I met with JD and his parents on 11/21/18 at the Baltimore Airport Marriot boardroom. We met first as a group for a half hour and then I met with JD alone for ninety minutes. I then met with JD and his father for another 15 minutes before concluding the assessment. JD requested to record the assessment and I recorded it as well.

Scope of assessment

My role, as hired by the College, began with a review of materials submitted from faculty, staff, the CARE team, campus psychological services, the inpatient treatment summary, and Dr. Cox's 11/14/18 evaluation. I then focused on conducting a violence risk assessment, exploring the potential risk of JD harming others. This is different from a mental health evaluation, which focuses more on diagnostic impressions and what type of care JD would need (e.g., inpatient, outpatient, medication).

The assessment centered on three main concerns:

1. JD's violent thoughts concerning participating in a school shooting, becoming a serial killer, killing himself, killing friends in a lab, and raping or assaulting women that he finds himself attracted to around campus.
2. JD's watching pornography with violent themes towards women around power/control, horror, and rape.
3. JD watching videos that depict gore and death, ISIS beheadings, and cartel assassinations.

First Impressions

In the week prior to my assessment, I spent five hours reviewing materials, talking with CARE team members, assessing social media, corresponding on over 50 emails, and reviewing records and the evaluation. My initial role was to augment the psychological assessment, given my experience with violence risk assessments and targeted violence.

The family was extremely cooperative, polite and engaging during our session together. JD's mother was understandably frustrated with the process so far and reported JD had no history of violence and that the OCD thoughts should not be seen as an indication of his potential for harming others. I praised the family for their willingness to work with me, and JD for seeking help for his thoughts and patiently working through the process.

JD was surprisingly insightful and articulate throughout the interview. He gave thoughtful and unguarded answers to questions in a consistent and forthcoming manner. His affect was appropriate throughout our meeting and he expressed reasonable concern for the severity of the situation. His answers seemed genuine and direct.

Violence Risk Assessment

When assessing the risk for targeted (planned, instrumental violence), my approach involves the use of a structured professional judgement (SPJ) model. A triage assessment (Pathways) was conducted as an initial review. This was followed by a non-clinical assessment of suicide risk (Suicide Wayfinder) and a complete Violence Risk Assessment (DarkFox). Summaries of these reports are found in the Appendix and attached PDF documents.

JD has shared some of his thoughts with a therapist and others in the hospital. These thoughts involve a direct threat against several of his friends at school. While the threat does contain a plan outlining how he would harm them, he is seeking treatment to not harm anyone. He does have intrusive thoughts of violence that I would characterize as violent fantasies, as are those related to his pornography and gore/death internet consumptions. There is some thought fixation on different groups he thinks about harming (e.g., people he is attracted to, his close friend, random people around campus), though these thoughts are disorganized, lacking a hardened focus and are separated from any desire to act. I would not characterize this as leakage, given the lack of any attack plan as well as a lack of a driven desire to cause harm. There is no evidence of last act behaviors or the creation of a legacy token (a manifesto or social media writing explaining a rationale for an attack).

There is no evidence of injustice collecting, feelings of persecution or deep grudges/ resentments. There is no evidence of negative writing. JD does have a history of some sporadic suicidal thoughts and superficial non-suicidal self-injury, but there are no reports of action steps, methods, or timing for suicide (mostly, he shares being sad and guilty following the intrusive violent thoughts). There is evidence of confused, odd, and troubling thoughts related to his OCD. JD shares a positive hope for the future and desires to return to school. He has not had a recent breakup of a relationship (he currently is very close friends with his ex-girlfriend Jordan). He appears to be very empathic to others and is disturbed by these intrusive thoughts. However, there are times that he seeks out pornography that very much has objectified themes.

JD was respectful and insightful during the interview and showed no defensiveness. He has several friends through his music (plays drums), and academics. He displays intense shame and remorse for his thoughts**,** shows tolerance for individual differences, and takes responsibility for his negative thoughts. Both JD and his parents deny any history of JD acting out violently or engaging in impulsive behavior. His current professors are extremely supportive and positive about his behavior and attitude in class. He and the family deny any access to weapons or guns. JD shares a history of playing more violent video games in high school, but he denies playing them now. There is no evidence of handling frustrations in an explosive manner. He reports minor drinking and occasional pot use**.** JD shares his use reduces the intrusive thoughts and improves his social anxiety.

JD has a history of mental health issues (social anxiety, depression, OCD, body dysmorphia) and is currently in treatment for the OCD, depression, and anxiety. He appears remorseful and lacks any oppositional attitudes. He did not demonstrate an entitled attitude about the outcome of the evaluation or his schoolwork. He has exceptional family support and is managing the stress of these events well. While the intrusive thoughts have been increasing for JD, his behavior seems to be consistent and non-violent at the college. There is no conduct history from the college.

Previous Concerns:

Prior to my assessment of JD, I raised several questions to Dr. Cox and Dr. Reid. I address these concerns here for clarity.

1. There was a discussion of past physical and verbal abusive behavior to JD's younger brother Chris. This appears to have been developmental sibling rivalry. Parents downplay the concern and there was no court or school involvement reported. JD agrees that the negative treatment of his brother was wrong, but not severe or

dangerous. He remains worried and remorseful that he has harmed his relationship with his brother and has been working on ways to improve this connection.

2. The violent intrusive thoughts related to harming his lab partners seem more directly related to other OCD symptoms and do not present a high risk of action. He has little history of impulsively acting out and sought help when these thoughts became more intense. JD has a long history of choosing coping mechanisms when feeling guilty, upset or overwhelmed by intrusive thoughts.

3. JD shared a history of watching gore, torture and murder videos on the internet. He talks of watching concerning videos of violent attacks and deaths (and example is www.bestgore.com). He appears to watch these more when upset or feeling shame. There remains a concern that the more he watches these, the more he will increase a tendency to objectify others and perhaps escalate his viewing to more novel and disturbing sites. Interestingly, JD denies liking scary movies, and it would be useful to further explore his triggers and rationale for watching these death/gore videos (perhaps related to punishing himself or wanting to be mood congruent with his feelings of disgust and shame around his intrusive thoughts).

4. The increase in porn consumption with escalating novelty and violent and horror themes. JD reports using porn with aggressive and/or degrading themes on daily basis for 1-2 hours. This porn use is separate from his watching of violent videos (he was very clear he does not masturbate to those). The hospital and his father have talked with JD and have installed blocking software for his technology. JD has been compliant with that course of action.

5. JD's shares his motivation for seeking therapy was to find help to reduce his intrusive, violent thoughts. This was a positive and mature step for him.

6. JD's father is from Myanmar. JD was born and raised in the U.S. and has traveled to Austria (his mother's nationality) and once to Myanmar. This travel seems positive for JD (he holds dual citizenship with the U.S. and Austria). This was originally a question I had based on the violence and civil war in Myanmar.

7. I explored more deeply JD's weapons access during the interview, there was no evidence of deception or guarding in his responses.

Protective factors

In any violence risk assessment, it is equally useful to explore both protective and risk factors. The following are protective factors for JD that help mitigate his risk.

- Successful academic progress and positive reports from professors.
- Supportive family system willing to work with the school and medical providers.
- Willingness to seek care and talk to others about his thoughts and concerns.
- Willingness to try medication to reduce symptoms.
- Willingness to allow cyber-blocking methods to be installed on phone and computer.
- Student and family deny access to weapons.

- Family and student report connections to multiple friends.
- Connection to music and drumming, involvement in December concert.
- Future desire to work with animals, long history of caring for birds and animals.
- Increased openness from his father to discuss mental health concerns in the family.

Recommendations

The following recommendations should be put into place to further support his positive momentum and treatment:

1. ***Weekly therapy appointments*** with a focus on:
    - Reducing intrusive thoughts of violence;
    - Increasing positive coping mechanisms (such as friends, talking to family, listening to music, engaging with his academics, caring for animals);
    - Reducing negative coping mechanisms (such as negative self-talk, watching violent and gory videos, self-injury through cutting);
    - Teaching harm reduction strategies for his porn watching related to the length of time and the movement towards more extreme torture and horror; and
    - Consultation with a specialist in porn addiction and offering additional harm reduction strategies around use (such as reducing the time of watching or the type of videos) in addition to cyber-locking mechanisms. (My concern here with only using these is their ability to be thwarted and the potential to increase the risk for JD to seek out other computers to watch blocked content). Another option would be a group treatment, or something like SLAA (Sex and Love Addicts Anonymous), though finding a group of younger people, or one that could more directly address pornography addiction would be helpful.
2. ***A signed release of information*** between his therapist and the counseling center at the College. Ideally, Dr. Reid or her designee could act as a liaison between JD's off-campus treatment and the CARE team. This will then require a release from the counseling center to update the CARE team. It may also be helpful for JD to meet on a regular basis with a staff member at the counseling center to offer additional support. This could be coordinated in a way that each of JD's treatment providers have areas they are working on with him to avoid overlap or mixed messages.
3. ***A case management meeting*** with parents, JD, Dr. Reid and Carla from the CARE team in early December to check on JD's progress and troubleshoot any problems that come up. I would suggest this occur a second time upon his return in January and again a month into the semester. This would be useful during high stress times as well or if new concerns need to be addressed. Ideally, if the campus had access to a case manager attached to the CARE team, this would be a more effective choice. If JD is receiving clinical care in two places, coordination of that care becomes essential to maintain clarity in treatment goals.
4. ***A follow up assessment*** in the spring semester. This could be done locally with one of our staff or could be an opportunity to train the CARE team on this process.

5. A referral and support from the ***ADA and/or disability services*** office. This could help support JD with his thoughts if they begin to impact his studies or if there is a need for additional accommodations. It would be helpful to work with his professors during his hospitalization to allow JD to complete his course work or obtain incompletes, allowing him to make up any missed work.

6. ***Debating the Tarasoff notification*** to those JD has thoughts of hurting. There were two main concerns when I first reviewed the case materials. The first was the three lab partners he was walking behind with a garden trowel and had thoughts of killing. The three students were not friends of JD and these thoughts seem more related to his intrusive thoughts with little evidence of a desire to act. There is little history showing impulsive action from JD and his willingness to talk about these thoughts immediately (at a high personal risk of hospitalization or separation from school) acts as a mitigating factor.

   The second concern was around Jordan, his ex-girlfriend who he remains attracted to and reports having had thoughts of killing or raping. JD considers her a close friend and the two had dated earlier in their freshman year. JD ended the relationship, citing "she was more into me than I was into her." They continue to be close friends, talking frequently and have begun a "friends with benefits" relationship. JD says he talks to her frequently about what has been going on and about his intrusive thoughts.

   At this stage, neither scenario would require a notification under Tarasoff. It would be useful to talk to JD to gauge his willingness to have a discussion with Jordan about his thoughts, with a person from the counseling staff and/or care team present to ensure 1) she knows what he has been thinking, 2) she is offered some resources and support if she needs it. Having this done voluntarily would help prevent a deterioration in his protective factors. In either case, there does not appear to be a likelihood of a high risk of him acting on these intrusive thoughts. A further safety step, however, would be ensuring his treatment providers are using a harm-reduction strategy to limit his pornography usage and reduce his exposure to death and gore videos.

Respectfully submitted,
Brian Van Brunt, Ed.D.