also described the analysis of documentation which she received as her first indication of threatening behavior, "Anytime I receive documentation of a student who is behaving in a way that is threatening to the rest of the community, I need to be concerned…I am going to monitor that student very closely." Tanya then offered her own philosophy on threatening behavior which she categorized in two very different levels:

> So, I'll synthesize here…there's acts of omission and acts of commission …the student who doesn't get out of bed for two weeks and who is very withdrawn, that's an act of omission…you know, extreme changes in personality, whether it's manic or depressive, but people have noticed it and they're scared. With commission, there is some sort of disturbing activity, outward acting out…when the commission involves making clear threats to others, it's obvious that I have a problem…I now have a situation that could be a threat.

Tanya's perspective presented both inward focus behavior (e.g., isolation, withdrawal) as well as outward focus behavior (e.g., direct threats to others) that are both concepts which have been frequently described in the literature as potentially threatening to a community (Bova, Cornell, & Groth, 2007; Fein, Vossekuil, & Holden, 2002; McEvoy, 2000; O'Toole, 2000; Vossekuil, 2002; Fein et al., 2002). As Delworth (1989) pointed out in her now classic *disturbed and disturbing* theory, it is the combination of both the disturbed student, who lacks maturity and social skills, and their disruptive behavior which poses the greatest threat to a campus community. Another SSAO

(Barbara) shared these concerns for potential violence on both the part of the very isolated student as well as the one who is disruptive to others:

> The potential for violence is obviously a huge concern for me…it's not just the really obvious threats, like, someone is threatening to kill another student and a lot of people are worked up about it and I'm getting a lot of reports about this one particular student, I mean, that's evident…it's the student who is really isolated, who has really shut down and who is just viewed as, I don't know, very awkward or not connected to anyone on campus…I'm just as concerned about that student as the one who makes obvious threats.

Barbara then linked these thoughts to the tragedy at Virginia Tech, when she added:

> I mean, you never really know, do you?...look at Cho and how isolated he really was, how his behavior was just really strange and a lot of people were really freaked out…you can't just focus on the student who is making obvious threats, I think you need to really take notice when you're getting reports on someone who is very isolated…someone who just has no friends…there could be a real potential for something very serious there.

Barbara's SSAO colleague Sally shared similar thoughts on the threat potentials posed by both the isolated student and the one who is very outwardly threatening:

> You can't just be concerned by the student who is clear in their behavior, you know, the one who is saying, I'm going to kill this person…I also need to be concerned about the student who is just isolating themselves from everyone…they're not going to class, no one sees them…they don't have any friends…you think about what happened at Virginia Tech…that kid was really isolated and he had a plan, if I get reports of a student like that, I need to be just as concerned…who knows what that person could really do?

The Communication of a Plan for Violence and Access to Weapons

When the SSAOs and CCDs considered behavior that was potentially threatening, they reflected on very serious elements that would immediately grab their attention. Those elements were the communication of a plan or the potential access to weapons. As several studies have pointed out, the communication of a plan of violence has consistently been found in the school shooting literature as an item of very serious concern for school officials (Bova, Cornell, & Groth, 2007; Fein et al., 2002; Verlinden, Hersen, & Thomas, 2000). Such a plan was also a key element found in the aftermath of the Virginia Tech shootings (Kleinfeld, 2007; Leavitt, Gonzalez, & Spellings, 2007; Massengill et al., 2007; Robinson, 2007). Some of the SSAOs shared stories of plans for violence on their campuses that had been thwarted before they could be realized. The SSAO Jane described one of these experiences on her campus:

> One day, I had a guy here from the FBI, and he was telling me that we had a national bomb threat, and I said, Oh! What?!...this guy was telling me that one of our students was telling people to bomb the National Organization of Women in Washington and this was the web site he had been accessing to learn how to make a bomb and tell others about it, and I was like, you're kidding me, right?!...they walked into one of our residence halls and arrested him and they walked him off campus. All I thought was if this kid knew how to make a bomb and he was encouraging others, what has he been planning on our campus?

Barbara's CCD colleague Mary shared a similar story of threatening behavior that not only involved the FBI, but also shut down her campus for five days:

> We had a threat over a year ago…did you hear about it?...we closed the campus for five days and it was a huge problem…we were able to work with the FBI and the local police department to identify her…she had written threats on the walls of woman's bathroom in one of our residence halls…the notes said things like prepare to die and there were several dates when we discovered a few of them…we did some forensic work

> with police and the FBI and we were able to narrow it down to a specific floor and four of the students that were suspected were students we were seeing in counseling….that was really, really huge for us!

While she had yet to experience a situation that posed a serious threat to her campus, SSAO Sally did reflect on the lessons of Virginia Tech and Northern Illinois University as obvious lessons which must be applied to any potentially threatening situation:

> If I ever thought a student was a danger to our campus, I would immediately involve our campus security and I would contact the parents…I can't think of any dean right now who wouldn't do the same thing, particularly after Virginia Tech and Northern Illinois…any dean who wouldn't take a threat like that seriously…they are going to end up in a lot of legal trouble…you need to do the right thing.

The findings also revealed the access to weapons as an additional concern for SSAOs and CCDs. As Deisinger et al. (2008) point out, the potential for threat is of great concern when the perpetrator "develops a plan to carry out harm and…has access to weapons and ammunition" (p. 26). The communication of a plan to others as well as access to weapons to carry out violence are also discussed at length in the literature as signs of concern for school officials (Bova, Cornell, & Groth, 2007; Fein et al., 2002; Verlinden, Hersen, & Thomas, 2000). While the SSAOs had shared their personal experiences with threats on their campuses, they had not actually experienced incidents with communicated plans of violence or weapons; rather, they discussed the possibility of access to weapons as a threat which they had considered when reflecting on threats to campus violence. As SSAO Jane described it:

> We haven't seen a lot of weaponry, but we don't know if it's being concealed and that's my greatest fear…We have more and more students

> come from near and far and so, perhaps, there's a lot more weaponry and we don't know that because it's concealed.

Jane had experienced reports of suspected weapons on her campus when she stated, "When we have had reports of potential weapons, we just check it out….we call the local police of campus security, but thus far, knock on wood, no weapons have been found." SSAO Tanya had also experienced various reports of potential weapons which all proved to be false. As she reflected on the possibility of a student with a plan who also had access to weapons, she shared her fears of such a possibility and framed her comments around the Virginia Tech incident:

> What really scares me is the incident that is really serious and that's gonna happen…it's going to happen and we're going to have no idea that it was there in the first place…Look at a place like Virginia Tech, there were enough people not talking to each other…there was some knowledge that this guy was a mess and he ends up killing all those people…I'm afraid that the real serious threat…the first time that we would know about it is when it actually happens.

The literature also addressed these fears of not being able to prevent an attack, due to its not being revealed to school officials beforehand as an unfortunate modern reality which caused great anxiety for school officials (Angle et al., 2007; Massengill et al., 2007; Moehlman, 2007). Amada (2001) placed a sober reality on such observations when he stated, "Genuinely violent behavior—murder, rape, arson, or assault and battery—is carried out stealthily, often concealed behind closed doors, and, for lack of witnesses, shielded from detection" (p. 113).

Unlike her SSAO colleagues, Barbara had not experienced reports of potential weapons on her campus; however, she also felt that the potential for violence with weapons was a real possibility that she must consider in the future, when she shared, "We

probably have been very fortunate here, but how many students actually have weapons or have access to them that we don't even know about?" As she reflected on this possibility, she made reference to her authority to enact an emergency suspension or involuntary withdrawal if such a threat actually did present itself. She further explained this concept when she said, "Initially, I could always invoke an interim suspension or an involuntary leave if I felt there was a credible threat, like with weapons or a plan…those policies have always been embedded in our code of student conduct." An analysis of the codes of conduct provided by the sample institutions spoke to this very point by finding a consistent policy which both gave the SSAO the authority to not only act on credible threats, but also to act as the sole institutional representative to invoke an interim suspension on the student. Barbara's institution, Institution D, as an example, listed a "Disruptive Students" policy within its code of conduct which gives the senior student affairs officer the authority to act on credible threats when it stated:

> If in the judgment of the Dean of Students, in consultation with other college officials, it determined that a student's behavior is disruptive to college functions, and/or presents a threat of harm or bodily injury to himself or herself or members of the college community, the student may be temporarily suspended from the college pending certification of professional assessment/counseling. (p. 12)

Institution B also gave ultimate authority to make a judgment of threat by the SSAO when it described, "The Office of Student Affairs may require immediate suspension and/or withdrawal from the university and/or campus housing if there appears to be a substantial imminent threat" (p. 18).

Pavela (1985) spoke to such authority as well as his recommendation for an emergency suspension policy in the face of a campus threat when he stated:

> If a student is behaving in a way which is threatening to the student or others…the vice-president for student services may initiate these procedures…the vice-president for student services is empowered with the discretion to define within his/her professional judgment what is sufficiently threatening and/or disruptive to warrant invoking this procedure. (p. 45)

While many of the SSAOs have fortunately not experienced severe forms of threatening behavior to their campus communities, the tragic events of Virginia Tech and Northern Illinois University have made them very conscious of how they analyze and act on threatening behavior. In addition, they consistently expressed fears that, despite their best efforts, they might not be aware of such threats. They further expressed this fear in almost foreboding terms as they anxiously anticipated such a threat actually happening on their campuses in the future. In a direct response to address such possible violence on an institutional level, all of the sample institutions had established policies which clearly gave the SSAO the authority to act on credible threats within an interim suspension or leave policy.

Research Question: Who, Both On and Off Campus, Has the Responsibility for Identifying and Addressing Student Mental Health Issues that May Result in Harm and What Role Does Each Person Serve in the Process?

The findings revealed the use of institutional threat assessment teams as a common practice at all of the sample institutions. These multi-disciplinary teams are formed on two levels. The first is a team comprised mainly of student affairs staff who analyze the behavior of students. The second is a campus-wide team which analyzes threatening behavior posed by a campus' faculty, staff, and students. While this latter team includes some student affairs staff members, it is broader in its team membership

and includes representation from human resources and faculty council. In this section, I will explore four concepts revealed in the findings:

1. Two distinct levels of campus threat assessment teams exist which four common elements are found at small institutions.
2. Such teams existed on an informal level in the era prior to the Virginia Tech and Northern Illinois shootings.
3. Irregularities are found in the frequency of some student threat assessment team meetings which causes frustration form some team members.
4. Few institutions utilize an anonymous reporting mechanism as a threat assessment tool.

Though these teams may have many different team names, such as: Student Support, Students of Concern, and Disruptive Behavior Assessment Team, to name just a few, they all utilize campus officials who discuss and analyze threatening behavior. Furthermore, these teams devise action plans which work to minimize a credible threat to the campus community.

Two Levels of Threat Assessment Teams: Student and Campus Teams

The creation of both campus and student threat assessment teams has become common in the period after the Virginia Tech (2007) and Northern Illinois University (2008) shootings. As Deisinger et al. (2008) pointed out:

> An increasing number of higher educational institutions are looking at ways to use this (threat assessment) process to identify and respond to students, faculty, and staff who may pose a danger to others on campus, may pose a danger to themselves, or who simply may be struggling and in need of assistance and resources (p. 14).

The process of threat assessment and the need for multi-disciplinary teams, that is, a variety of institutional offices who are part of this process, are also highly recommended in the post-mortem literature which examined the Virginia Tech shootings (Angle et al., 2007; Flora et al., 2007; Leavitt, Gonzalez, & Spellings, 2007; Massengill et al., 2007). Furthermore, many states have enacted laws which require the establishment of such threat assessment teams at their respective institutions of higher education (McGinn, Raymond, & Henning, 2007; Rasmussen & Johnson, 2008).

While the findings revealed that such teams may have a variety of different names, they all have one common purpose—to discuss, analyze, and make recommendations on how to address behavior which may pose a serious threat to their campus communities. The findings revealed two distinct team levels in use at the sample institutions. The first was a student threat assessment team which was housed within the division of student affairs. For purposes of simplification, I hereafter refer to the Student Threat Assessment Team as STAT. The primary focus of the campus STAT, which was composed of both student affairs staff members as well as representatives from other campus offices, was to make recommendations and devise action plans for students of concern. The second was a team which dealt with threats posed by members of the broader campus community that could be represented by students, faculty, and staff at the institution. Since this latter team also dealt with students as part of its activities, the student team's concerns often "fed into" the larger campus threat assessment team. For purposes of simplification, I hereafter refer to the Campus Threat Assessment Team as CTAT.

The findings revealed three common elements found within each campus STAT. First, the STAT and the students which were both discussed and analyzed as part of its deliberations often provided information to the greater CTAT. SSAO Tanya described how her campus CTAT (known as DBAT—Disruptive Behavior Assessment Team) operated in this manner:

> The DBAT is used when we really have a high level of concern and we needed to make a fast response. It dealt with all campus issues, so that might include faculty and staff that we're concerned about…there is often redundancy since the same students that we are discussing in our EASST (Early Action Support Team) are also discussed at the DBAT meetings.

Tanya's SSAO colleague Sally discussed a similar procedure at her institution and described it in terms of national trends:

> Our STAT group is really where the action is, at least on our campus. But, you know, ever since Virginia Tech and Northern Illinois, the trend has been to have a larger threat assessment team that also looks at faculty and staff mental health issues…our STAT group often provides the subject matter for the campus threat group since we haven't had a lot of concerns yet with faculty and staff issues.

Fellow SSAO Jane described similar perspectives when it came to student concerns being discussed at the CTAT level:

> We have a larger behavioral concerns team and right now, it's still in its infancy…there are academic people on it, like our Associate Dean of Academic Advising and Human Resources, but there's not a big link with faculty and staff mental health issues there, so, even though we have discussed student concerns in our student team, we often bring them up again there…I guess we're just lucky that we haven't had those same concerns with our faculty and staff.

The second common element found was the purpose of the STAT which was to openly discuss and analyze student behavioral concerns and to develop action plans of

how to proceed. The SSAO Katherine further elaborated on the purpose of her campus STAT:

> The biggest thing we do is to bring the names to the table and at that point, we have a discussion about who is best to handle it…and normally, either myself, residence life, or counseling will do the actual follow-up with the student…in many cases that is where a behavioral agreement happens.

The SSAO Tanya described a similar process at her institution with regard to the purpose of the SSAT:

> We convene the team and the team has a discussion about the student and we kind of put our heads together and figure out what is appropriate and then, the team makes a recommendation to me…at that point, it's really up to me to devise an action plan, something that is going to address the behavior.

Tanya's SSAO colleague Sally discussed the various perspectives that each member of the team brings to the process:

> Well, I think each of us comes with our own view of what a threat is, but I have to say that we've all worked together so closely that it's really a dialogue about what we should do…we bring our respective expertise to the student situation and we openly share our knowledge of the student and their behavior…we all share the responsibility in the process…we sometime struggle with our opinions, but it's always a good debate and we always come to some decision in how we are going to address the student's behavior.

On the other hand, SSAO Lisa described her campus STAT process in terms of specific team roles:

> All of the team members are really our ears on the ground, they have pieces of information about this student and we get together to try and put those pieces together…and, everyone within the group has specific roles, like the Director of Counseling has certain tasks she would complete because of the discussion or what we've decided to do with a specific student or Residence Life would have a follow-up role if the student is a residential student. I would have a follow-up role if there were certain things where I needed to speak with the parents.

The SSAT's sharing of information and developing an action plan as a result of member dialogue was a common thread found within all of the SSATs. Putting together such various pieces of information has been described as both the suggested creation and the major purposes of a threat assessment team (Angle et al., 2007; Bova, Cornell, & Groth, 2007; Leavitt, Gonzalez, & Spellings, 2007; Massengill et al., 2007). Deisigner et al. (2008) elaborated further on this purpose when they described this team as:

> A team of people who, with their connections throughout the campus, can gather pieces of information and assemble them into a larger picture…this facilitates a more comprehensive picture of what a person of concern is doing, saying, and considering, and enables the team to develop and implement an integrated management strategy to address those concerns. (p. 5)

Documents also revealed this same objective of information sharing as well as the announced creation of a SSAT. In its internal procedure, labeled "Homicidal Threat Protocol," Institution F described its SSAT, the Disruptive Behavior Assessment Team (DBAT), as a sub-group of the greater CTAT with a defined purpose when it stated, "The cornerstone of this protocol is the process of having the DBAT review each report of concerning behavior and make an assessment of risk, and to consult with and make recommendation to the Dean of Students" (p. 1). In similar approach, Institution D created a "Threat Response Protocol," in which it described its SSAT as "a multi-disciplinary team of several campus offices which complies with the requirements of the Illinois Campus Security Act of 2008" (p. 1). This particular protocol, which was designed to be distributed to all campus offices, urged all of its readers to report acts of concern to the SSAT when it stated, "If you observe a threatening behavior or situation, it

is imperative that you take the threat seriously and immediately contact the appropriate resource" (p. 3).

The third common element found in the SSAT was an understanding of FERPA (The Federal Educational Rights and Privacy Act of 1974) and how it did not neither bar information sharing, nor impairs its action plans. Several SSAOs made direct reference to the Virginia Tech and Northern Illinois University incidents when they described their legal understanding of FERPA and appropriate information sharing. As SSAO Sally explained:

> From a legal perspective, we know that we can meet behind a closed door and have an open discussion…I know the Virginia Tech report made a lot of people realize that FERPA doesn't stop us from having those discussions…I think that was actually a good thing that came out of that whole tragedy.

Sally's SSAO colleague Barbara also described her clear understanding of what is and is not allowed under FERPA when she said, "I think on a national level, we now understand that FERPA doesn't ban us from talking to each other…I can't imagine that anyone doesn't understand that, especially after Virginia Tech."

SSAO Jane also described this same understanding:

> It's about closing the circle…it's about sharing information to put it all together and the only way to really do that is to get together and share as much as you know about this kid…I think before Virginia Tech, there were a lot of us running around worried about getting sued by a student if we talked about them, but I think that's all changed since Virginia Tech…I think we all get that the law is actually on our side, not against us in doing what we need to do.

Before Virginia Tech and Northern Illinois University: The Informal Practice of Student Threat Assessment Teams

Another common element found with threat assessment teams was an acknowledgment on the part of the SSAOs that such a group had actually existed in an informal manner, for many years on their respective campuses. This realization was framed around a timeline which placed emphasis on both the Virginia Tech and Northern Illinois University incidents as "watershed" moments that made threat assessment teams into a more formalized and national practice within student affairs. The SSAO Sally described this past practice:

> I would say that up to ten years ago, we would meet as a group of deans and directors for breakfast and, for an hour or so, we'd go over the students that we had concerns about, and it was usually four or five students. We'd split up who was going to do the follow-up with the students and it was just a very informal thing. Now, it's just more formal and it's pretty obvious that it's because of what happened at Virginia Tech…I know the law is now mandating threat assessment teams on a lot of campuses so that's another reason why it's more formal, more open now.

Sally's SSAO Colleague Jane also described the informal practice of sharing information about students of concern that had existed in the past:

> When I first started working in student affairs here, we would have a meeting of the campus minister, a counselor, the resident director, and myself about every two weeks or so. We talked about students we were concerned about and they were almost always residential students, and then, we would decide who was the best person to approach the student...and, we're talking fifteen years ago! This is a small campus and if we had a student who seemed disturbed and who was disruptive, everybody knew about it.

Jane began to laugh and adjust in her chair as she reflected on her institution's past practice and then said:

> It's kind of funny, isn't it…some things never change…I mean now, it's just more of a formal thing, you know, something that everyone is doing and it's getting a lot of attention, but we always did it and we weren't worried about getting sued or something like that.

SSAO Tanya also described a similar past practice at her institution:

> You know, I was kind of surprised when after the Virginia Tech shootings, everyone was talking about how we couldn't share information and stuff like that…Donald (her CCD) and I met with Public Safety and that goes back many years, and we always felt comfortable just talking about students that were on our radar screen…it was just very informal, you know, something we didn't necessarily talk about with everyone on campus, but it was there.

The Irregularity of Threat Assessment Team Meetings

The findings also revealed two key differences amongst the institutions in the forms of organizational structure and the formalization of SSAT meetings. As for the latter, the majority of the institutions had regularly-scheduled SSAT meetings which took place on a monthly or bi-monthly basis. These were regularly scheduled meetings for the team members and they took place, regardless of actual concerns present or not. The SSAO Sally described the regularity of her SSAT meetings:

> We meet as a student support group every Thursday…it's on all of your calendars…sometimes we have a lot of student situations to discuss and when we don't, we usually just go back and talk about the follow-up that we did with past situations and we talk about how the student is doing and if there is anything else that we should be doing.

Sally's SSAO colleague Tanya described a similar regularity about her campus' SSAT when she stated, "We meet every Monday afternoon and we usually always have some student to talk about." The SSAO Jane also described the frequency of her SSAT meetings when she said, "The team knows that we meet every other week on Wednesday and they have it blocked out on their calendars…we all hold that day and time for the

meeting." While these regularly-scheduled SSAT meetings were common amongst the SSAOs, some CCDs described frustrations with, what they perceived as, the irregularity of such meetings. The CCD Colleen described her frustration with this irregularity:

> Unfortunately, the group has met only once this year which I think is a bit of an issue. My concern is that we need to start meeting on more of regular basis and set up sort of a plan because I don't want it be like last year, you know, if a threat comes up and we're all like, 'Oh my God!' and we're all running around trying to figure out what we should do.

While CCD Vicky spoke very highly of her campus' SSAT, she also expressed similar concerns to Colleen:

> We do meet, but it's more on an as needed basis and I don't know, I just think it makes sense to have us meet on a regular schedule, that we're all putting this meeting on our schedules…we have plenty of student situations to talk about and if we met more frequently, I just think it would be a good thing for everyone.

Another difference found was the actual staff member who served in the role of chairperson for the campus SSAT. While many of the sample institutions had the SSAO serve as the SSAT chairperson, some chose different staff members to serve in this role. Two of the sample institutions had either their CCD or the Director of Student Care serve as the chair or co-chairperson of this committee. When asked why the CCD served as the chairperson of her campus STAT, SSAO Katherine explained:

> These situations often deal with mental health issues and so, I think, it makes sense to have our head counseling person as the lead of this group…many of the situations need to be analyzed from a psychological perspective and that's what Mary (Katherine's CCD) does for the group.

In a similar vein, CCD Vicky co-chaired her campus SSAT with the Director of Student Concerns. One may recall that this latter position, which was found to be unique

within the institutional sample, was a case manager who deals with all student mental health situations. Vicky viewed this structure as very effective for her campus SSAT:

> The Director of Student Care is really our campus person who manages all of the mental health follow-up, like the behavioral agreements, and so I think it makes perfect sense to have her co-chair the group with me…I know that we are probably unique since we have this position and a lot of other schools probably don't, but we're lucky to have it…I think it's good to her and I co-chair it…Lisa (her SSAO) is really the head of discipline, not the psychological person who can really analyze these situations…I don't think that role should be part of what she does here.

The Use of Anonymous Reporting Mechanisms in Campus Threat Assessment

A final concept revealed in the findings was the use of an anonymous reporting mechanism to report concerns of threat. These reports could be submitted by anyone in the campus community with some level of anonymity. The findings revealed that even though such mechanisms have been recommended in the threat assessment literature as a valuable tool to report credible threats (Bova, Cornell, & Groth, 2007; Dunkle, Silverstein, & Warner, 2008; Leavitt, Gonzalez, & Spellings, 2007; Sokolow, 2007), only two of the six sample institutions had such a system in place. The findings further revealed that even in those cases, the mechanism did not always guarantee anonymity to the reporting party. SSAO Tanya explained this dynamic about her campus reporting mechanism:

> We have an on-line referral mechanism, but it's not completely anonymous because you had to log-in to use it and to be able to send a report to the threat team…so, the person who was referring could request to be anonymous to the student that they were concerned about, but they were always known to the DBAT (Disturbing Behavior Assessment Team).

She offered further explanation as to why the mechanism did not need to be completely anonymous on her campus, when she stated, “There’s a high level of helping one another here and a comfort level with ratting people out if that needs to happen.”

The SSAO Jane described a similar reporting mechanism on her campus in terms of confidentiality when she revealed, “We have a Red Flag First Alert system, but it’s not completely confidential, I mean, there is not a guarantee that the submitter of the report is going to be anonymous...and, I admit, that’s a concern for me.”

While threat assessment variances were found in such elements as: the team chairperson, the frequency of team meetings, and the use or non-use of an anonymous reporting mechanism, the use of both a Campus Threat Assessment Team (CTAT) and a Student Threat Assessment Team (STAT) was a common practice at each sample institution. In addition, members of these teams served in advisory roles as they both assessed threatening behavior and devised action plans in how to address such behavior.

Research Question: How are Behavioral Agreements Evaluated for their Effectiveness?

In this last research question, the findings revealed a consistent lack of formal evaluation procedures for behavioral agreements as well as threat assessment practices. The SSAOs and CCDS candidly expressed not only their lack of such procedures, but also their desire to create more formal procedures on their campus. While some SSAOs and CCDs viewed their informal discussions in the aftermath of situations which utilized behavioral agreements as acceptable, they also expressed dissatisfaction with the lack of formality in their process.

The Lack of Evaluation and the Desire to Create More Formal Evaluation Procedures

While both behavioral agreements and the use of campus threat assessment teams have become common practices in managing student mental health and addressing threatening behavior, the SSAOs and CCDs expressed their use of an evaluation process or as the findings revealed, the absence of such a process, in terms which expressed bewilderment and dissatisfaction with their current lack of such a process at their respective institutions. This dissatisfaction led both the SSAOs and CCDs to share their desire for a more formal process of evaluation for both behavioral agreements as well as the activities of their respective campus threat assessment teams. The SSAO Jane paused for quite some time as she struggled with her thoughts on her campus' evaluation of such policies and procedures. She had a puzzling look on her face as she began her response:

> I mean, when I really think about it, we just don't take the time to evaluate the behavioral agreements...I mean, how do we know that they are effective? And, I have to be honest, I really don't know how to assess them well enough.

When Jane thought of the procedures of her campus threat assessment team, she expressed similar views on the lack of an evaluation process; however, she expressed her greater concern of the lack of training for the team:

> The behavioral concerns team needs training, absolutely! We need to take this process much deeper and really look at what we did and if it made a difference…we don't want to just go back to what we were fourteen years ago…the threats are lot more serious and the team needs to know what they're doing.

Both her views on the procedural evaluation led Jane to express a sense of professional embarrassment as she reflected on this process further. She began to adjust

in her chair and chuckle when she said, "Wow, I guess I'm kind of embarrassed here…I'm just realizing that we don't take the time to formally examine any of this stuff!"

Jane's CCD James also concurred with her opinions on the lack of evaluation as well as the desire to have such a process in place:

> I think we don't do a lot of self-examination which is probably not a good thing…Not even probably, it is not a good thing! We need to be a little more purposeful…And I'm hopeful that a little more assessing of our own methodology and our own sort of operational procedures will be a good thing for us.

When James reflected further on the purpose of such an evaluation, he thought for a moment and then said, "Are we getting the results we want to get? Or at least as much as we can and as best as we can? I would say right now, we haven't begun that process yet."

Another institutional pair, SSAO Katherine and CCD Mary, also acknowledged their lack of evaluation with both behavioral agreements and threat assessment teams and the subsequent need to do more. The SSAO Katherine was very direct in the lack of such processes when she explained, "There's not a process in place for assessing the effectiveness of either behavioral agreements or our threat assessment team, not at this point." She then clarified the importance of implementing such a process and expressed it in legal terms:

> Litigation and court decisions are huge with these procedures and it definitely has an impact on all of us…I mean, all of these court decisions have happened and they are going to continue to happen…I think we're all doing our best to avoid some horrific tragedy, I mean that's why we're all doing these things, right?

While Katherine's CCD, Mary, expressed the lack of evaluation processes, she expressed her viewpoint around the need for better data collection:

> I don't think we have an official assessment process and I don't think there's any good record keeping…that's a really good point when you think about behavioral agreements, we need to be keeping data on all of these situations…we need to know the current status or if it's been resolved.

Mary then had a very contemplative look on her face, as if she was giving thought to what she could do on a personal level, to make the process more efficient:

> So, I can do something like that internally here, but we're still kind of refining the process, but I do think it's getting better…I know that we are making better attempts here in counseling to keep track of the students under behavioral agreements, you know, the ones that we've seen here.

Mary then reverted back to discussing the current lack of evaluation processes when she shared, "I would say it's just outcome oriented right now…did the student's behavior improve enough to make them able to be part of the community and succeed in school? It's pretty much that."

The SSAO Barbara and her institutional colleague CCD Amy also expressed similar viewpoints on their lack of such processes at their institution. At first, SSAO Barbara discussed a semi-structured process, but then seemed to step back from that particular viewpoint:

> I would say, qualitatively, we sort of go through a debrief, but in terms of quantitative assessment, there really isn't anything. I mean, I guess we could sort of look at caseload and think, okay, was there success here or not? So, kind of an environmental scan approach, like kind of a debriefing approach on each as that involved behavioral agreements.

Barbara's facial expression then suddenly changed and she began to laugh and adjust in her chair. She then said, "I 'm just realizing that we really don't do any good assessment…not a good thing, right?!"

As Barbara thought of evaluation further, she then framed her views around both the sheer energy involved in and the sense of relief felt around the resolution of student mental health situations:

> I think there's just some feeling of we survived it! We survived mentally, kind of working through this kind of mental gymnastics involved in persuading, of talking the student into getting help…of just caring for the greater community and then, it's like, we're done and we just want to move on!

Barbara's CCD Colleen felt that such processes did not only exist at their institution, but that the evaluation process was a novel concept that should be pursued when she commented, "No, we don't really do anything, but it's an interesting point, I just never really thought about it, that's a great idea!...we just don't take the time to really evaluate what we're doing."

Another institutional pair, SSAO Tanya and CCD Donald, also acknowledged their lack of assessment with policies and procedures. Tanya was very candid in her thoughts:

> I really have done nothing with assessment…we are just really poor on assessment in all sorts of ways and I'm not very proud of it, but we just don't…I think Donald (her CCD) may have his own internal assessment procedures, but I don't ever really follow-up with assessment.

She then paused for a moment and began to laugh while she thought of another response. She then revealed, "I mean, if I don't hear anything further about the student, I assume everything is working, that it's fine." Tanya then offered further clarification to

her comments in a manner which viewed assessment is a good process when she added, "I mean, that's not to say that there shouldn't be an assessment mechanism of some sort, we're just not very good at it."

Tanya's CCD Donald also acknowledged the lack of assessment with regard to policy and procedure:

> We haven't really done a great job with any assessment, particularly in terms of assessing their effectiveness, outside of, I think, paying attention when they haven't worked or maybe doing some debriefing after a meeting that didn't go well with a student.

Donald then discussed current efforts that are being made at his institution to try and develop better assessment procedures:

> This year, we're moving to have a more formal meetings with the Disruptive Behavior Assessment Team (DBAT), to go over the cases that we had and figure out what we need to do in the future….I think we're going to reflect more regularly and that will be a great sort of check and assessment.

Donald then reflected specifically on the behavioral agreement assessment process and he shared his desire for the evaluation of such agreements when he stated, "What I really want is to ask the student, was the behavioral agreement effective for you?...It would be great to get that data!"

Informal Discussions as a Method to Evaluate Behavioral Agreements and Their Effectiveness

While many of the institutional pairs of SSAOs and CCDs expressed the lack of formal assessment processes and subsequently, the desire to have such processes in place, some SSAO/CCD pairs felt they did, in fact, assess such policies and procedures through reflective analysis and resulting conversations about student mental health situations.

The SSAO Lisa felt that assessment did take place at her institution; however, she expressed such assessment in more informal terms:

> We do an assessment on whether or not the agreement worked and , if didn't, we talk about it as a team…I think that type of informal assessment leads us to change them for students in the future…it's really a case management type of assessment process. We have conversations about things like maybe this student needed to have more counseling or maybe this one needed more sanctions to better control their behavior…we try and mold them toward what would be most appropriate for another situation that could pop up in the future.

Lisa's CCD Vicky concurred with her SSAO's observations on assessment. She expanded on these thoughts:

> I think the Wellness Board itself is always continually talking and assessing our approach and our documentation in these situations…it not a formal process, but if something comes up, we all discuss it and I think we all sort of take it in and have it serve as a lesson for future situations.

When probed further on whether she felt comfortable with such an informal assessment process, Vicky explained, "I am very comfortable with it…we have good discussions and the whole Wellness Board is part of the process, I think it works well."

Institutional colleagues SSAO Sally and CCD Bruce utilized a similar informal process of assessment at their institution. While their process also involved informal conversations amongst student affairs personnel and the threat assessment team as the primary method used in assessing policy and procedures, their responses gave very little detail about such conversations. As SSAO Sally described, "We are in constant assessment mode…like when we are rewriting our student handbook each year, it's essentially an assessment of our student policy."

While Sally's CCD Bruce also discussed assessment as an on-going process at his institution, he provided very little detail of how such a process is actually conducted; rather, his thoughts were more complimentary to their procedures for addressing student mental health situations:

> Oh yeah, we have lots of conversations, but I think we've had to do a lot less of it just because all of these things work really well here…things works pretty seamlessly so, we almost don't have to think about it too much.

When Bruce thought further about his institution's assessment processes, he framed his response around the importance of accurate data collection, when he stated:

> I think we've created a good tracking system for all of the mental health situations, but we might want to figure out who will sift through all of this data, I mean, who's going to keep track of all of them? We should create a system where people on the threat assessment team can click on something and see the number of letters that are outstanding, just as an example, and we don't have that right now.

Bruce then thought further about his suggestions regarding data collection:

> I've been working in this setting for a long time and we're going to see more and more students and they're going to be bringing more and more alarming problems, so, we need to have more thorough data on all of them…I anticipate that we'll continue to talk about assessing all of this, you know, to examine if what we're doing is really valuable or not.

The findings regarding assessment and evaluation revealed the lack of such processes as a commonality amongst much of the institutional sample. While some of the institutional pairs felt they did practice assessment on an informal level, the findings demonstrated the general lack of formal assessment processes for both behavioral agreements as well as campus threat assessment teams. Furthermore, the findings

revealed that all of the SSAOs and CCDs viewed the assessment of such procedures as a necessary and worthwhile venture.

Summary of the Study Results

The findings demonstrated both commonality as well as striking differences amongst the SSAOs and CCDs in their use of behavioral agreements. In summary, seven themes were revealed in the findings. First, SSAOs and CCDs demonstrated strong instincts of personal care as they created and implemented behavioral agreements at their respective institutions. Second, they viewed the behavioral agreement process as a method by which they both demonstrated care for the student as well as insured a level of safety for the greater campus community. Third, while self-harm and psychiatric hospitalization proved to be imminent indicators leading to behavioral agreement, instances of mental health without such dynamics relied on the personal connections established with, as well as the persuasion practiced with students in order to achieve a level of participation in the behavioral agreement process. Fourth, while the CCDs viewed mandated psychotherapy as a controversial, if not unethical concept, the SSAOs viewed its use as an acceptable method to address both mental health conditions and problematic behavior. The CCDs adhered to the ethical principles of their psychological profession which viewed psychotherapy as a voluntary process and not appropriate as a disciplinary mechanism. Fifth, the use of multi-disciplinary teams in performing campus threat assessment was a common approach utilized at all of the sample institutions. While such teams may have existed in an informal sense in the pre-Virginia Tech and Northern Illinois University period, its use has become formalized in the period

thereafter. Sixth, while some SSAOs and CCDs made great distinctions between mental health and disruptive behavior as well as the need to adjudicate such behavior through the campus conduct process, they also exhibited strong empathy and careful thought in light of underlying mental health conditions. Finally, while the SSAOs and CCDs felt strongly that the assessment of their policies and procedures regarding student mental health and threat assessment were important, they also openly acknowledged the lack of such processes at their institutions. I now further explore all of these concepts in Chapter VI: Conclusions, Implications for Practice, and Recommendations for Future Research.

CHAPTER VI

CONCLUSIONS, IMPLICATIONS FOR PRACTICE, AND RECOMMENDATIONS FOR FUTURE RESEARCH

> I do appreciate structure as it relates to behavioral agreements, because it is inside that structure that these students can thrive at our institution…we have to really ask ourselves, can we gather enough information to build an agreement that really motivates them?

This comment made by an SSAO nicely summarized the overall concern and logic behind the use of behavioral agreements both to manage student mental health concerns and minimize threats to campus communities. Like many of the other SSAOs and CCDs interviewed for this study, this SSAO's comments capture both the appreciation for the structure that is created by the behavioral agreement as well as the strong sense of personal care that was demonstrated consistently throughout the findings. The behavioral agreement, which was a common practice at all of the sample institutions, proved to be a tool in which the institution took progressive steps to manage both student mental health concerns and, at the same time, safeguarded campus communities from potentially violent behavior. One CCD, whose perspective was consistent with many of the other SSAOs and CCDs in the study, offered an overall purpose for the behavioral agreement:

> The expectation of the behavioral agreement is that you will comply with the steps laid out and you will maintain your behavior. You will do what it takes to live up to your side of the behavioral agreement…We will show you what it takes or what we have to offer you to maintain your behavior;

> so, if you need some assistance, if you need some support, these are the services that are available to you.

Thus far, in this study, I have identified and categorized many aspects of behavioral agreements through the lenses of those who create and implement these agreements on a daily basis. I have also analyzed various institutional documents which described behavioral agreements as well as policies and procedures which managed threatening behavior. Having presented the results in relation to the study's research questions, I now turn my attention to drawing conclusions based on the overall findings of this investigation.

Conclusions

In this section, I elaborate on the eight main conclusions of this study. First, I discuss the finding that all the sample institutions are experiencing dramatic increases in both the severity and complexity of student mental health issues. Second, both SSAOs and CCDs believe that behavioral agreements create needed structure and a sense of adult responsibility for students with mental health concerns. Third, four common elements exist all behavioral agreements: the initial meeting, limitations on behavior and community expectations, mandated psychological assessment, and mandated psychotherapy. While some small institutions believe they practice unique approaches in their behavioral agreements, these approaches simply use different terminology which describe the same process. Fourth, while mandated psychological assessment is a common practice within behavioral agreements, mandated psychotherapy which directly results from the assessment remains a highly controversial practice that is not consistently enforced by small institutions. CCDs oppose its use within behavioral agreements due to

the ethical principles of the psychology profession; yet they reluctantly accept its use due to organizational power dynamics. While SSAOs fear litigation as result of mandated psychotherapy, they also view its use as helpful in managing mental health and threatening behavior. Fifth, the use of a check-in person to conduct follow-up with students is a unique approach in the behavioral agreement process which may offer a compromise to mandated psychotherapy. Sixth, the manifestation of student mental health concerns is a strong consideration for SSAOs in the student conduct process. Seventh, the use of campus threat assessment teams has become the most accepted method in managing threatening behavior; furthermore, it has evolved into two distinct teams, the first being an overall campus team and the second being concentrated on student issues. While such teams have become commonplace, the use of an anonymous reporting mechanism to report threatening behavior has yet to be realized at small institutions. Finally, a lack of formal evaluation procedures exists for the behavioral agreement process; however, a strong desire to create such procedures. Each of these nine conclusions will act as over-arching groupings in which several sub-conclusions will be presented.

The Growing Mental Health Problem

Both the SSAOs and CCDs consistently expressed dramatic increases in student mental health concerns on their respective campuses. Furthermore, they described such concerns as both more severe and complex than in years past. They also anticipated rising levels of such concerns as they looked to the immediate future. While these impressions of rising mental health issues on college campuses nationwide are also

widely referenced in the literature (Benton et al., 2003; Boyd et al., 2000; Carter & Winesman, 2003; Cooper & Archer, 2002; Franklin, 2009; Ghallager, 2005, 2006, 2007; Levin-Epstein, 2007; Soet & Sevig, 2006; Volker, 2006), a scholarly debate has arisen between the afore-mentioned scholarly group and those who view such impressions as anecdotal and lacking in empirical validity (Bishop, 2006; Males, 2007; Schwartz, 2006; Sharkin, 1997; Sharkin & Coulter, 2005). While the latter group has acknowledged the *impressions* of rising student mental health concerns, they claim there is an overall lack of knowledge regarding the overall picture of campus mental health (Kitzrow, 2003; Silverman, 1993; Silverman et al., 1997). These divergent viewpoints can be best summarized by scholars within each camp. For example, Kadison (2004), who represented the group which attested to dramatic increases in student mental health concerns, stated, "Without question, concerns about the mental health of college students have risen substantially over the past decade" (p. B20). On the other hand, one can cite the lack of empirical results which are represented by the other group of scholars, in the viewpoint of Schwartz (2006) who, when criticizing one such study stated, "The actuarial indices of client psychopathology indicated that student clients did not become acutely distressed over the 10-year period of the study" (p. 335).

Small institutional counseling centers are in further need of additional resources. While the scholarly debate on college student mental health may rage on, the results of this study demonstrated not only the impressions of rising mental health concerns, it further demonstrated such rises in the form of quantitative data that CCDs had captured within their campus counseling centers and discussed within this study. These numbers

represented a continuum in which increases of 20 to 40% in usage were discussed on the low end to increases of over 100% of usage on the high end. While CCDs further expressed these figures in terms of rising caseloads that strained their available resources, The SSAOs concentrated on the management of student mental health concerns as being one of their most significant and albeit, most time-consuming job responsibilities.

The CCDs consistently viewed rising mental health caseloads as justification for their need for further resources from their respective institutions. As CCD James explained it:

> The trend has been that there are more students entering college who have significant histories of mental health issues, so they are going to make more and more of these students coming to college. The colleges have to do more to catch up…the monies aren't there in the same way that they are at the high school level. We need more counselors on college campuses who can address these issues.

James further demonstrated his views on the need for more resources when he assessed the national college landscape on mental health, when he stated:

> If you're a school with obvious greater resources, you know, like Harvard, Yale, or Brown, who have billion dollar endowments, I'm sure they have great counseling centers that are fully staffed….it's the smaller schools, like us, that have limited resources and we need to do more….We really are doing the best we can, but without the resources necessary to provide services to all the students that need it, we are going to have people who just slip through the cracks.

James' CCD colleague Donald agreed with the pressing need for further resources in campus counseling centers:

> Sometimes, all of the cases are very difficult to manage and sort of alarming. There are times when I feel we look more like a community mental health operation than a student development office…the cases are going to continue to rise and the only way that we are going to have a shot

> in managing all of them is with more psychological staff…it has to be an institutional priority.

This common viewpoint held by the CCDs of the apparent lack of as well as the need for resources within campus counseling centers has also been described in the professional literature (Draper et al., 2002; Foley, 2008; Kadison & DiGeronimo, 2004). The national ratios of counselor-to-student have consistently remained unchanged for the past several years (Ghallager, 2006, 2007). Lee (2005) discussed this resource dilemma in terms of the forced limited usage of counseling center services when she stated, “Due to financial constraints, institutions have been put under pressure to utilize short-term or brief treatment methods” (p. 26). Thus, while the literature has suggested a ratio of one full-time psychologist for every 1,000 students (Barr & Rando, 2008), the reality is reflected in Ghallager’s (2006, 2007) annual counseling center directors surveys, which found a national ratio of 1: 1,697.

Senior Student Affairs Officers firmly believe that rising mental health concerns will only increase in the immediate future. The SSAOs discussed the impressions of rising student mental health concerns in terms of job priorities as well as the large amounts of time needed to attend to such increases. As was discussed in the previous chapter, the SSAOs and their reflections on the vast amount of time needed to manage student mental health concerns were consistent with the findings presented in the literature on SSAOs and the management of mental health concerns (Belch & Marshak, 2006; Ghallagher, 2005, 2007). I conclude that SSAOs at small institutions have prioritized the management of student mental health concerns as, if not the most pressing, one of greatest responsibilities of their position. This conclusion is further demonstrated

by the SSAOs' nostalgic reflections in which such priorities were not the case several years ago. Thus, I further conclude that an evolution of job responsibilities has taken place for small institution SSAOs in which student mental health concerns have "crept to the top" of their responsibility portfolio. A typical comment which expressed such an evolution of job responsibilities was made by SSAO Sally:

> I've been here for a very long time, more than 20 years, and I remember when I first started, we had some mental health situations, but they seldom involved hospitalization or really threatening behavior…in the past 10 years, that has all changed. Dealing with mental health situations is, by far, my biggest job responsibility and I don't see that changing any time soon.

Consistent with Sally's views, the SSAOs viewed the continuation of student mental health concerns as a rising trend that would continue without any abatement of such concerns in the foreseeable future. I would conclude that the SSAOs have accepted whether reluctantly or simply put, realistically, the fact that both the rising numbers of mental health concerns as well as the time constraints that the management of such concerns will take as common realities of their job responsibilities.

Pre-college and societal factors are the root causes of rising student mental health concerns. The SSAOs and CCDs offered insight and explanation as to *why* such concerns may be occurring as well as *how* pre-college efforts could be enacted to better manage such concerns for the entering college student. Greater societal concerns were cited as a contributing variable to the rise of college student mental health concerns by CCD Mary:

> I think it's a whole social societal issue that's going on here. We have break downs in families and we have disenfranchised whole groups of people. We have subcultures in our society that struggle just go get

> through a day. I think we do what we can, but it's almost like putting a band aid on a cancer. These are societal problems that need grass roots changes from the bottom up…I just think we need some bigger societal changes. I truly believe that what's going on in our society is only exacerbating all of the mental health issues that we're seeing.

The SSAO Tanya concentrated on the development of today's youth prior to their college experience as paramount to addressing mental health:

> I would like to see emotional intelligence to become a subject that is taught in our schools. Ultimately, nothing can be created anew at the higher educational level, especially when it comes to mental health…by that time, we've got some pretty formed human beings…we should be talking about mental illness in our schools and breaking down the active stigma around mental health…wouldn't it be lovely if, when they came to college, they at least had an inkling about what's going on in here (points to her head) and how it affects them as people?

The awareness of mental health concerns at the pre-college level was a dynamic that was shared by many of the SSAOs and CCDs. I conclude two themes from the findings: First, the SSAOs and CCDs agreed that the stigma surrounding mental health has become less so due to greater societal knowledge and acceptance of such issues. Second, this awareness has resulted in two possibly unintended effects: The first, being the misuse or overuse of psychiatric medications. The second, being the lack of proper follow-up care with a psychiatrist. The CCD Vicky's comments were typical of this latter point:

> The use of psychotropic medications is just huge…we're seeing more and more of it and I think my main concern with that is that more and more pediatricians are the ones prescribing those types of drugs…you really need to be under the care of a psychiatrist and a psychologist when you are using these types of meds…we're just putting a band on it…is anyone recommending therapy when these kids are taking these medications? They just think that they can take these medications and everything will be fine. That really worries me.

The overuse and misuse of psychiatric medications are also topics which have been widely described in the literature (Arehart-Treichel, 2002; Barry, 2002; Becker et al., 2002; Benton & Benton, 2006; Clemetson, 2006; Eudaly, 2003; Magna-Zito et al., 2007). Some scholars have even suggested that the traditional-aged students within the millennial generation are "the most medicated generation" in U.S. history (Downing, 2006; Hollingsworth, 2004). Specific research on the adolescent (pre-college) population, for example, claimed that a three-to-five fold increase in the use of anti-depressant medications by young adults since 1992 (Barry, 2006) as well as a four-fold increase in the diagnosis of bipolar disorder in America's youth since 1994 (Gelene, 2007). Furthermore, a specific group of scholars repudiated these data based on their perspective that the increased use of psychiatric medications are the direct result of misdiagnosis in adolescent behavioral problems (Harris, 2005; Hazell, Carr, Lewin, Ketrina, 2003; Kim-Cohen et al., 2003). Similar in scope to the scholarly debate on the impressions of rising mental health concerns, another group of scholars suggested that such claims of misdiagnosis and overmedication are simply not true, due to actual sample and terminological limitations (Fischer, 2007; Hattig & Steigerward, 2007; Hutz & Martin, 2007; Klein, 2007; Luther & Becker, 2002; Luther & Latendresse, 2005; Mayo & Christenfeld, 1999; Schmidt, 2007). I conclude that the SSAOs and CCDs experience rising numbers of students who enter their institutions already taking psychiatric medications and as a result, they are concerned that proper follow-up, in the form of continual treatment with a psychiatrist and psychologist, are too often not taking place.

Senior Student Affairs Officers have a desire to gather information on student pre-college mental health before the student matriculates to the institution. The SSAOs and CCDs firmly believed that the gathering of pre-college mental health conditions of their entering new students will help them to be pro-active in providing mental health services to newly-matriculated students. I conclude that SSAOs and CCDs desire better systems to gather such information prior to the student's matriculation to the small institution. The SSAO Jane's comments were typical of the sample with regard to this conclusion:

> We need to do more on the admissions end. When you think about it, any institution is gathering a lot of information on its incoming class. We can build upon this information by asking students about their prior mental health histories…you can simply wrap it in with other health information that you put together…if we had that information, self-disclosed by the student, we could actually be more proactive in connecting with the student in need.

Jane's SSAO colleague Barbara shared thoughts which demonstrated this same viewpoint and offered ideas for implementation:

> I'd like to see more communication between high schools and our deans of students. I wish there was, at least some level of communication in place…perhaps those students with previous mental health treatment could be encouraged to find us and meet us, so they could talk to us and we would know them as they come in, we'd know what to expect or what their history is…that would be a great help!

Behavioral agreements create needed structure and foster a sense of adult responsibility. I conclude that SSAOs and CCDs believe that behavioral agreements create structure for the student as well as help to foster a sense of adult responsibility in the student. Furthermore, I conclude that this structure acts as a means to set and enforce behavioral limits with students. While the literature is particularly lacking in its

discussion of behavioral agreements in general, the primary use of such agreements as a means to create structure for students with mental health issues is recommended by some scholars (Amada, 2001; Deisinger et al., 2008; Pavela, 2007; Zdziarski, Dunkel, & Rollo, 2007). The emphasis on the structure created in managing students with mental health concerns via the behavioral agreement was consistently evident in the findings in two forms. First, such structure acted in an almost *in loco parentis* role by creating expectations that may have been provided to the students, in the past, by their parents. Second, the same structure clarified expectations of the steps necessary to fulfill the behavioral agreement in a manner which placed emphasis on adult responsibility. Thus, I conclude that behavioral agreements provide structure to students with mental health concerns who experienced highly-structured environments prior to their arrival at college. Such home environments often involved parents who provided rigid structure to their son or daughter who has been diagnosed with a mental health condition and who is now participating in psychiatric treatment which may include psychiatric medication to manage his or her condition (Howe & Strauss, 2000, 2003; Kadison & DiGeronimo, 2004; McGinn, Raymond, & Henig, 2007; Twenge, 2006). Such parental structure has also been described in terms of over-intrusiveness as the literature discussed the modern dynamic of "helicopter parents" (Eudaly, 2003; Gibbs, 2009; Howe & Strauss; Kadison & DiGeronimo, 2004; Stepp, 2002). SSAO Lisa's comments nicely captured this conclusion:

> We get a lot of students with prior mental health treatment and many of them have very involved parents who have made sure that they keep all of their appointments with their psychiatrist and that they are taking their medications as required. When they get here, that structure is gone. They

> need someone to tell them that you have to keep these appointments at our counseling center or that you have to continue to take your meds. A behavioral agreement puts it all in writing...it sounds very parental, but it's necessary…these are newly independent young adults and when they are managing a mental illness, they need to have that structure in place.

Lisa's comments were typical of many of the university officers in the study. CCDs also shared these same sentiments with relation to the adherence to psychiatric appointments and medications. The CCD Mary's comments summarized the viewpoints of her colleagues:

> A lot of these students had "helicopter parents" at home who made absolutely sure that they were taking their medications and keeping appointments. They get here and they are completely independent from their parents…it's easy for them to just not follow-up with a psychologist or to just stop taking their medication. Like I'm feeling great and so what if I miss a few doses of my medication? That's where the trouble really begins…it can just spiral out of control.

By placing emphasis on scheduled psychological appointments as well as the expectation that the students will take their prescribed medication as directed by their mental health provider, I further conclude that the behavioral agreement enforces expectations that such psychological management steps will be taken by the individual student.

I also conclude that SSAOs and CCDs believe that such structure fosters a sense of adult responsibility in the student. As Arnett (2000) has pointed out, traditional-aged college students (18-24) are in a state of flux known as "emerging adulthood" in which they move back and forth between early adolescence and full adulthood. The same human development principles are also found in the classic psychosocial development theories that have formed the scholarly basis of the student affairs profession (Barr &

Dessler, 2000; Chickering, 1969; Chickering & Reisser, 1993). I conclude that SSAOs and CCDs understand the unique developmental stages of their traditional-aged college students. Furthermore, I conclude that their use of behavioral agreements gives students with mental health concerns the opportunity to act as their own adult manager of their mental health condition. The CCD James summed up this perspective when he stated:

> I think behavioral agreements afford us the opportunity to have a student take responsibility for themselves and their mental health condition…we are up front and adult with them…we're saying, listen, these are the things you must do to manage your mental health and these are the behaviors that are not appropriate…maybe, they've been supported at home in their immaturity historically, but now, we have to treat them as mature, independent adults…we want to bridge the gap to adulthood in a way that's supportive but also pushing them toward selfhood.

This same approach of fostering adulthood also applied to the behavioral accountability that is inherent within the behavioral agreement. I conclude that SSAOs and CCDs firmly believe that behavioral agreements "set a bar" on what is acceptable and non-acceptable behavior within the campus community. Another common theme which emerged in the data was the importance of the behavioral agreement as a written document which established complete clarity between the institution and the student when it came to acceptable behavior. The CCD Donald summarized this viewpoint:

> You're putting all of these expectations in writing and it's very effective…you're saying, these are what the specific expectations are and you're sort of giving the student a chance. If he or she acts out again, you can hold them accountable for the behavior…when you put in writing, they can't come back and say, well, I didn't know that I couldn't do that. It's crystal clear.

His CCD colleague James agreed with the importance of setting limits in writing:

> If you're going to manage your mental health issue, these are the ways we suggest that you do it. The agreement is going to say, don't act out. It's

> all connected as a way to help the student control their anger and at the same time, make them aware of our campus resources that can help them.

I conclude that behavioral agreements serve both to set clear expectations as well as behavioral limits with the students who are placed in them. I further conclude that SSAOs and CCDs view such self-responsibility as a major educational goal of the undergraduate experience.

Behavioral agreements are active partnerships which rely on an ethos of care. Another conclusion of this study is the strong sense of personal care that is utilized by SSAOs and CCDs in both creating behavioral agreements and forming strong personal connections with students. Another more simplistic way to summarize these conclusions is that both SSAOs and CCDs do not view behavioral agreements lightly; rather, they believe their creation requires a delicate touch in order to establish a personal connection. Every part of the behavioral agreement process demonstrated an ethos of care on the part of the SSAO and CCD. SSAO Tanya summed up the importance of such personalization in the behavioral agreement process:

> For me, it's about taking the extra half-hour to really get to know the student, to get a little more context into their life and what's really going on with them… After I've made that connection, I can say to them, the only thing likely to get in the way of your success is right in front of you. The sooner that you acknowledge that and allow us to help you, the better off you'll be…As I get to know them on a personal level, they will better understand my position. I think the development of the personal relationship contributes to my success with students who we place in behavioral agreements.

Tanya's SSAO colleague Barbara also shared reflections on the importance of personal care in creating successful behavioral agreements:

> I really talk to the student on a personal level and do my best to make a connection with them. That's where it really kicks in…I'm telling them that they are a good person and you're going to do great things here, but we need you to get healthy and you're going to need some help to do that. We're going to help you connect with the people who can help make that happen. If you establish that connection, students are going to more fully engage in the agreement. They will become better adjusted and have more likelihood that they are going to engage in a more healthy way on campus.

While this sense of success in the behavioral agreement relies heavily on the personal relationship, I further conclude that it then transforms into an active partnership between the student and the institution. The SSAO Jane commented on this dynamic:

> It's much more about what goes into the behavioral contracting process with each student, it's about the whole relationship that goes into it. You need to build a grown-up agreement that's going to encourage the student's development. The agreement has to be highly individuated in a way that really motivates them. It's really about forming a partnership between me and the student—it's highly personal.

The CCD Mary further expanded on the issue of forming a partnership with the student:

> You have to keep the humanity in the behavioral agreement process. It's really about forming a partnership with the student where you find a nice balance of putting restrictions in that will keep them and the community safe. You don't want to make it so punitive that it becomes overbearing, almost like they can't move. They need to feel comfortable with all of the steps required in the agreement. It's the only way that you are going to have a chance at really being successful with it.

Another conclusion of this study is that in order for behavioral agreements to have the best chance of success, they must be delicately crafted in a highly personable manner. The resulting personal relationship conveys a strong sense of individual care to the students and it motivates them to comply with the various elements laid out in the actual agreement.

Four Common Elements to All Behavioral Agreements

I conclude from the findings that small institutions consistently utilize four common elements within their behavioral agreements. While some small institutions believe they are using unique approaches in the behavioral agreement process; in reality, they are simply using the same process with different terminology. These terminological differences are more indicative of an institutional philosophy rather than new methods of practice. Despite the behavioral agreement process being given a different name, such as a Commitment to Treatment or Wellness Board Commitment to Care Plan, the core concepts of the behavioral agreement remain the same.

The first common element in behavioral agreements is the importance placed on the initial meeting between the SSAO and the student. As was previously discussed, great care is demonstrated, on the part of the SSAO, toward the student in the establishment of a behavioral agreement. This sense of care is most profoundly exhibited during the first common step of all behavioral agreements--the initial meeting between the SSAO and the student. I conclude that the personal approach utilized by the SSAO in both conducting the initial meeting as well as gaining a sense of collaboration between the SSAO and the student is critical to achieving a successful agreement. The important role which empathy plays in this process is discussed, albeit in a more general sense, in the literature (Amada, 2001; Belch & Marshak, 2006; Dannells, 1990; Dannells & Consovlvo, 2000). As Amada stated:

> A key task, therefore, is to retain the capacity to enter into, accept, and mirror anxious students' subjective worlds…Such an approach demonstrates that someone understands and cares…The interpersonal

> climate that empathy creates helps us ultimately to shake the foundations of the students' anxiety.

The SSAO Katherine shared comments on a specific example of such an initial student meeting nicely summarized this approach:

> I first met with her to discuss these reports, she was just very, very angry. I needed to take the time and really try and connect with her, I mean, try and develop a personal relationship with her. I needed her to feel that we cared about her…I wanted to explore the cause of her anger and I needed her to realize that her anger might be a personal issues also, a psychological issue…I needed her to understand that she couldn't continue to do this…that we would get her help.

The importance of the initial meeting between the SSAO and the student also relies heavily on one crucial element in the behavioral agreement process—the power of persuasion. However, the use of mandated psychotherapy as part of the behavioral agreement, which I will explore in further depth within this chapter, remains a highly controversial topic. Therefore, I conclude that the SSAO's interpersonal skill of persuasion is a vital element in the behavioral agreement process. If the SSAO can persuade the student to enter into the various steps of the behavioral agreement, which may include the student's personal willingness to enter into psychotherapy, two fundamental elements take place. First, the SSAO is essentially upholding the ethical principles of the psychology profession which strongly views psychotherapy as a voluntary process (Amada, 1994, 2001; Archer & Cooper, 1998; Boyd et al., 2002; Gilbert & Sheilman, 1995; Kiracoffe & Wells, 2007; Van Brunt & Ebbeling, 2009); thus, the SSAO avoids a possible internal conflict with her campus psychological staff who may also hold firmly to the ethical principles of the psychology profession. Furthermore, some campus psychologists may view involuntary participation in psychotherapy as a

dynamic which "can severely restrict the use of campus psychological services operation" (Boyd et al., 2003, p. 168). Second, the literature has consistently pointed to the voluntary acceptance of psychotherapy as offering the best chance of successful behavioral change (Amada, 1994, 2001; Kiracoffe & Wells, 2007; Prochaska, 1999; Prochaska & Norcross, 2001).

The SSAOs and CCDs consistently viewed persuasion as a fundamental skill which the SSAO must possess and master in order to achieve desired behavioral agreement outcomes. In particular, SSAOs became very animated in both their verbal and non-verbal responses when the dynamic of persuasion, an element of the behavioral agreement process was raised. Senior Student Affairs Officer Tanya's comments were typical of her colleagues with regard to the importance of persuasion. She raised her voice with inflection and used her hands to demonstrate emphasis when she stated:

> Oh, It's huge! I need to build a level of trust so they trust me when I tell them, hey, you've got these issues and I don't view them as a fault, I believe you can work on these issues and we have a counseling center and it's free, it's part of your tuition, so take advantage of it, do it now!

While persuasion and its use in the initial meeting fall under the authority of the SSAO, the CCDs also displayed strong reactions on the importance of persuasion in the behavioral agreement process. The CCD Colleen best summarized this collective sentiment on persuasion:

> Honestly, I think the role of the dean (of students) is huge…it's really about that first meeting when she sits down with the student and she's giving the message that we care about you and that we want you to be successful here…she's telling them that she's worried about them. She's telling them, let's work on this together.

I conclude that the initial meeting which takes place between the SSAO and the student is the initial starting place for the behavioral agreement. This meeting not only becomes a very personalized conversation, it also serves to both develop a strategy in how to proceed. At the same time, the meeting serves to develop a personal bond between the SSAO and the student. The additional conclusion reached is that persuasion is a critical factor involved in creating a behavioral agreement that will result in both the successful outcome of behavioral change and the elimination of problematic behavior which is disruptive to the greater community.

The second common element in behavioral agreements is the establishment of behavioral limits and greater community expectations. Another conclusion of this study is that small institutions utilize behavioral agreements to establish behavioral limits in the context of greater community expectations with student who they place under behavioral agreements. As Deisinger et al. (2008) pointed out one of the main purposes of the behavioral agreement is to:

> Get the person to agree to engage in certain behaviors (e.g., attend class regularly) and agree to stop performing certain behaviors (e.g., classroom disruption) or both—in exchange for something the person wants, such as to continue enrollment or maintain a position. (p. 73)

The limitations of undesirable behavior which may be disruptive to both academic and non-academic environments on the campus are recommended as a strong element of the behavioral agreement (Amada, 1994, 2001; Pavela, 2007; Van Brunt & Ebbeling, 2009). Emphasis is placed on behavioral limits as a means both to enforce code of conduct expectations as well as safeguard the greater campus community from disruptive behavior (Amada, 2001; Dannells, 1990; Dannells & Consolvo, 2000; Stone & Lucas,

1994). One can further conclude that the establishment of behavioral limitations within the agreement serves a dual process: the management of student mental health concerns and the consistent enforcement of the institution's behavioral code of conduct. One can further conclude that these expectations, which are put into writing, establish absolute clarification of behavioral limits, such that, students cannot claim that they were not aware of, nor that they did not perceive that they would be held accountable to the specific behavioral limitations set forth in the agreement. The SSAO Tanya's comments were typical of her SSAO colleagues when she described the importance of these written expectations:

> I would make the student read every word of the agreement aloud to me…it's very important to me…it made me feel that the student was really internalizing all of the elements of the agreement and that they understood what they were agreeing to do.

As Deisinger et al. (2008) stated behavioral agreements often involve an exchange of some sort, in which the student is agreeing to behavioral limitations in exchange for his or her continued enrollment at the institution. I conclude that this "carrot and stick" approach is utilized within the established behavioral limitations of the agreement. Thus, the student who does not concur with the expectations placed upon them, risk being disenrolled at the institution. This point is consistently clarified in both the sample behavioral agreement letter which the institutions provided for this study as well as the consistent comments made on this subject by the SSAOs. The SSAO Lisa's comments summarized this approach when she stated, "The steps are made clear in the written agreement that if you do not follow these directives, your registration as a student can be jeopardized."

The third common element in behavioral agreements is the use of mandated psychological assessment when there is suspicion that underlying mental health concerns may be a contributing variable to behavioral problems. The SSAOs and CCDs utilize mandated psychological assessment in cases where underlying mental health concerns are strongly suspected to be the cause of a behavioral problem. This assessment is also used to determine psychological treatment recommendations for the individual student. As I discussed earlier in this dissertation, mandated *assessment* differs greatly from mandated *psychotherapy*. While the assessment may include several sessions with a campus psychologist, I conclude that these sessions are not considered to be psychotherapy; rather, they are used to create a psychological profile for the SSAO which will help further determine a course of action. I conclude that the actual enforcement of these treatment recommendations is inconsistent at small institutions. Further defined, some small institutions actively enforce such recommendations, while others take a voluntary approach which relies on the student's own actions, to enter into psychological treatment. This latter approach also relies strongly on the aforementioned principle of personal persuasion, such that the urgency of such treatment is "strongly recommended" by the SSAO as he or she addresses the student. Thus, I conclude that there is variance in the actual use of mandated psychological assessments within the behavioral agreement process at small institutions. In addition, the consistent exception to this variance is found in self-harm situations in which small institutions mandate several psychotherapy sessions, as part of the mandated assessment, to further evaluate the psychological condition of the student who has exhibited self-harming behavior. At the conclusion of

these mandated sessions, one again arrives at the same point of variance with either the enforced or voluntary approaches to treatment.

I conclude that SSAOs rely heavily on the CCD's clinical expertise in both reaching a psychological diagnosis and providing treatment recommendations for the student. The SSAOs consistently expressed their lack of clinical expertise when it came to proper diagnosis; therefore, SSAOs depend on the CCD and their professional experience as psychological clinicians, to provide a psychological profile of the student. SSAO Lisa's comments were typical of her colleagues on the importance of the CCD's clinical judgment when she stated, "As student affairs officers, we are not trained to make clinical judgments, I lean to Vicky (her CCD) to have that knowledge…her professional opinion is very important in determining how we will proceed." The recognition of the CCD's expertise as playing a pivotal role in the behavioral agreement process is also discussed within the literature as a recommended practice (Amada, 1994, 2001; Kiracoffe & Wells, 2007; Pavela, 2007; Van Brunt & Ebbeling, 2009).

The fourth common element found in behavioral agreements is the requirement of a signed release which permits information sharing between the psychologist and the SSAO. Whether the student in a behavioral agreement participates in mandated psychological assessment or treatment, I conclude that the SSAO *requires* the student to sign a release of information so that the psychologist who is assessing or treating the student can openly communicate with the SSAO about the student's attendance, and possibly his or her mental health diagnosis of the student. Since psychotherapy is a process which is governed by both professional ethics and laws of confidentiality

(Amada, 2001; Gilbert & Sheilman, 1995; Kiracoffe & Wells, 2007; Stone & Archer, 1998), a psychologist must have the student client's written permission to be able to speak with designated individuals (such as the SSAO). If the SSAO is to establish an enforceable behavioral agreement, he or she must, in turn, have confirmation that the student is attending the required therapy sessions. Thus, the signed release allows for such attendance to be verified. The most significant conclusion is that such a release is required, not recommended, within the behavioral agreement process. Such a stance is contradictory to the ethical principles of the psychology profession which views the signed release as a completely voluntary process on the part of the client (Amada, 1994, 2001; Boyd et al., 2003; Gilbert & Sheilman, 1995), and, as such, the client "has the freedom to give or withdraw their consent at any time for any reason" (Kiracoffe & Wells, 2007, p. 62). The findings consistently demonstrated the signed release as a requirement and not a recommended or voluntary action within the behavioral agreement process. Furthermore, I conclude that the SSAOs consistently utilize the signed release for one purpose—to verify attendance in required sessions. I further conclude that SSAOs safeguard protections of client confidentiality by not requesting specific information on the content of the psychological sessions. In addition, SSAOs make a conscious effort to communicate these specific limitations of the release with the student as part of the behavioral agreement process. The SSAO Tanya's perspective was typical of this approach:

> I don't want to know what they are talking about, but I want to know if they're in compliance with the agreement…It's fascinating to me how much students just assume that we're talking about them all the time and

> that I have all the details about their deep personal experiences…All I want to know is that they're going.

I conclude that this approach of limiting the information is utilized for two reasons. First, it serves to create a level of comfort for the student so that the specific information shared in the psychotherapy process will be kept in confidence between the therapist and the student. Second, it serves to gain the student's permission as a "willful" participant in the signed release process. One can argue that such actions, on the part of the SSAO, may create the illusion of full participation by the student since it is truly a requirement and not a voluntary option within the behavioral agreement. On the other hand, one could also argue that by regulating themselves to having only attendance verification, SSAOs are actually upholding the ethical principles of the psychology profession by not demanding to know the actual content discussed within therapy sessions. Thus, I further conclude that SSAOs practice self-regulation by limiting themselves to verification of attendance as the sole element of the signed release.

The Unique Elements Practiced in Behavioral Agreements Are Not Actually Unique; Rather, They are Terminological Differences Which Describe the Same Process

While all of the small institutions in this study utilized behavioral agreements both to manage student mental health concerns and minimize threats to campus communities, two of the institutions framed their behavioral agreement process around unique terminology. This terminology consisted of two approaches. The first was a Commitment to Treatment strategy and the second was a Wellness Board Commitment of Care approach. As I further examined the specifics of each approach, I conclude that the

various elements of each are not, in fact, unique; rather, these approaches are a different way of "packaging" the same behavioral agreement process under the guise of unique terminology. The behavioral agreement process and its various steps (e.g., initial meeting, mandated psychological assessment, and mandated or voluntary psychological treatment) remain the same. Both the SSAOs and CCDs at these two institutions seemed convinced that their approaches were not behavioral agreements, per se; instead, they felt their approaches offered an alternative to the traditional behavioral agreement model which is practiced at other small institutions. SSAO Tanya demonstrated the sentiment she held for her campus' different approach:

> We use a commitment to treatment approach; so, it's not a behavioral agreement. It's not that a student promises not to this or that, it's an actual commitment to psychological treatment. In our process, the student is acknowledging that their life is important and that their disruptive behavior is affecting their life and the lives of others around them. They understand that in order to be able to stay at Institution C, they have to commit to this treatment plan. They are saying that they are making a commitment to their own life, that they are making a commitment to their own health…We also make it very clear that if they don't follow this treatment plan, we can then intervene.

This same approach, utilizing different language, was also practiced by Institution F. There, SSAO Lisa, who had became so overwhelmed by the time demands needed to manage rising mental health situations, created a Wellness Board to provide leadership to the management of all student mental health concerns. This board which is composed of several student affairs offices examined every student mental health situation and designed action plans, in the form of commitment of care letters. Lisa was adamant in her perspective that her campus' commitment of care approach was different than traditional behavioral agreements. She demonstrated this point when she commented,

“We don’t give mandates, we give directives.” While one could argue that *mandates* and *directives* both describe *required action,* the specific steps involved in each care letter are exactly the same as other institutions’ behavioral agreement letters. There is one truly unique element within Institution F’s approach—a director of student care. This position which is very new within American higher education is a full-time case manager, housed within the division of student affairs, who actively manages each student mental health case (Van Brunt, 2009; Van Brunt & Ebbeling, 2009). The scarcity of this position on a national level may be due in part to two reasons. First, student affairs divisions like other institutional departments must compete for scarce resources. This resource dynamic is most probably further intensified in the current national economic climate. Second, possibly due to this financial reality, the SSAO has remained the gatekeeper of student mental health concerns as part of his or her greater portfolio of student crisis management responsibilities (Barr & Desler, 2000; Barr & Sandeen, 2006; Zdziarski, Dunkel, & Rollo, 2007). SSAO Lisa offered an explanation of the responsibilities of her director of student care when she stated:

> I needed someone who would make sure that the releases were signed and that would follow-up with the counselor to make sure that the student was keeping their appointments and doing what they were supposed to do, like following the counselor’s directives.

While the use of a mental health case manager as a staff member within a student affairs organization remains a concept which is still developing on a national level, I would conclude that the approaches chosen by the aforementioned institutions are not unique approaches to student behavioral agreements. Instead, these approaches are using different language to describe the same concept. I would also conclude that while the

university officers may *feel* they are practicing a unique approach, they are simply labeling the same actions steps with different language.

While Mandated Assessment is a Common Practice within Behavioral Agreements, Mandated Psychotherapy Remains Highly Controversial and Results in Tension Between SSAOs and CCDs

While mandated psychological assessments may be a common practice in behavioral agreements, the enforcement of the treatment recommendations which result from the assessment is another matter. Such treatment involves mandating continued psychotherapy within the behavioral agreement. It is here that I found great controversy amongst the SSAOs and CCDs. On the one hand, CCDs held firm to the ethical principles of the psychology profession which viewed mandating treatment as both unethical and/or completely unproductive in achieving behavioral change. While SSAOs feared litigation as a result of mandating psychotherapy, they also viewed its use as a means both to help the student and minimize behavior that may be disruptive or potentially threatening to the campus community. These distinct viewpoints are also widely represented in the literature (Amada, 1994; 2001; Archer & Cooper, 1998; Boyd et al., 2003; Gilbert & Sheilman, 1995; Kiracoffe & Wells, 2007; Kitzrow, 2003; Pollard, 1995, 2001). As a result of the findings of this study, I further conclude that small institutions vary in their actual enforcement of mandated psychotherapy as part of the behavioral agreement. These different approaches are captured in two distinct groups. The first finds the SSAO mandating the treatment recommendations as part of the behavioral agreement. The second finds the SSAO *strongly urging* the student to follow

such recommendations; thus, there is no requirement that continued psychotherapy which results from the psychological assessment *must* be followed by the student in order to fulfill the conditions of the agreement. The SSAO Tanya's comments summarized the perspective of the mandated treatment recommendation group:

> I wait for the recommendations from Donald (her CCD) and I then amend the agreement so the student now understands that they must follow these treatment recommendations. It's usually something like they are going to see a therapist twice per month and get an evaluation from a psychiatrist, to consider if they should be taking medication for their condition.

The non-enforcement group, however, viewed such a practice as unethical, if not illegal, in the behavioral agreement process. This group advocated for psychotherapy as a chosen process which is not mandated for the student. Furthermore, they viewed the enforcement approach as typical of behavioral agreements in the past and whose validity was no longer acceptable within the modern legal environment. The requirement of psychological treatment and the consequences which institutions may pursue for non-compliance have become a "hot button issue" for many legal scholars, who warn that institutions may be unduly creating *special duty* in such approaches (Bickel & Lake, 1999; Henning, 2007; Kitzrow, 2003; Mealear, 2003). From a legal perspective, a *special relationship* may be an unintended result. This relationship then serves to further establish a *legal duty* to prevent harm (Baker, 2005; Blanchard, 2007; Bower, 2007; Pavela, 2006; Wolnick, 2007). Therefore, while an institution may have the best of intentions in helping students with their mental health condition through the use of mandated treatment, this practice could act to also create an undue burden of psychological care on the institution and as a result, leave the institution vulnerable to

possible litigation. This is due, in part, to the possibility of self-injurious behavior on the part of the student and/or the possible violation of the student's civil rights (Baker, 2005; Bickel & Lake, 1999; Blanchard, 2007; Bower, 2007). This former point of possible injury or death by possible suicide was a topic of national attention in the *Shin v. MIT* case (Baker, 2005; Blanchard, 2007; Pavela, 2006; Wolnick, 2007). As was evident in the findings, many of the SSAOs and CCDs within the non-mandated treatment group were well aware of this legal case and they made direct reference to it in their justification for not mandating psychological treatment.

The SSAO Sally explained this perspective of the non-enforcement group:

> It used to be the case that if it was determined that a student had to follow treatment recommendations, that would be in the behavioral agreement and, if they didn't follow the treatment plan, they couldn't be at the institution. Now, that has all changed. We cannot mandate treatment per the law, the law has changed and our practices have changed with it. Now, we really rely on persuasion, you know, something like, we really, really think you should take a voluntary leave and here's why and this is why we really, really think you should do this. So, we don't ever say you must follow the treatment plan. We can and do mandate assessments, but not the recommendations.

While SSAOs and CCDs demonstrate mutual respect for each others' perspectives, CCDs harbor strong feelings around some mandated practices. While the findings revealed the SSAOs and CCDs to have a mutual respect for each other and their respective roles, the CCDs harbored feelings of frustration and resentment toward the SSAO when it came to mandated psychological practices which directly involved the campus counseling center. These shared feelings represented both inherent power dynamics within the supervisory relationship between SSAO and CCD as well as a reluctant acceptance on the part of CCDs to accept mandated practices. I conclude that

CCDs take one of two stances when it comes to mandated psychological practices. The first finds the CCD not only voicing opposition, but also harboring feelings of resentment about such a decision. The second finds the CCD expressing a more subdued form of concern which then results in them "letting go" of any feelings of possible resentment. In either case, there is an acceptance, whether reluctant or not, on the part of the CCD to accept their supervisor's decision. Such acceptance demonstrates the CCD's understanding of organizational structure which finds them below the SSAO in the administrative hierarchy. The viewpoint which harbored feelings of caution within the supervisory relationship was demonstrated by CCD Mary's comments:

> I know my place in the pecking order of hierarchy around here. I will say my peace and I will voice my objection and it's happened…I always keep in mind that I have a different perspective, the clinical perspective and I see the world in those terms especially when it come to mandated therapy…I put everything in writing…I want to have it documented that I didn't agree, but I always acquiesce…It's her (SSAO) call and I have to respect that…I mean, what choice do I really have?

The supervisory relationship as a power issue is also referenced in the literature. Gilbert and Sheilman (1995) describe such an issue as directly contributing to the CCD feeling "pressure to accept mandated referrals for psychological treatment" (p. 17). Amada (2001) expanded further on the power dynamic of the SSAO-CCD relationship when he stated, "Some psychotherapists undertake mandated therapy…even when they have ethical objections to this practice…when administrators authoritatively insist that students be seen, the psychotherapist who refuses to comply may be placing themselves and their program in jeopardy" (p. 111). I conclude that while SSAOs and CCDs may come to a general understanding of mandated psychological practices on their campuses,

there is a deeper resentment held on the part of the CCD about such practices. I further conclude that CCDs do not refuse to carry out such practices due to the fear that such opposition could put their jobs in jeopardy.

A Truly Unique Element in the Behavioral Agreement Process is the Use of Student Affairs Staff Members to Serve as Follow-Up Facilitators When Psychological Treatment is not Mandated

One critical element of all behavioral agreements is the need for active follow-up. Such agreements create specific action steps and each one requires both verification and monitoring of the required actions set forth upon the student. In particular, the actual personal counseling offered to the student, whether voluntary or mandated, requires on-going management by someone at the institution. The lack of proper follow-up in managing continual student psychological care was a major conclusion reached in the post-Virginia Tech literature (Chesbrough et al., 2008; Leavitt, Gonzalez, & Spellings, 2007; Massengill et al., 2007). While the literature acknowledged an overburdened campus mental health system as a national problem (Amada, 2001; Boyd et al., 2003; Cooper, 2005; Draper et al., 2002), tragedies such as the Virginia Tech incident unfortunately awaken us to the reality that institutions must do *something* to actively monitor and/or engage students of concern (Flynn & Heitzman, 2008; Foley, 2008).

Institution D enacted such an approach which proved unique to the behavioral agreement process. Institution D's SSAO chose not to pursue mandated psychotherapy with some students; rather, she chose to create required weekly or semi-monthly

meetings as an action step within the behavioral agreement. As Institution D's SSAO Barbara further explained:

> Sometimes, you have students that you know would benefit from counseling but they are just not motivated to be in therapy, they're just not going to make the commitment to it. In those cases, I have some of my professional staff meet with the student on a regular basis. I mean, these are really check-in meetings, where the student just sits down and talks with my staff member about what's going on with them, you know, how they are doing in classes and what they do with their time when they are not in class.

Barbara described the goal of this check-in process as a means to get students to better understand the psychotherapy process in a manner where they become comfortable with the concept to the point that they will voluntarily enter into psychotherapy. As she described it:

> The staff member builds a personal rapport with the student during their regular meetings and they talk about therapy with the student as something that they can consider. It's not uncommon for the student to make their first appointment with our counseling center after a few meetings with my staff. It's great because you don't have to mandate it, the student is choosing to begin therapy on their own. When that happens, I feel we have really achieved a good outcome.

The concept of utilizing this check-in process between a designated student affairs staff member and a student is advocated as a viable alternative to mandated psychotherapy (Van Brunt, 2009; Van Brunt & Ebbeling, 2009; Wilcox, 2010). Van Brunt and Ebbeling describe this approach in their Aggression and Management Education Program (AMEP) model in which the behavioral agreement requires regular meetings with a member of the student affairs staff. Their model consists of ten meetings which begin with the facilitation of the personal relationship. This meeting continuum then progresses to active discussions on psychotherapy and culminates with the student

voluntarily taking action to enter into psychotherapy. If the student chooses psychotherapy earlier in the ten meeting cycle, the required meetings with the student affairs staff member continue until its required completion. The personal realization that one can benefit from psychotherapy and more importantly, be ready to engage in behavioral change, are key concepts in behavioral change theory (Prochaska, 1999; Prochaska & DiClemente, 1984; Prochaska & Norcross, 2001; Stone & Archer, 1998; Wampold, 2001). Pollard (2001) pointed to the importance of the personal choice in pursuing therapy and behavioral change when he stated, "Attempts to assist clients to change before they have successfully negotiated the appropriate stage for change to occur will result in failure" (p. 66).

I conclude that the role of the check-in person also serves to adhere to the ethical standards of the psychology profession, which strongly views psychotherapy as a voluntary process which should not be forced upon a student (Amada, 1994, 2001; Archer & Cooper, 1998; Boyd et al., 2003; Gilbert & Sheilman, 1995; Kiracoffe & Wells, 2007; Van Brunt & Ebbeling, 2009). Furthermore, I conclude that by utilizing this check-in role, the SSAO achieves two additional outcomes. First, the SSAO avoids a direct conflict with the CCD who may object to the use of mandated psychotherapy within the campus counseling center. Second, the SSAO creates a system of follow-up in which the institution is engaging with the student on a regular, personal basis. In other words, the institution is *doing something* to try and help the student rather than performing no follow-up at all.

The Manifestation of Student Mental Health Concerns is a Strong Consideration for SSAOs in the Student Conduct Process

The findings revealed SSAOs and CCDs to be in two distinct groups with relation to student mental health concerns and their consideration in the student conduct process. While one group viewed the violation of conduct regulations as indicative of invoking the student conduct process regardless of mental health concerns, the other group exhibited strong empathy and careful consideration of mental health conditions as a contributing variable to student misconduct. I conclude that both groups, regardless of their decision to pursue judicial action or not, demonstrated some level of empathy and compassion in how they proceeded. While the literature clearly demonstrated that the manifestation of mental health concerns is not an excuse for disruptive behavior (Amada, 1994; 2001; Munch & Shapansky, 2003; Pollard, 1995; 2001; Stone & Archer, 1998), it also points to levels of sensitivity and empathy in order to arrive at an appropriate response (Belch & Marshak, 2006; Van Brunt & Ebbeling, 2009; Wilcox, 2010). The CCD Bruce nicely summarized this latter viewpoint when he shared:

> When there are conduct violations, that's something for the conduct people to decide. If there's conduct that they have become aware of, there's probably some value in the conduct people responding to the behavior. I think good conduct people will go over the greater background and that might include the student's mental health issues. Good conduct people will use tact and empathy in deciding how to hold the student accountable.

I conclude that as SSAOs and CCDs analyze behavioral reports, they begin to assemble a picture of the student which may reveal greater mental health issues as a contributing variable to his or her misconduct. While SSAOs and CCDs do not ignore

such infractions nor do they view them as excuses for misconduct, they purposefully pause and consult with one another in order to decide the best course of action. I further conclude that the SSAO-CCD consultation may result in the finding that judicial action may exacerbate the mental health condition and thus the judicial process is not appropriate for some individual cases. Belch and Marshak (2006) speak to this conclusion when they described violations as "a manifestation of an illness rather than willful misconduct" (p. 472).

Campus Threat Assessment Teams Have Become the Most Practiced Method in Managing Threatening Situations

This study confirmed that the use of campus threat assessment teams was the most common practice utilized by small institutions both to analyze threatening behavior as well as to develop specific actions plans to minimize threats to campus communities. I conclude that these teams have developed on two distinct levels with unique chairperson roles found in each. First, a student team analyzes threatening behavior which is posed by students only. While this particular team is built around a core of student affairs staff members (e.g., residence life, counseling center, dean of students) and includes both public safety and legal counsel, the actual chairperson varies from the most common (the SSAO) to the less common (the CCD or Director of Student Concerns). Second, the campus threat assessment team is much broader in scope in that it analyzes all threatening behavior which may be posed by any faculty, staff, or student on the campus. Only the SSAO and CCD are found on this particular team. In addition, representatives from human resources as well as faculty governance groups are also found in this

configuration. Unlike the student team which is chaired by a professional student affairs staff member, the campus team is chaired by either public safety or legal counsel. The use of these multi-disciplinary teams has been strongly recommended in the wake of the shootings at both Virginia Tech and Northern Illinois University (Angle et al., 2007; Leavitt, Gonzalez, & Spellings, 2007; Massengill et al., 2007). As the U.S. Department of Education (2008) stated, "The department encourages…the establishment of a university threat assessment team to manage student situations which may pose a threat" (p. 74389). Furthermore, many states have since enacted laws which mandate the use of such teams within institutions located within the state (McGinn, Raymond, & Henning, 2007; Office of the Governor of Illinois, 2008; Rasmussen & Johnson, 2008). In the timeframe immediately following the Virginia Tech tragedy, much national discussion focused on the confusion that university officials may have had with regard to the legal parameters surrounding FERPA (The Federal Educational Rights and Privacy Act of 1974). As a result of this study, I conclude that such confusion no longer exists amongst SSAOs or CCDs; rather, they clearly understand their legal right both to discuss and analyze threatening behavior as a means to protect their respective campus communities. The SSAO Barbara's comments nicely summarized this point when she shared, "I think on a national level, we now understand that FERPA doesn't ban us from talking to each other…I can't imagine that anyone doesn't understand that, especially after Virginia Tech."

While the formalization of threat assessment teams has now become standard practice at small institutions, I further conclude that their use at these institutions existed

in a much less formalized manner in the era prior to both the Virginia Tech and Northern Illinois University shootings. This conclusion directly contradicts much of the literature which viewed such a practice as not occurring in the past, due to confusion over FERPA (Angle et al., 2007; Bova, Cornell, & Groth, 2007; McGinn, Raymond, & Henning, 2007; Rasmussen & Johnson, 2008). The SSAOs with longevity in their campus positions consistently spoke to this point within the findings. For example, SSAO Tanya summarized this past practice:

> You know, I was kind of surprised when after the Virginia Tech shootings, everyone was talking about how we couldn't share information and stuff like that…Donald (her CCD) and I met with Public Safety and that goes back many years, and we always felt comfortable just talking about students that were on our radar screen…it was just very informal, you know, something we didn't necessarily talk about with everyone on campus, but it was there.

There is variance in both the frequency of student threat assessment meetings as well as the use of anonymous reporting mechanisms. Two additional conclusions arise from this study. First, some members of student threat assessment teams are dissatisfied with the low frequency of such meetings. Second, the use of anonymous mechanisms to report threatening behavior is not consistently practiced among small institutions. While the findings revealed the majority of institutions to have regularly scheduled student threat assessment team meetings, it also revealed irregularity within some institutions. I conclude that such irregularity is not only a point of frustration held by some team members, it also speaks to the desire to develop such meetings on a more frequent, formalized basis regardless of whether there are actual concerns to discuss or not. Counseling Center Director Colleen nicely summarized these sentiments:

> I just think it makes sense to have us meet on a regular schedule, that we're all putting this meeting on our schedules…we have plenty of student situations to talk about and if we met more frequently, I just think it would be a good thing for everyone.

While the use of an anonymous reporting mechanism has been strongly recommended as an effective practice to minimize potentially threatening situations (Bova, Cornell, & Groth, 2007; Dunkle, Silverstein, & Warner, 2008; Leavitt, Gonzalez, & Spellings, 2007; Sokolow, 2007), very few small institutions in this study have implemented such a system as part of their campus threat assessment protocols. While some institutions have implemented partial anonymity in their reporting mechanisms, complete anonymity has yet to be realized as a threat assessment practice at small institutions. As a result of the findings, I conclude that SSAOs desire a completely anonymous reporting mechanism as a means to more fully capture information on threatening behavior that would not normally come to them by a community member who may be afraid to come forward with such information. As SSAO Jane shared, "It's not completely confidential, I mean, there is no guarantee that the submitter of the report is going to be anonymous…and, I admit, that's a concern for me."

The Lack of Evaluation of Policies and Procedures and a Desire to Formalize Such Procedures

One of the most revealing findings of this study was the consistent lack of evaluation procedures with regard to behavioral agreements and threat assessment policies. The SSAOs and CCDs were very candid and forthcoming about the lack of such procedures on their respective campuses. Furthermore, they expressed general dissatisfaction with the absence of such procedures. The importance of assessment

procedures within student affairs has been described as a way to "analyze mistakes, failures, and miscues" (Zdziaraski, Dunkel, & Rollo, 2007, p. 118). Sandeen and Barr (2006) also reiterated this need for assessment within student affairs organizations:

> Student affairs staff deal with critical issues that affect the lives and the educational success of students…Assessment may be the best way to ensure a strong educational and ethical commitment to quality services and programs in student affairs. (p. 144)

As a result of the findings, I conclude that SSAOs and CCDs are not only dissatisfied with the absence of assessment procedures, they also desire such procedures to be formally implemented on their campuses. While they acknowledged informal discussions of such procedures amongst their student affairs colleagues, they felt such discussions failed to offer the formal level of assessment necessary in determining if such policies and procedures were actually successful in both managing student mental health concerns and minimizing threats to their respective campus communities. They consistently expressed a shared sense of relief at the conclusion of such student situations to the point that when they were resolved, they simply moved on without actively evaluating their actions. Senior Student Affairs Officer Barbara nicely summarized this perspective when she shared:

> I think there's just some feeling of we survived it! We survived mentally, kind of working through this kind of mental gymnastics involved in persuading, of taking the student into getting help…or just caring for the greater community and then, it's like, we're done and we just want to move on!

I conclude that the time commitment as well as the level of energy involved in managing such situations when they arise cause SSAOs and CCDs to simply "breathe a sigh of relief" that such situations are over. Thus, the extra step required to actually

evaluate their efforts does not take place due to the additional time and effort required to formally do so. I further conclude that while SSAOs and CCDs jointly acknowledge the lack of such procedures, they also strongly desire to create more formal evaluation procedures.

I have presented and discussed eight major conclusions drawn from this research study. These conclusions offer valuable insight into how SSAOs and CCDs view behavioral agreements as student affairs practitioners. Having discussed these eight conclusions, I now turn my attention to how these conclusions offer implications for professional practice.

Implications for Practice

> I think it will be interesting to see what happens with the professional preparation programs. I think behavioral agreements is a subject that we could use a lot more study in…I haven't seriously engaged in this subject in a long time and yet, we're all using them to try and manage all of the mental health situations on our campuses.

This statement from one of the SSAOs places not only emphasis on the future of professional preparation programs in student affairs, it also acknowledges that while behavioral agreements are a common practice amongst student affairs professionals, very few studies exist which examine their effectiveness in managing student mental health. Based on the findings from this study, several implications exist for future practice. In this section, I discuss these implications, particularly as they pertain to various stakeholder groups.

Implications for Institutional Leadership

Based on the conclusions of this study, five implications for practice are relevant to institutional leadership: a) establishing pre-matriculation mental health histories of incoming students, b) an examination of counseling/student ratios in campus counseling centers, c) establishing agreements with local mental health providers which provides coverage under student insurance policies, d) publishing behavioral agreement procedures within the institution's student policies, and e) reviewing legal aspects of the required actions set forth in behavioral agreements which act to guide university officials on practices which are both accepted and supported by the institution.

The findings of this study revealed a consistent desire to establish the pre-matriculation mental health histories of incoming students in order to provide support to them as they entered the institution. This desire is due in part to the mounting evidence that more students are entering college with previously diagnosed and treated mental health conditions (Arehart-Treichel, 2002; Barry, 2002; Becker et al., 2002; Clemetson, 2006; Eudaly, 2003; Magna-Zito et al., 2007; Sax et al., 2000). University officers wish to take proactive steps to continue appropriate treatment for incoming students that will not only allow them to be successful at the institution but will also avoid disruptive behavior that could result by the discontinuation of such treatment. Amongst the many pieces of information which institutions gather from incoming students, health information is established for the purposes of enrollment in the required student health insurance policy as well as appropriate support from existing institutional services (e.g., disability services); thus, questions seeking information on health history and needs

should include questions about both physical and mental health. If such voluntary information produces previous mental health diagnosis and treatment, the admission office should provide this information to the SSAO and CCD. The CCD will then make contact incoming students to determine their plans for continuation of their treatment once they enter the institution. If the appropriate release forms are in place (e.g., FERPA release), such communication may also include the student's parents. The CCD will consult with the student on not only the services offered within the campus counseling center, but also the availability of private mental health providers which are covered under the student's health insurance benefits. This conversation which includes the agreed-upon treatment plan should be documented in a student file which is kept within the campus counseling center. By establishing this treatment plan, the institution accomplishes several desired outcomes. First, it demonstrates a level of personal care and commitment to incoming students and their family which further establishes a partnership between the institution and the student. Second, it is taking proactive measures to best insure both the personal and academic success of the student. Third, while not a guarantee that the student will follow such a treatment plan once matriculated, the institution is at least establishing and documenting a treatment plan which has been discussed by its officials. If disruptive behavior occurs, the institution can point to the proactive efforts made to intervene prior to the student's arrival on campus.

The second implication for institutions is an examination of campus counseling staff-student ratios. As was discussed in the previous chapters, concerns about over-burdened campus counseling centers and low counselor/student ratios have become a

reality for many institutions as they manage student mental issues (Boyd et al., 2000; Carter & Winesman, 2003; Cooper & Archer, 2002; Levin-Epstein, 2007; Soet & Sevig, 2006; Voelker, 2006). This reality, combined with recent legal proceedings (e.g., *Shin v. MIT*) which found institutions paying large sums of money for injurious liability, should be given careful consideration by institutional leadership. Recommended counselor/ student ratios (Cooper, 2005; Ghallager, 2005, 2006, 2007) should be compared to the actual ratios which are now in place at the institution's counselor center. The increase in campus psychological staff is fundamentally a financial resource issue which must be weighed against other institutional priorities; however, institutional leadership cannot ignore the national legal precedent which has been established as a result of not only the *Shin v. MIT* case, but also the unfortunate tragedies which occurred at Virginia Tech and Northern Illinois University. If institutional leadership decides not to increase its psychological staff, it runs the risk of large financial implications resulting from the self-injurious behavior of student clients and/or their possible violent actions against members of the university community. Once institutional leadership has established current counselor/student ratios, they should actively consult with both the SSAO and CCD to gain their professional insight into recommended ratios which offer the best protection against foreseeable danger.

Since the financial realities of institutional budgets may not allow for lower counselor/student ratios, institutions must examine their student health insurance policies such that mental health benefits are part of the overall coverage of their policy. This benefit should provide coverage with local mental health providers that will allow for

continued psychological treatment for the student. Even with lowered counselor/student ratios, many campus counseling centers must practice short-term counseling models for student clients (Belch & Marshak, 2006; Benton & Benton, 2006; Cooper, 2005; Kitzrow, 2003); therefore, the establishment of both mental health coverage as well as agreements in place to provide such services by private mental health providers which are near the campus are actions which the institution can implement to best avoid possible litigation as well as threatening behavior which could endanger its campus community.

In addition to the financial consideration of increasing campus psychological staff, institutions should also consider the possibility of hiring a full-time case manager to provider oversight to its student mental health caseload. As was discussed in Chapter IV, the case manager position is still very much in its infancy within American higher education; nonetheless, its use has begun on a national level due in part to the rising caseloads of student mental health which are being experienced on the nation's college campuses. Furthermore, the findings of this study confirmed the impressions of the considerable time and energy that SSAOs are experiencing in trying to manage more complex and severe student mental health concerns (Belch & Marshak, 2006; Kadison & DiGeronimo, 2004; Kitzrow, 2003; Rasmussen & Stokes, 2008; Stokes, 2007). By establishing a case manager position, the institution not only consolidates the management of such concerns under one designated university official, it also affords the SSAO the opportunity to provide leadership to other critical areas within the student affairs portfolio (e.g., student life/student activities, health services, multicultural affairs, etc.). As is the case with both increases in campus psychological staff and a campus case

manager, the allocation of financial resources as a result of budgetary priorities ultimately rests with university leadership.

An examination of this study's institutional sample revealed that only one of the six institutions discussed the use of behavioral agreements in its published policies. This finding was applicable to both hard copy as well as on-line information. Since institutions are utilizing behavioral agreements as a common tool both to manage student mental health concerns as well as disruptive behavior, they should, at a minimum, publish the logic behind such agreements as well as the basic elements in them to students and their families. I would recommend the following language to be used to explain the logic involved in the usage of such agreements:

> When a student's behavior is either in violation of the campus code of conduct and/or is determined by the Dean of Students to be disruptive to the functioning of the university, the Dean of Students may place the student in a behavioral agreement. This agreement establishes action steps with which the student must comply in order to remain enrolled at the university. Such action steps may include, but are not limited to, an appropriate psychological assessment and/or treatment in order to insure the student's personal success and avoid further disruptive behavior.

Dependent on the institution's protocol involved in its student conduct process, further language may be added that is inclusive of additional action steps. These may include: required meetings with a student affairs staff member, completion of educational assignments (e.g., a reflection paper), or a judicial review of the student's behavior. By openly discussing the use of behavioral agreements in policies, incoming students and their families, who frequently review such policies both prior and during the enrollment process, are made aware of why and how behavioral agreements are utilized as part of the student conduct process. When the institution chooses not to publish information on its

use of behavioral agreements, it gives two unfortunate impressions. First, students and their families may be confused and/or resentful of a process which is not known to them, but also places the student under considerable responsibility in which their non-compliance could result in disenrollment at the institution. Second, the non-disclosure of behavioral agreements may send the impression that the institution is deliberately hiding a practice that could be unethical or illegal. Thus, one could argue that by not openly discussing behavioral agreements, the institution may open itself up to a legal challenge by its students and their families.

Since the decision by the institution to utilize behavioral agreements involves both institutional and individual student rights and responsibilities, a thorough legal review of such a practice should be, at the direction of university leadership, conducted and disseminated to student affairs leadership by the institution's legal counsel. This review should give clear direction on which action steps can be legally pursued and defended by the university should litigation be pursued by any student. For example, as was discussed in previous chapters, some institutions choose to mandate the treatment recommendations of the mandated psychological assessment as part of the behavioral agreement. Legal counsel should give clear definition to whether such action is allowed on the SSAO's part. Thus, this legal review is critical to both the SSAO and CCD in determining what action steps are within their right to mandate within the behavior agreement process. Not only does such a review provide legal protection for the institution, it also gives needed clarity to the university officers who create and implement such agreements on behalf of the institution.

Implications for Graduate Program Directors and Deans

The findings of this study also revealed implications for graduate coursework within higher education/student affairs. Specific courses which cover college student mental health and/or counseling should review and discuss behavioral agreements as a tool which is utilized by student affairs professionals to manage student mental health concerns and disruptive behavior. Since the findings revealed behavioral agreements to be a common practice within the student affairs profession, graduate students should not only familiar with the purpose and common steps of such agreements, they should also have a knowledge base which allows them to execute behavioral agreements in a professional student affairs position. This knowledge base can then be further specialized under the direction of the SSAO within the context of the institution's student conduct and mental health protocols. This curriculum should include the common steps mentioned in previous chapters, such as: the initial meeting between the student and the SSAO, the establishment of behavioral limits which comply with community standards of conduct, signed releases of information, the use of mandated psychological assessment, and the possibility of mandating psychological treatment. Such coursework can utilize two pedagogical methods to review behavioral agreements. First, case studies and discussion can be used to determine how and why behavioral agreements can be appropriately utilized to manage student mental health as well as minimize threatening behavior. Second, SSAOs at local institutions can be invited as guest speakers to discuss real-life scenarios they have encountered when designing and implementing behavioral agreements within their respective campus communities. In light of the national attention

resulting from the Virginia Tech and Northern Illinois University tragedies as well as the growing impressions of student mental health as a pressing issue within the student affairs profession, coursework which discusses and analyzes behavioral agreements is very timely in response to a national trend on the nation's college campuses.

While the findings of this study found variance in whether institutions mandate psychological treatment as part of behavioral agreements, the use of persuasion and its importance as a skill amongst SSAOs became very apparent. Student affairs practitioners' ability to establish relationships with students which not only allow them to discuss highly personal matters but also afford them the opportunity to persuade a student to take voluntary action, such as entering into psychotherapy in order to address behavioral concerns, is a skill which proves very valuable in the creation of successful behavioral agreements. As was discussed in Chapter IV, mandating psychological treatment is a highly controversial practice which not only creates tension with campus psychological professionals, it may present legal challenges with individual rights; therefore, if student affairs professionals can learn and master the interpersonal skill of persuasion and adapt this skill in their professional practice, they are not only to able obtain voluntary compliance with psychotherapy which offers the best chance for engagement on the part of the student, they are also respecting the ethical principles of their psychological colleagues who view voluntary student action as the most acceptable way to conduct therapy. Furthermore, I would argue that the curricular emphasis on persuasion may also have the long-term effect of producing student affairs practitioners who view voluntary treatment as the most ethical and logical means to structure

psychotherapy within behavioral agreements. This long-term effect could then result in the eradication of the current tension which exists between SSAOs and CCDs around mandated psychological treatment in behavioral agreements. In addition, student affairs professionals, particularly those in entry level positions (e.g., residence hall directors) utilize the skill of persuasion not only in student discipline, but also within their supervisory work with resident advisors and their advisory capacity with student leaders. The ability to persuade students within these various professional responsibilities also has great merit in achieving desired outcomes with student populations.

Implications for SSAOs

The findings and resulting conclusions of this study offer several valuable implications for SSAOs and their use of behavioral agreements. While some institutions may utilize different terminology not only to establish a philosophical foundation for their approach to behavioral agreements but also to differentiate their professional practice from their institutional peers, both the common elements as well as the desired outcomes of the behavioral agreement remain the same. In addition, as I discovered in assessing the current literature base on behavioral agreements, very little scholarly review has been published in this area. In order both to create a more unified approach to behavioral agreements which is representative of its purpose and desired outcomes as well as to create more public transparency about behavioral agreements as a common practice within higher education, SSAOs should attempt to utilize common terminology within behavioral agreements. This approach serves two specific purposes. First, student affairs practitioners begin to speak a "common language" when it comes to behavioral

agreements, thus, when they seek to examine their usage of these agreements on their individual campus, they can discuss various elements with their colleagues in a manner that is not confusing due to terminological differences. Second, as scholars attempt to further study behavioral agreements, the use of common terminology also allows them to easily find and analyze these agreements for scholarly purposes. If SSAOs wish to take a philosophical stance with regard to behavioral agreements, they should create a separate philosophy statement which is reflective of the rationale and purpose of such agreements. This statement can be published in both public documents (e.g., student code of conduct) as well as internal protocols.

The use of signed releases of consent was not only utilized by SSAOs within behavioral agreements, their use was a required and not a voluntary action on the part of the student held to the agreement. As was discussed in previous chapters, this requirement directly conflicts with the voluntary stance which is taken by the psychological profession with regard to signed releases (Amada, 1994, 2001; Kiracoffe & Wells, 2007; Pollard, 1995; Stone & Archer, 1998); nonetheless, its use is necessary in order for SSAOs to know both the outcomes of mandated psychological assessments and, in some cases, the verification of attendance with mandated treatment. The reality of this requirement should be reflected in two ways by the SSAO. First, he/she must make sure that the signed release requirement is part of the published regulations on behavioral agreements. These regulations must be consistent in both hard copy as well as on-line versions of such policy. Second, SSAOs must communicate this expectation directly to their CCD. The CCD should know up front that the signed release is necessary in order

to move forward with a behavioral agreement which is established by the SSAO. The CCD also should also feel comfortable in immediately communicating the possible denial of such permission by the student to the SSAO in particular cases. This communication allows the SSAO to then reconsider the behavioral agreement all together. Without such knowledge, the SSAO assumes that such permission has been granted and that the behavioral agreement is moving forward as planned.

The findings of this study further revealed a sense of self-regulation on the part of SSAOs when it came to limiting themselves to the actual information revealed within the signed release. These limits concerned two specific elements—psychological diagnosis and verification of attendance. These self-imposed limits amount to good practice amongst SSAOs for three reasons. First, the SSAO respects the sensitivity involved in the confidential matters discussed between therapist and student client. By not expanding the signed release to include the revelations of such content, the SSAO is upholding a sacred principle within the psychology profession which views such discussions as highly confidential. Second, a level of personal comfort is created for the students since they know that the issues discussed within the therapy process will be kept in confidence between themselves and the therapist. Third, by honoring the content of therapy sessions as strictly confidential, the SSAO actually facilitates a more successful therapeutic experience which may find the student more willing to personally engage with the therapist since he/she knows the matters discussed will be kept in strictest confidence.

The use of mandated psychological assessment was found to be a common practice within the findings of this study. However, mandated *treatment*

recommendations which turn into mandated *treatment requirements* were found to be a completely different topic in which SSAOs and CCDs exhibited strong opinions both in favor and against such requirements within the behavioral agreement. If the SSAO's intention to use the results of mandated psychological assessment as a means to require the student to enter into mandated therapy, SSAOs must clearly communicate this expectation to their CCD prior to ordering the assessment. This requires a purposeful conversation between the SSAO and CCD in which both parties can express their ethical concerns and desired outcomes about the mandated assessment. While the SSAO may believe that mandated therapy will result in more effective management of a student's mental health and the possible minimization of disruptive behavior, he/she should also be open to the concern brought forth by the CCD about the use of such a method. In particular cases in which the student is exhibiting psychotic behavior that is highly disruptive to the greater campus community, the SSAO must effectively advocate for the usage of mandated assessment as well as mandated therapy as appropriate management responses with the CCD. Such a task is neither easy nor comfortable for either party. It requires the SSAO to both establish and communicate a consistent rationale for such utilization with the CCD. In addition, the SSAO bears the responsibility of communicating such a policy within the institution's written code of student conduct or publicized mental health protocols.

The findings of this study further confirmed the debate between the psychological and student affairs communities about mandated psychological treatment in which psychological professionals adhere to the ethical standards of the client voluntary

entering into the therapeutic process (Boyd et al., 2003; Kiracoffe & Wells, 2007; Stone & Archer, 1998). SSAOs, on the other hand, viewed mandated therapy sometimes acceptable in managing both student mental health concerns as well as minimizing threatening behavior (Dannells & Consolvo, 2000; Deisinger et al., 2008; Ghallager, 2006, 2007; Van Brunt, 2009). As a result of this study's findings, I find merit in both sides of this debate; however, I firmly believe that extreme mental health situations in which students are exhibiting psychosis that is severely impairing their ability to function and/or is highly disruptive or threatening to a campus community, justifies the use of mandated psychotherapy as a management tool. In the wake of the Virginia Tech and Northern Illinois shootings, much national scrutiny was placed on institutions in what they actually do to try to both manage and minimize such devastating behavior. Institutions vest their authority and accountability in the SSAO to decide upon actions which offer the best protection against similar tragedies occurring on their campuses. Therefore, SSAOs should utilize mandated psychotherapy in very select situations in which they establish a threshold for its appropriate use. Specific factors must be met in order to pursue mandated psychotherapy and/or psychiatric treatment. These factors include: extreme psychosis which clearly indicates a chronic mental health condition, behavior which is highly disruptive to the functioning of the university, and the manifestation of mental health issues which directly results in behavior that is threatening to any member of the university community. These threshold conditions must be openly discussed with the CCD and must be captured in written form within the institution's policies and procedures. Furthermore, as was previously discussed in institutional

recommendations, legal counsel must give its blessing to such a practice as a legally defensible method within the behavioral agreement process.

In cases where such a threshold is not met as well as situations where the CCD believes the student is not ready to fully engage in the psychotherapy, the SSAO should strongly consider the use of staff as *check-in facilitators* within the behavioral agreement. This particular practice has been advocated for mental health situations in which students are resistant to therapy due to their uncomfortable feelings about its use and/or their non-awareness of their own mental health condition (Van Brunt, 2009; Van Brunt & Ebbeling, 2009; Wilcox, 2010). Van Brunt's educational programming model calls for a series of several meetings with a staff member in order to build a personal relationship with the student of concern. As these meetings progress, the subject of psychotherapy is discussed with the student; however, there is not an expectation that student will seek out psychotherapy as a result of the meetings. Rather, the focus is "to address concerning behavior through a fixed number of educational meetings" (p. 2). I recommend a new outcome in which the focus of these meetings is not on simply discussing concerning behavior, but is based around a final outcome of having the student voluntarily enter into psychotherapy. As each meeting progresses from the initial establishment of the relationship between the student and the facilitator to one of comfort and trust, the facilitator discusses psychotherapy as a process which is beneficial to the student in both addressing his or her behavior as well as personal development.

Senior Student Affairs Officers should recruit facilitators not only within their own divisions of student affairs, but also in the greater student services areas which exist

on their campuses. The SSAO must seek out staff members who have a professional preparation background in counseling. Some staff members outside of student affairs may also have this skill set. The SSAOs should call for staff who both have such skills and who are interested in participation as a *student intervention facilitator.* I would also encourage the participation of staff members who have personally engaged in and benefited from therapy in their own personal lives. Such personal experience adds a level of credibility which may translate into more effective persuasion between facilitator and student. Once this group has been established, the SSAO and CCD should prepare a thorough training program required for all student intervention facilitators. This training program should take place at periods within the academic calendar that are less busy (e.g., end of each semester). Based in part on Van Brunt's eight-meeting mandated educational programming model (2009), each of the eight meetings required between the student and the facilitator will be discussed in both expected content and personal delivery style. Unlike Van Brunt's model, emphasis is placed on the discussion of psychotherapy by the second or third meeting. In addition, the SSAO and CCD establish the common goal of the student voluntarily seeking treatment as a consistent expectation of the mandated meetings. While there is no guarantee that voluntary psychotherapy will directly result from the meetings, I believe this approach offers the best chance for such an outcome.

The use of student intervention facilitators serves several purposes. First, there is a system put in place in which purposeful interaction occurs between the university and the student of concern. Should the student engage in threatening behavior, the institution

can demonstrate its concerted efforts to consistently engage the student in the consideration of psychotherapy. Second, the SSAO upholds the principle of voluntary treatment which is held as an ethical standard within the psychology profession. Thus, SSAOs reduce tension that could exist between themselves and the CCD over the use of mandated psychotherapy. Third, the SSAO utilizes a network of staff who both have counseling skills and who desire to engage with students on a personal level. Fourth, by including more staff to attend to students of concern, the SSAO is lessening the caseload on an already-burdened counseling center. Thus, the counseling center is able to concentrate its efforts on students who desire to be in therapy and not those who are forced to be there against their will.

The findings of this study also stimulate several recommendations with regard to current threat assessment practices. Unlike the national impressions which found confusion over FERPA amongst university officials, this study confirmed a clear understanding about information sharing as it related to threat assessment practices. The more revealing issues were confusion over disability law and the use of behavioral agreements to address threatening behavior if the student had declared his or her mental health condition as a documented disability. While the SSAOs and CCDs seemed to understand that threatening behavior is not tolerated under current disability law, they expressed hesitation and concerns about potential litigation. As was suggested in the institutional recommendations section of this chapter, I strongly urge all SSAOs to seek out their institutional legal counsel for a review of their current behavioral agreement practices in relation to state and national disability law regulations.

Senior Student Affairs Officers revealed worries about students of concern who do not "appear on the radar screen." As was revealed in the findings, students with an inward focus who tend to be isolated or withdrawn, also known as *disturbed* students (Delworth, 1989), cause SSAOs great concern. They worry that not only is their behavior not known to them, it may be silent behavior that may cause the greatest tragedy on their campus. In addition, while the threat assessment literature strongly recommended the use of anonymous reporting mechanisms for the very purpose of capturing such behavior (Bova, Cornell, & Groth, 2007; Fein, Vossekuil, & Holden, 2002; Leavitt, Gonzalez, & Spellings, 2007; Massengill et al., 2007; Verlinden, Hersen, & Thomas, 2000), the lack of such mechanisms were evident within the study's institutional sample. Therefore, SSAOs should work to establish anonymous reporting mechanisms as part of their overall threat assessment efforts. The establishment of such a mechanism offers the best possible method to capture and report threatening behavior by those who not only observe such behavior but also may be afraid to report it due to their fear of retaliation on the part of the identified student. While there is no guarantee that all threatening behavior whether anonymous or identified will be reported to campus officials, the added level of anonymity at least allows for information to be both be known and investigated for probable cause.

The findings also revealed concerns about the lack of consistent Student Threat Assessment Team (STAT) meetings. I suggest that SSAOs schedule regular STAT meetings through the academic year. Many divisions of student affairs conduct regular staff meetings. Since this day/time is already held on most staff members' calendars, the

SSAO can utilize the weeks in which such meetings are not held as the standing meeting for the STAT. During these meetings, all staff members should openly discuss students of concern and their current actions to address threatening behavior. The SSAO should insure accurate record-keeping of each case by taking notes which are later transcribed to a spreadsheet which lists the students discussed as well as current actions being employed by staff. These spreadsheets should be created with columns that reflect the following items: Name of student, type of concerning behavior, interaction with staff member, current actions being taken (which include a behavioral agreement), and a final column which indicates resolution to the situation. These spreadsheets should be archived annually and kept within the dean of student's office.

The use of evaluation procedures which examine threat assessment policy was also found to be consistently absent within the study's findings. Not only did the SSAOs and CCDs readily admit the lack of such procedures, they also expressed a consistent desire to implement evaluation procedures. The SSAO should take leadership in creating more formal evaluation procedures as they relate to both behavioral agreements and current threat assessment protocols. Since the findings demonstrated that there is a heightened sense of activity around the management of student mental health situations and threatening behavior, SSAOs should declare two periods at the end of each academic semester in which the STAT gathers to formally discuss the students of concerns from the preceding semester. In these discussions, each situation should be discussed and an analysis of the effectiveness of the actions taken should be discussed and recorded in writing. These discussions should focus on three questions. First, if the action taken was

a behavioral agreement, were the specific elements useful in helping students address their behavior and/or mental health condition? If not, what other action steps could have been considered or added to offer better assistance to the student? Second, were the threat assessment actions taken helpful in minimizing threatening behavior? If not, does the STAT have suggestions of additional steps that could have been taken to minimize such behavior? Third, how did each situation directly impact the staff who managed the situation? In now looking back on the situation, could additional actions have been taken to reduce the professional or emotional burden on the staff? The written records of these evaluations should be strongly considered by the SSAO as he/she continues to revise and develop campus threat assessment protocols. In addition, the evaluation results can be presented and discussed with the Campus Threat Assessment Team (CTAT). Such discussions not only make this team aware of such efforts, they may also serve to inform the practices of this group in creating more effective campus threat assessment policy. Finally, SSAOs should consider the use of a threat assessment expert as part of their evaluation procedures. Since the Virginia Tech and Northern Illinois University shootings, several threat assessment experts have become prominent on a national level due to their writings and models on effective threat assessment protocols (Bova, Cornell, & Groth, 2007; Cornell et al., 2007; Sokolow, 2007). The findings of this study found two institutions had entered into contractual relationships with such experts for the purposes of training and evaluating their current threat assessment protocols. If the SSAO has the financial resources within his/her budget, the use of such experts may provide a valuable and objective opinion in the evaluation process.

Implications for CCDs

This study's findings further reveal several implications for CCDs. As they perform mandated psychological assessments, CCDs should be aware that such assessments may lead to such recommendations being mandated by their SSAO. While such assessments have become commonplace at many institutions nationwide (Ghallager, 2006, 2007; Kiracoffe & Wells, 2007), their use by the SSAO in determining mandated psychotherapy represents a new reality for some CCDs. The CCD should seek clarification from their SSAO if such assessments will ultimately determine mandated psychotherapy as part of a behavioral agreement. If, as was demonstrated by some of the findings in this study, the SSAO believes that the assessment does, in fact, justify mandated psychotherapy, the CCD should present other variables for further consideration by the SSAO in each individual case. These variables may include: the determination that the student is not ready to actively engage in therapy, the disturbing behavior is not the direct result of the manifestation of a mental health condition, or by mandating therapy, the SSAO could actually further exacerbate the disruptive behavior presented by the student. Since the study's findings demonstrated the importance in which SSAOs place on the clinical expertise of their CCDs, the CCD has a credible level of professional influence that he/she should exert with the SSAO. If the SSAO ultimately still chooses mandated therapy, the CCD should also closely monitor the progress of the student's mandated therapy. If the CCD can provide data which prove this decision to not be productive in addressing the student's behavior, the CCD should in turn, present

these findings to the SSAO as a means to influence future consideration of mandated assessment for the purpose of mandated therapy.

While CCDs may object to the use of mandated therapy on ethical grounds, they must also realize the environment in which they are practicing psychology. In more simple terms, if a psychologist *chooses* to work at a university, he or she is, in fact, *accepting* the realities of this particular work environment in which mandated psychotherapy may be a chosen method to both manage serious mental health conditions as well as minimize threatening behavior. Even if the psychologist chose to practice his or her profession in the private sector, he/she could encounter the same set of circumstances. Several scholars have pointed to one such example by the legal system's wide-spread use of mandated psychotherapy as an educational alternative to incarceration (Deisinger et al., 2008; Pollard, 1995; Van Brunt, 2009). As Pollard stated, "The call to university officials, including counseling center personnel, is to simply make the same connection" (p. 48). Thus, campus psychologists must accept the reality of mandated student clients as a significant part of a campus' overall efforts to manage student mental health and minimize threatening behavior. In turn, if the SSAO adopts the practices of both a threshold of determination for the use of mandated therapy as well as the use of student intervention facilitators as I have suggested in an earlier part of this dissertation, campus psychologists are engaging in mandated psychotherapy on a very minimal level.

Since the acceptance of mandated psychotherapy may be a "difficult pill to swallow" for some CCDs and which, as this study's findings revealed, may also contribute to tension between the SSAO and CCD, I strongly encourage CCDs to pursue

two specific courses of action. First, the CCD should conduct a frank discussion with his or her SSAO on his/her philosophy on the use of mandated psychotherapy. This discussion serves to establish a clear understanding of how mandated psychotherapy can and will be used by the SSAO in specific student situations. This knowledge allows the CCD to communicate the SSAO's philosophy with the counseling center staff. While campus psychologists may not completely agree with such a philosophy, they will at least have an understanding of how and when it will be used within behavioral agreements. Second, the CCD should raise concerns about or objections to mandated psychotherapy in individual cases in which he/she strongly believes its use will prove to be non-productive with and/or damaging to the student client. As was evident in this study's findings, SSAOs purposefully seek out the clinical judgment of their CCD as they consider options in how to effectively manage the student of concern. While the SSAO may have expressed a philosophy on mandated psychotherapy, this does not mean that the CCD's clinical expertise cannot influence the SSAO's opinion; therefore, the CCD should exert his or her clinical influence within student cases where he/she strongly believes that mandated therapy is the wrong course of action. I also further recommend that the CCD be prepared to present alternative courses of action which still allow for the effective management of the particular student situation.

Since this study's findings also confirmed that student usage that is overburdening many campus counseling centers which results in limited counselor/student sessions (Cooper, 2005; Ghallager, 2006, 2007; Kadison & DiGeronimo, 2004; Kitzrow, 2003), the use of outside providers has become a modern necessity of college student mental

health. Therefore, CCDs should work to establish a network of local outside providers with whom they have a level of confidence in the delivery of mental health services to their students. Once a network of local providers has been established, the CCD should capitalize on this relationship by inviting these providers to participate in counseling center staff meetings. Since these providers may conduct therapy with many of the institution's students, they are to some degree, an extension of the campus counseling center; thus, it makes sense for these providers to have a more personal relationship with the institutional counseling center staff. The CCD could invite these therapists as guests to counseling center staff meetings. Two areas of interest can be discussed during these meetings. First, private therapists can discuss the general mental health patterns they perceive with the students that are sent to them as well as limitations imposed by legal parameters (e.g., signed releases of information). Second, the counseling center staff can discuss their expectations of private therapy and how it relates to managing behavior within the campus community. In order to mitigate the financial burden of such services to students, these providers should also be covered under the student insurance plans of the institution.

Another theme which emerged from this study's findings involved diagnoses of outside mental health providers. The CCDs expressed consistent concerns that some providers seem to rush to quick judgments about their students which were neither thorough nor indicative of the seriousness of the presenting mental health condition. When these frustrations occur, I encourage CCDs to not simply accept such outcomes, but to actively reach out to these providers to further explore how they arrived at these

particular diagnoses. Such a practice not only demonstrates professional responsibility, it also exhibits a strong sense of personal care for the student. By communicating with the private provider, the CCD is doing his or her best to provide the most effective mental health care plan that will insure success in managing students and their behavior.

Finally, in order to establish a successful student intervention facilitator model which was presented earlier in this chapter, the CCD and the counseling center staff must play a pivotal role in the training of these staff members. Since these facilitators will utilize counseling skills as they interact with students in the course of their mandated meetings, the CCD should create and deliver a comprehensive training program which discusses basic counseling expectations as well as limitations within such a model. The CCD should create a clear understanding amongst facilitators that some counseling issues are both beyond their particular skill set and need to be addressed by the campus psychological staff. The CCD should also present methods in which the facilitator can successfully discuss therapy in a manner that establishes a level of comfort with the student. The culmination of these efforts will then result in the student choosing therapy at which time, a "hand-off" occurs to the campus counseling center. Thus, the cycle of first addressing the student's behavior through the initial intervention meeting and ending with the student ultimately choosing therapy as a course of action is now complete.

As I have discussed here, the implications of this study have potentially far-reaching effects. In particular, the student intervention facilitator model adds a new dimension of professional practice to the current efforts within behavioral agreements. Such a model not only has the potential to have more students voluntarily seek therapy, it

also lessens the current tensions which exist between SSAO and CCDs around issues of mandated therapy as a behavioral management tool.

Recommendations for Future Research

This study has helped to fill a significant void in the literature on the use of behavioral agreements. By exploring the viewpoints of the two institutional officers who design and implement behavioral agreements, this study provides much needed data for a variety of stakeholders, including: institutions, graduate program administrators, and student affairs professionals. The subject of behavioral agreements remains widely uncovered within the current literature and further studies are needed to more thoroughly explore this practice in both managing student mental health and minimizing threats to campus communities. What follows are three suggested areas for further research that I have identified through the process of conducting my own analysis. When combined with the already existing literature on college student mental health and threat assessment, these areas will, I believe, provide a more comprehensive picture of behavioral agreements and their use within higher education.

Current Impressions of College Student Mental Health

While both the literature as well as the findings of this study confirm the anecdotal impressions of significant rises in both the complexity and severity of college student mental health, there exists a gap in actually establishing consistent empirical evidence of such claims. Therefore, I suggest that institutions strongly consider their participation in several national studies which are currently underway. These studies include the Active Minds project and the College Student Mental Health Initiative

through the Center for the Study of Higher Education at Pennsylvania State University. By actually following and measuring such increases, the establishment of such dramatic increases could be empirically proven as a national trend. Since this study also mirrored the growing impressions that incoming college students are arriving at their chosen campuses with an already-established mental health history, I would encourage a study which follows the efforts of campuses that actually gather such histories in the pre-matriculation stage. As was demonstrated by the findings of this study, student affairs officers desire to have such information before students actually enter their campus community. It would be particularly interesting to examine if these same officers view this process as effective in managing student mental health. Impressions of overburdened counseling centers and short-term counseling models have also received much attention in the current literature; however, the use of private providers to provide counseling services and the relationships they have with counseling centers have not received this attention. I would recommend studies which specifically examine both the relationship between counseling centers and mental health providers as well as the perceived effectiveness of private mental health providers in managing a campus' student mental health concerns.

Behavioral Agreements

This study acted to fill a void in the current literature on behavioral agreements. While it represents an effort to provide insight, there is much room for further study on behavioral agreements within higher education. This study was conducted with a small college sample and the results may be directly reflective of more highly personal

practices which can be achieved with small student populations. I suggest that a similar study be performed at large institutions to examine if the same results would be achieved. Larger institutions are more complex and the daily management of student mental health concerns as well as threat assessment may be conducted by student affairs staff who are not at the senior level (e.g., senior student affairs officer or counselor center director). Therefore, studies conducted at larger institutions in which student affairs officers actually devise and implement behavioral agreements could reveal further insights into the impressions of mid-level managers. Since this study revealed the use of non-counseling center staff in conducting mandated meetings with students as an alternative to mandated therapy, a study which examined the impressions of student intervention facilitators who conduct such meetings could prove to be very insightful. The use of mental health case manager as a student affairs position was also revealed in this study. While this practice is very new to higher education, its use appears to be growing. A study which examined the perspectives of these case managers in both managing student mental health as well as their efforts to try to minimize threatening behavior could prove to be very valuable.

Threat Assessment Protocols

Much national attention is now focused on what institutions are actually doing to minimize threat to their campus communities. Studies which thoroughly examine the varied efforts that institutions currently employ to manage threatening behavior are not only timely, they are very much needed in the current climate. While this study examined the now-common practice of threat assessment teams and their efforts to

address threatening behavior, there are undoubtedly unique approaches that exist within the higher education community which are not as common in scope. Therefore, I would encourage a study which first establishes the use of unique practices and then further examines these practices for their effectiveness in minimizing threatening behavior. Such data could prove to be highly valuable to current national practice. This study also discussed the lack of anonymous reporting mechanisms to report threatening behavior and suggested the implementation of such a mechanism within threat assessment protocols. A study which compared campuses where such mechanisms are in place to those where they are not in use could be very valuable in determining if anonymity measurably makes a difference in capturing more incidents of threatening behavior. These suggestions prove that there are many aspects of both behavioral agreements and threat assessment that can be further explored and added to the current knowledge base of such practices.

Final Comments

> There's always going to be students who need help but don't want it and they are going to act out in different ways…There's always going to be people who choose to manifest their emotional issues through socially unethical ways and we're going to do our best to mitigate that and hopefully we can do a better job but we're not going to stop it all.

This comment made by one of the CCDs in this study captures the sentiments of the current state of mental health on college campuses as well as the efforts being made to both manage mental health as well as to minimize campus violence. As I write these final comments, the nation has experienced two additional tragedies on college campuses with links to mental illness and violence. The first occurring two months ago when a

graduate student stabbed his dissertation advisor to death at Binghamton University. The second just occurred this past week when a faculty member shot and killed three of her colleagues after being denied academic tenure (Franke, 2010). As each year passes, it seems that we will continue to experience mental health situations which may pose deadly threats to our campus communities. It is critical that the behavioral methods and threat assessment protocols used in managing such situations be studied and discussed in the higher education community. While, as the CCD's comments reflected, there is no guarantee that we will be able to predict and stop every tragedy, we have a duty to discuss and explore the various methods that are being used to address such situations on the nation's college campuses.

This research has begun to examine these methods through the experiences of those who manage such situations on a daily basis. Their shared perspectives offer valuable insights to student affairs practitioners as they consider behavioral agreements as a tool to manage college student mental health and disturbing behavior. These same perspectives also provide valuable knowledge of threat assessment procedures and their effectiveness in minimizing threatening behavior. I challenge others interested in these topics to join me in further devising both qualitative and quantitative means to explore behavioral agreements and threat assessment procedures. As seen in this investigation, behavioral agreements have the potential to not only help students address their personal mental health; they may also act to significantly mitigate the potential for campus violence.

APPENDIX A

LETTER TO COOPERATING INSTITUTION

Date

Name
Title
Institution
Address

Dear Ethics Committee Chair,

I write to request authorization to conduct a study at your institution for my doctoral dissertation at Loyola University Chicago examining the use of behavioral agreements by student affairs administrators in managing student mental health concerns. My qualitative study seeks to a) clarify the expectations of your senior student affairs officer as well as your counseling center director in managing such a process b) explore the various types of behavioral agreements utilized to manage behavior that could pose a threat to a campus community, and c) explore if, and how, the expectations of these two student affairs officers align or differ.

My goal is to gain insight into this topic by interviewing pairs of senior student affairs officers (SSAO) and counseling center directors (CCD) at six different institutions.

The information gathered in interviews with the SSAO and CCD will only be used for the purpose of my research. The identity of your institution as well as those SSAOs and CCDs who volunteer to participate will not be revealed. The enclosed Synopsis of the Research Study will provide you with more detailed information.

I hope to speak with you in more detail about the process necessary to gain your ethics committee's approval of my study. Please contact me via e-mail at: d-geiger@sbcglobal.net . I look forward to hearing from you soon.

Sincerely,
Douglas A. Geiger
Email: d-geiger@sbcglobal.net
Phone: (312) 907-8199

APPENDIX B

SENIOR STUDENT AFFAIRS OFFICER INVITATION TO PARTICIPATE

Date

Name
Title
Address

Dear___________________________________,

I write to invite you to participate in a research study for my doctoral dissertation examining how and why senior student affairs officers (SSAOs) and counseling center directors (CCDs) manage potential threats to their campus community by students with mental health concerns through the use of behavioral agreements. As a doctoral student in the Higher Education program at Loyola University Chicago, I hope to identify the expectations that you, as the SSAO, have for this process as well as to gain insight into the various methods chosen to implement behavioral agreements in an attempt to minimize threats to the greater campus community.

In addition to interviewing six senior student affairs officers, I seek to interview six counseling center directors at the same institution to gain knowledge of experiences and expectations of the student behavioral agreement process. In order to fully compare and contrast these personal experiences, I ask that, should you decide to participate in this study, that you not discuss your participation with your counseling center director until after the interviews are completed. In return, I will ask the same of the participating counseling center directors. Participation in the study will involve an audio-taped interview lasting approximately 60-90 minutes. I will later transcribe the interviews and ask you to review the transcription for its accuracy. Furthermore, I will ask for a copy of your student handbook and any documents containing policies and procedures related to student behavioral agreements for the purpose of document analysis.

I will hold the data obtained from the interview in strict confidence, and you will be identified through the use of a pseudonym. Furthermore, all information related to your institutional identity will be removed prior to my analysis. No one at your institution will know of your involvement in the study should you decide to participate.

I have enclosed a synopsis of the research study for your review in making a decision to participate. I greatly appreciate your consideration. Please respond to me via e-mail at: d-geiger@sbcglobal.net if you would like to participate or if you have any questions. I will acknowledge your e-mail and am happy to contact you via phone to discuss the study in greater detail.

Sincerely,
Douglas A. Geiger
E-mail: d-geiger@sbcglobal.net
Phone: (312) 907-8199
Encl

APPENDIX C

COUNSELING CENTER DIRECTOR INVITATION TO PARTICIPATE

Date

Name
Title
Address

Dear___________________________________,

I write to invite you to participate in a research study for my doctoral dissertation examining how and why senior student affairs officers (SSAOs) and counseling center directors (CCDs) manage potential threats to their campus community by students with mental health concerns through the use of behavioral agreements. As a doctoral student in the Higher Education program at Loyola University Chicago, I hope to identify the expectations that you, as the CC D, have for this process as well as to gain insight into the various methods chosen to implement behavioral agreements in an attempt to minimize threats to the greater campus community.

In addition to interviewing six counseling center directors, I seek to interview six senior student affairs officers at the same institution to gain knowledge of similar and contrasting experiences and expectations of the student behavioral agreement process. In order to fully compare and contrast these personal experiences, I ask that, should you decide to participate in this study, that you not discuss your participation with your senior student affairs officer until after the interviews are completed. In return, I will ask the same of the participating senior student affairs officers. Participation in the study will involve an audio-taped interview lasting approximately 60 minutes. I will later transcribe the interviews and ask you to review the transcription for its accuracy. Furthermore, I will ask for a copy of your student handbook, and any documents containing policies and procedures related to student behavioral agreements for the purpose of document analysis.

Your decision to participate in my study does not, in any way, influence your employment at your institution. I will hold the data obtained from the interview in strict confidence, and you will be identified through the use of a pseudonym. Furthermore, all information related to your institutional identity will be removed prior to my analysis. No one at your institution will know of your involvement in the study should you decide to participate.

I have enclosed a synopsis of the research study for your review in making a decision to participate. I greatly appreciate your consideration. Please respond to me via e-mail at: d-geiger@sbcglobal.net if you would like to participate or if you have any questions. I will acknowledge your e-mail and am happy to contact you via phone to discuss the study in greater detail.

Sincerely,
Douglas A. Geiger
E-mail: d-geiger@sbcglobal.net
Phone: (312) 907-8199
Encl

APPENDIX D

SYNOPSIS OF THE RESEARCH STUDY

Synopsis of the Research Study:

The Use of Behavioral Agreements by Senior Student Affairs

Officers and Counseling Center Directors to Manage Student Mental Health Concerns

and Minimize Threatening Behavior.

Researcher Background

My name is Douglas Geiger and I am a Ph.D. Candidate in the program in Higher Education in the School of Education at Loyola University Chicago. I received a master's degree in Higher Education/Student Affairs from Michigan State University. I am currently the Dean of Students at Illinois Institute of Technology (IIT), where I serve as the university's senior student affairs officer.

Research Purposes

The recent tragedies at Virginia Tech and Northern Illinois University have made the management of student mental health concerns a major focus of national attention. While those of us who work in student affairs have noticed increases in both volume and severity of student mental health concerns on our campuses, much of American society remained unaware of such trends until these most recent tragedies and their coverage by the national media. It has been the senior student affairs officer and, in many cases, the combined efforts of counseling center directors, who are responsible for both managing such situations as well as minimizing threats of harm to their respective campus communities.

A review of the literature indicates that many student affairs units are utilizing campus care teams both to identify threatening student behavior as well as to recommend various options in managing such student situations. While the literature recommends various methods which can be utilized in framing student behavioral agreements, the specific reasons of how and why such methods are chosen by senior student affairs officers and counseling center directors remains largely underexplored. This study seeks to address this question by interviewing both of these student affairs officers in the context of their planning and implementation efforts involving the use of student behavioral agreements. It further seeks to compare and contrast the expectations that each of these officers hold for the behavioral agreement process in minimizing threats to campus communities.

Participant and Institutional Selection

The small (1,000-7,000 students), private institution serves as the institutional focus for this study. I seek to interview pairs of senior student affairs officers (SSAOs) and counseling center directors (CCDs) at the same institution for the purpose of comparing their respective responses. In order to preserve the genuineness of their responses, I am requesting that each respective officer not discuss his or her participation in the study prior to their personal interview.

Expectations of Participants

Consent to participate in this study is sought from both the institutional SSAO and CCD. Both participants are asked to meet separately with the researcher for a 60-90 minute interview which will be audio-taped for later transcription and returned to participants for their review. In addition, I will also analyze institutional documents (e.g., student handbook) which describe student conduct policy and procedures.

Potential Participant Benefits

This study offers a number of benefits to participants. First, both senior student affairs officers (SSAOs) and counseling center directors (CCDs) are provided a forum through which they can candidly express their experiences with the student behavioral agreement process. Second, both the SSAO and CCD will be making a valuable contribution to the existing professional literature which exists on behavioral agreements and college student mental health. By sharing their in-depth knowledge of this process, they are adding a new dimension to the already existing literature which focuses on successes and frustrations with behavioral agreement tools that are experienced daily in the field.

Potential Participant Risks and Ensuring Confidentiality

A potential risk could exist if any personally identifiable data are inadvertently revealed. In order to avoid such a risk, strict confidentiality of all records will be maintained and the names of study participants and institutions will be kept confidential with the consistent use of pseudonyms. During the study, the list of actual participant names will not be kept in the same location as the research data. This will be done to prevent a linkage between the two. All raw data, including transcripts, will be destroyed within one year following the completion of the study.

Treatment of Results

In order to further ensure the accuracy of the data collected, participants will be given the opportunity to review the transcript of their personal interview with the study researcher. In addition, a summary of the dissertation will be made available for any interested participants.

APPENDIX E

LETTER TO DECLINE OFFER TO PARTICIPATE

Date

Name
Title
Address

Dear______________________________,

Thank you for responding to my invitation to participate in a research study for my doctoral dissertation examining the use of behavioral agreements in managing student mental health concerns. Though your willingness to participate is greatly appreciated, I no longer need your participation at this time.

Please accept my personal appreciation of your willingness to help with my research project.

Sincerely,

Douglas A. Geiger
d-geiger@sbcglobal.net
Phone: (312) 907-8199

APPENDIX F

SIGNED CONSENT OF PARTICIPANTS

Project Title: The Use of Behavioral Agreements by Senior Student Affairs Officers and Counseling Center Directors to Manage Potential Threats of Harm to Campus Communities by Students with Mental Health Concerns

You are being asked to participate in a dissertation research project being conducted by Douglas Geiger, a doctoral student in the Higher Education program at Loyola University Chicago.

The purpose of this study is to examine how senior student affairs officers (SSAOs) and counseling center directors (CCDs) manage potential threats of harm to the campus community by students with mental health concerns through the use of behavioral agreements. The researcher will be conducting audio-taped interviews with 12 people (6 pairs of both SSAOs and CCDs) at six small, private universities. The interview will take place on the campus of participants and will take approximately 60 minutes of your personal time.

If you agree to participate, you will be asked questions about your professional background and expectations of the student behavioral agreement process. Since both SSAOs and CCDs from the same selected institution will participate in this study, I am requesting that you not discuss your participation with your institutional colleague prior to your personal interview. In order to further ensure confidentiality, your name and identity will not be used in the work; rather, pseudonyms will be used in all writings, publications, or presentations in order to fully protect your identity and that of your institution.

The interview is completely voluntary and you may refuse to answer any questions at any time or withdraw from participation completely without penalty. Furthermore, you may interrupt to ask questions concerning the research or research procedures at any time.

If you agree to participate, you will be adding to the body of knowledge about behavioral agreements and college student mental health.

If you have any questions about this research study, you may contact the researcher, Douglas Geiger at d-geiger@sbcglobal.net or the researcher's faculty advisor, Dr. Terry Williams of Loyola University at twillia@luc.edu. If you have questions about your rights as a research participant, you may contact Loyola University's Compliance Manager at (773) 508-2689.

Your signature below indicates your consent to participation in this research project.

____

Signature of Interviewee   Date

____

Signature of Investigator   Date

APPENDIX G

INTERVIEW PROTOCOL FOR SENIOR STUDENT AFFAIRS OFFICERS

A. Biographical Information (All of this information will be obtained via phone call or e-mail with the participating interviewee).

1. What is your current position at this institution?
2. What academic degrees do you hold?
3. What institutions granted your degrees?
4. Does student conduct management fall under your portfolio of job responsibilities?
5. How long have you been practicing student conduct management as part of your job responsibilities?

B. Identification of Student Mental Health Concerns and Possible Threat to the Campus Community

1. To what extend is student mental health a concern for you on your campus? Why?
2. In what ways is student mental health linked to specific student behavior that concern you?
3. Who on campus, beside yourself, is involved in analyzing situations which involve student mental health concerns?
4. What is the role of this/those other person (s) in responding to these issues?
5. What behavior lead you to believe that a student's conduct may pose a threat to your campus community?

C. Student Conduct and Behavioral Agreement Methods

1. If you determine that mental health concerns contribute to a violation of campus rules, in what ways might this influence how you choose to address the behavioral concerns?
2. Under what circumstances would you utilize a behavioral agreement in responding to the student misconduct?
3. Under what conditions do you collaborate with your colleagues in creating agreements? With whom?
4. What are some of the most common elements of such behavioral agreements?

D. The Use of Mandated Psychological Assessment and Psychotherapy

1. Under what conditions might you utilize mandated psychological assessment as a behavioral agreement tool? What role does your counseling center serve in this process?
2. Are there circumstances, when you might mandate psychotherapy as a part of a behavioral agreement? If so, what are they and how would you determine who could conduct the therapy?
3. What kinds of protections are in place for students who enter into behavioral agreements?
4. How might a student's own self-awareness of his or her mental health condition or ability to change behavior influence your approach with each student?

5. To what extent does your counseling center director support the use of behavioral agreements with students and if differences of opinion between yourself and the counseling center director arise, how are they addressed?

E. Effectiveness and Assessment of Behavioral Agreements

1. To what extent do you believe behavioral agreements are effective in minimizing threats to the campus community? Why?
2. What methods involved in behavioral agreements have both worked well and not worked well?
3. How are behavioral agreements assessed for their effectiveness and what role, if any, does the CCD serve in the assessment?
4. Looking ahead into the future, do you anticipate modifying your use of behavioral agreements? If yes, what changes might be made and why?
5. What other views do you have regarding how student mental health issues should be addressed in the months and year to come?

APPENDIX H

INTERVIEW PROTOCOL FOR COUNSELING CENTER DIRECTORS

A. Biographical Information (all of this information will be gathered prior to the interview, via a phone call or e-mail to the participating interviewee).

1. What is your current position at this institution?
2. What academic degrees do you hold?
3. What institutions granted your degrees?
4. Does student conduct management, as part of the delivery of campus counseling services, fall under your portfolio of job responsibilities? If so, how?
5. How long have you been involved in participating in providing counseling services, as part of student conduct management, in your job responsibilities?

B. Identification of Student Mental Health Concerns and Possible Threat to the Campus Community

1. To what extent is student mental health a concern for you on your campus? Why?
2. In what ways is student mental health linked to specific student behaviors that concern you?
3. Who on the campus, beside yourself, is involved in analyzing situations involving student mental health concerns?
4. What is the role of this/these other person (s) in responding to these issues involving student mental health concerns?
5. What behaviors lead you to believe that a student's conduct may post a threat to your campus community?

C. Student Conduct Management and Behavioral Agreement Methods

1. If you determine that mental health concerns contribute to a violation of campus rules, in what ways might this influence how you choose to address the behavioral concerns?
2. Under what circumstances would you utilize a behavioral agreement in responding to student misconduct?
3. Under what conditions do you collaborate with colleagues in creating behavioral agreements? With whom?
4. What are some of the most common elements of such behavioral agreements?

D. The Use of Mandated Psychological Assessment and Psychotherapy

1. Under what conditions might student conduct officer utilize mandated psychological assessment as a behavioral agreement tool? What role do you or your staff serve in this process?
2. Are there circumstances when a student conduct officer might mandate psychotherapy as part of a behavioral agreement? If so, what are they and how would you determine who would conduct the therapy?
3. What kinds of protections are in place for students who enter into behavioral agreements?
4. How might a student's own self-awareness of his or her mental health or ability to change behavior influence your approach with each student?

5. To what extent do you support the use of behavioral agreements with students and if differences of opinion between yourself and the SSAO arise, how are they addressed?

E. **Effectiveness and Assessment of Behavioral Agreements**?

1. To what extend do you believe behavioral agreements are effective in minimizing potential threats to the campus community? Why?
2. What methods involved in behavioral agreements have worked well and not worked well?
3. How are behavioral agreements assessed for their effectiveness and what role, if any, do you serve in this assessment?
4. Looking forward ahead into the future, do you anticipate modifying your use of behavioral agreements? If yes, what changes might be made and why?
5. What other views do you have regarding how student mental health issues should be addressed in months and year to come?

APPENDIX I

TRANSCRIBER CONFIDENTIALITY AGREEMENT

Transcriber Confidentiality Agreement

I,____, agree to transcribe the interview
(Insert Printed Name)

for the doctoral research of Douglas Geiger entitled, "How and Why Senior Student Affairs Officers and Counseling Center Directors Manage Potential Threats to the Campus Community by Students with Mental Health Concerns Through the Use of Behavioral Agreements." I will maintain strict confidentiality of the data files and transcripts. This includes, but is not limited to the following:

- I will not discuss them with anyone but the researcher.
- I will not share copies with anyone except the researcher.
- I agree to turn over all copies of the transcripts to the researcher at the conclusion of the contract.
- I will destroy the audio files I receive upon conclusion of the contract.

I have read and understand the information provided above.

____

Transcriber's Signature Date

____

Researcher's Signature Date

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The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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