2019

# 2018 Fall Newsletter

Nova Southeastern University

# OFFICE OF SUICIDE & VIOLENCE PREVENTION

NOVA SOUTHEASTERN UNIVERSITY

**Quarterly Newsletter – Fall 2019**

***School Violence and Suicide***

In this issue:



Congratulations to Dr. Scott Poland on being awarded the Helping Parkland Heal Award from the City of Parkland for his work in the aftermath of the tragic shooting at Marjory Stoneman

## UPDATE TO SENATE BILL 2070

The Florida Department of Education and the Florida School Safety Center created a training this summer for all county school districts. This was in response to Senate Bill 2070, which requires all Florida county schools to have procedures in place to assess threats of violence towards others and threats of violence towards self. Dr. Poland from NSU and Dr. Cornell from the University of Virginia were selected to provide the three training sessions of four days each. The training sessions were conducted in the Orlando area to provide a central location for school personnel attending from every county in the state. The training outlines clear procedures for assessing threats of violence towards others and threats of violence towards self. It was emphasized that the vast majority of suicidal students have no thoughts of harming anyone but themselves. Research has found however that approximately 2/3 of school shooters were suicidal. Historically, suicide assessment instruments used in the schools have not included questions about homicidal thoughts. The training emphasized that all students believed to be suicidal should be asked whether they believed anyone else was responsible for their circumstances and whether or not they had any thoughts of harming others. If a suicidal student expresses an intent to harm someone else, then in addition to suicide assessment, a violence assessment procedure must be implemented.

UPCOMING PRESENTATIONS:

*"Suicide Prevention is Everyone's Business"* NSU Library on 9/26/19 at 2:00 pm, Dr. Poland

*"Psychiatric Emergencies: Relational Suicide Assessment and Involuntary Hospitalization"* 9/12/19 for medical students, Dr. Flemons

*"Approaches to Hypnosis and Psychotherapy"* Mexico & AZ, Dr. Flemons

*"Stress Management"* 10/31/19 for medical students, Dr. Flemons

*"Relational Suicide Assessment: Risks, Resources, and Possibilities for Safety"* 11/8/19, Dr. Flemons

# CYBERBULLYING AND SUICIDE

**Samantha M. Guy**

Over the past decade, incidences of cyber-bullying have almost doubled, as more individuals now have greater access to electronic devices (Cook, 2018). While traditional bullying typically takes the form of physical, verbal, or relational harm, like social exclusion, it can also occur indirectly, such as rumor spreading. Cyberbullying can be similarly defined with the addition that it includes the use of computers, cell phones, and other electronic devices as forms of contact (John et al., 2018). Whether via an online format or in person, bullying is bullying, and it involves threatening or mean acts of aggression designed to inflict harm towards another individual (Online Sense, 2017). Both acts refer to the repeated and willful harm of another individual that can have severe and lasting effects on the bully's target (Hinduja & Patchin, 2018).

According to the Cyberbullying Research Center (2018), approximately 1 out of 4 teens (21%) have reported being cyberbullied, and 1 out of 6 teens (13%) have admitted to being the perpetrator of cyberbullying. Although traditional bullying is still more common than cyberbullying, the most frequent forms of cyberbullying include hurtful comments and rumor spreading (Bullying Statistics, n.d.). With over 80% of teens having regular access to cellphones, this form of bullying does not discriminate between factors of race, ethnicity, or gender. Victims of cyberbullying are much less likely to report harmful acts and only 1 in 10 teens will inform their parents that they have been victimized. Additionally, fewer than 1 in 5 incidents of cyberbullying are reported to law enforcement (Cyberbullying Research Center, 2018). Although some states have taken action to formally criminalize cyberbullying, most have left this challenge for the schools to deal with, leaving them responsible for developing formal policies aimed at identifying behaviors and enacting disciplinary responses (Hinduja & Patchin, 2014; Cyberbullying Research Center, 2018).

One of the major distinguishing features of cyberbullying as compared to traditional forms of bullying is the extent to which an individual can be subjected to harm. In traditional bullying, occurrences usually take place in person. For youth, they often occur at or around school and during the day. Most often, acts of bullying are premeditated by the bully and reach a much smaller targeted audience (Lohman, 2012; Scully, Newhouse, Murray, & Bates, n.d.). Cyberbullying, however, can occur at any time and in any location. With greater access to the internet and through the use of handheld, mobile devices, bullies have the ability to reach their victims from almost anywhere in the world. In addition, these targeted individuals can be victimized and bullied at all hours of the day, receiving no respite from harmful attacks. Oftentimes, cyberbullying occurs anonymously and can also target and spread to a much larger and even possibly global audience (Lohman, 2012; Scully et al., n.d.). It can be done impulsively and is often extremely difficult or impossible to remove from public access (Feinberg & Robey, 2010).

While adverse impacts of bullying have long been recognized, recent studies have begun to demonstrate an association between cyberbullying and self-harm or suicidal behavior (John et al., 2018). Bullying is often associated with a variety of mental health problems, including self-harm, suicidal ideation and behaviors, depression, and anxiety (John et al., 2018). These impacts of bullying have also been found to be associated with cyberbullying, and many of these health issues are often mediated through traditional bullying (John et al., 2018). Studies have found that over 85% of individuals involved in cyberbullying are also involved in traditional bullying (John et al., 2018). In 2018, John et al. conducted the largest meta-analysis to systematically review the association between cyberbullying and suicidal behaviors or self-harm. A total of 20 studies, covering a population of over 150,000 individuals under the age of 25, were examined. The results concluded that victims of cyberbullying are not only at a greater risk of both self-harm and suicidal behaviors, but that perpetrators of cyberbullying are also at an increased risk for both health threats (John et.al., 2018).

Although the evidence base in this field has grown, there is a clear need for more research and greater improvement in the quality of future studies, particularly in the areas of developing a clearer more concise definition of cyberbullying and utilizing more validated assessments of self-harm and suicidal behaviors (John et al., 2018). While more research is still needed, research has highlighted the impact of cyberbullying on youth and demonstrated a need to include this topic in school prevention efforts. When approaching any antibullying program, schools should always incorporate a whole-school approach that also includes suicide awareness for students and staff. In addition, because of the suggested association between cyberbullying perpetrators and suicidal

behaviors, schools should recognize the vulnerabilities of these students and view these behaviors as an opportunity to support rather than to punish (John et al., 2018). Furthermore, schools should encourage help-seeking for victims of cyberbullying, as these students are less likely to report and find help than victims of traditional bullying. When working with youth, clinicians, counselors, and school psychologists should routinely ask about experiences of cyberbullying as the pervasive and persistent nature of this problem can lead to feelings of hopelessness associated with suicidal behavior (John et al., 2019). Cyberbullying can have lasting and impactful effects on youth. Prevention and intervention efforts are essential to stop this cycle and improve supports for both victims and perpetrators alike.

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# GUNS AND SUICIDE

## Interview with Dr. Michael Anestis by Dr. Scott Poland and Karly Hauser

**Scott Poland [SP]: What got you so interested in suicide prevention and, specifically, the role that guns play in suicide?**

Michael Anestis [MA]: Yeah, sure. I first began as a suicide researcher in 2005. I went to Tallahassee for graduate school, working with Thomas Joiner as my major professor. But I was interested in trying to work then to become a suicide researcher, because it's a complicated problem that would do some good for the world. It keeps you interested and feels like you can make a contribution that that is worth something. And then, with firearms, that has become a focus for me over the last handful of years. It really just comes from living where I live now in South Mississippi. Gun ownership is very high there, and 70% of every suicide death or a subset of all the suicide deaths in Mississippi are firearms suicide deaths. So it's a situation where guns are prevalent, gun suicides are prevalent, and nobody's really talking about or doing anything about it here. It's starting to change a little bit now, but it was a situation where I saw something that could make a tangible impact on the suicide rates if we put our energy towards it, so that it could be of national and local use.

> "Separating an individual from the method that they are intending on using for suicide is the most powerful tool we have to keep suicidal people alive"

**[SP] Absolutely. I'm a survivor of suicide. My father actually shot himself, so I certainly know about the lethality of guns. A quick question, in some of the Western states, in gun shops, there's suicide awareness literature available, anything like that happening in Mississippi?**

[MA]: It's not happening just yet. I've been talking with the Department of Mental Health who are pretty forward thinking about this now and are talking about utilizing some of these approaches like we've read about with gun shops, but also several other things, such as putting together short soundbite clips going about 30 seconds, almost commercial length or less

with credible messengers from military, concealed-weapon instructors, folks like that who would be taken seriously to talk about this issue. Also, using billboards, trying to get some grants to do huge messaging campaigns and trying to get suicide prevention material put in with every firearm sale in the state. So they're talking about some big ideas. Mississippi, unfortunately, doesn't tend to lead in these type of things and when they do, it doesn't tend to be in a positive way. So we're certainly not the first to be talking about these kinds of things, but I'm thrilled by the conversation I had with the Department of Mental Health a few weeks ago, so we'll see how that evolves.

**[SP]: That's great. I'll let Karly say hello and start with some questions.**

**[MA]: Yeah, sure.**

**Karly Hauser [KH]: Hi there, Dr. Anestis. I'm Karly. I'm a first year student here at Nova in the Psy.D Clinical Psychology program.**

[MA]: Hi, nice to meet you.

**[KH]: Hi, nice to meet you too. So, I have a few questions, and I just want to say, first of all, I really enjoyed reading your book, *Guns and Suicide*. I tried my hardest to find any holes in the argument you presented and was not able to, so excellent.**

[MA]: That's always great to hear.

**[KH]: Yeah, so my questions here are pretty general. The first one is what makes suicide deaths an epidemic in the US?**

[MA]: Sure. I've had this conversation with folks who have wondered whether the use of "epidemic" outside of its medical context is the best approach or not. So when I talk about an epidemic of suicide in the United States, I'm referring to a problem of a large scope that is impacting the health outcome of Americans, which could be addressed through intervention. I think that the way that a lot of huge epidemics, in the media or in things like blood, is meant to convey the scope of the problem, even if it departs slightly from the medical definition of the word. So what makes suicide an epidemic is because it's a profoundly large problem in our country, being the 10th leading cause of death. So I think that by definition, that's a substantial problem that again is impacting the health outcomes of Americans.

**[KH]: Understood. Thank you so much. So we'll go into the second question. Why are the means used in suicide attempts so important?**

[MA]: They are important for a number of reasons. The first is that what method you chose to use will radically impact what the outcome's going to be. So the most common method by far in the US is intentional overdose, yet it's only 2 to 3% of those attempts that result in death. So almost everybody survives, and what's important about that majority of folks who survived the attempt or attempts, approximately 90% never go on to die by suicide. This is because folks tend to use the same method over and over again. On the flip side, with firearms, 85 to 95% of all attempts result in death. And so even though few use them in attempts (less than 5% of all suicides attempts involve firearms) more often than not when someone in the US dies by suicide, it's this method, because they never get a second chance.

And so the method matters for that reason. The method also matters, because it speaks about the demographics of suicide. When most folks think about a suicidal person, I think what they picture is something fundamentally different, often a young female who's been in and out of mental health treatment. We know this person's been in agony, and maybe they've been seeking help, so we've been trying our best to help, but it just didn't work, and they ultimately took their life. And that certainly happens. I don't want to belittle that narrative. But actually the typical American story of suicide involves a middle aged or older white male who has never engaged with the mental health system. Therefore, it's possible he never tells anyone he's thinking about suicide and dies on his first attempt, using a handgun that he has likely owned for a long time. There's nothing the mental health system can do when nobody knew he was at risk for suicide until he was dead. And so the method also matters, because it speaks to this group of folks that we're not seeing in our clinics and we're not seeing in our research samples because we don't know who they are. The method is important, because perhaps the only way we can actually intervene with that population is focusing on what they might use, instead of what made them want to use it.

**[KH]: Thank you so much for that. It was a really good explanation. Which brings me to my next question, and this one was something I found particularly interesting in your book, the topic of how firearm suicide is a cultural epidemic.**

[MA]: Well it's way more prominent within certain cultures, such as within gun-owning culture, which is a pretty heterogeneous group. Obviously, the gunning-owning culture would be a big part of it, but I think that one way to come at answering this question is looking at some of the research that a couple of my graduates and I've been reading recently, which looks at the types of things that prevent people from or decrease the likelihood that somebody will seek help for suicide before they've died. In those who die by suicide using firearms, what you see are people who have more socially conservative political views. You see folks who endorse higher level of religiosity. You see these groups that belong to demographics where there's a lot of emphasis on not seeking help, not talking about emotions. So it's just more prevalent in those groups in part, I think because A., they're more likely to own a gun

and B., they're also less likely to embrace the mental health system we currently have that would otherwise be trying to treat their sort of agony or their desire for death. So it's culturally-bound in that we have these mechanisms for helping people that I think better address the folks more vulnerable to using other methods for suicide, besides firearms. There are always exceptions, however, such as people who have extremely liberal political views who go on to die by using a gun. It's probably less likely to be their gun because they're less likely to own it, but maybe they just bought it and it worked. And you also find folks with all sorts of religious views and living in all sorts of geographic locations who die by suicide. So I wouldn't say it's purely a conservative or Christian problem or anything like that, but the demographics backup that these groups of people that tend to be more reticent to speak about what they're experiencing and to engage with the mental health system are more likely to utilize this method. And because of this, they die in particularly elevated rates.

[**KH]: Okay. That definitely answers that question. Another one of my questions has to do with the suicide rates in the broader culture of the U.S compared other regions, like you discuss in your book about the suicide rates in Japan and how that's comparable to that of the U.S.**

[MA]: Yeah. So that is one of the two or three most common counter-arguments that guns really don't matter in terms of suicide deaths because you look at Japan or South Korea and gun ownership is almost nonexistent there, yet their suicide rates are through the roof. And, you know, first of all, I agree. I can imagine how high their suicide rates might be if gun ownership was prominent there. But even putting that aside, you have to remember the role of guns in suicide to understand it. Guns don't cause people to become suicidal, they make suicidal people more likely to die. The method that is most commonly used in a particular area is going to vary, as well as the success of means safety (efforts to make specific methods less deadly or less available for attempts). This is going to vary depending on whether the method is highly lethal and also whether it's common and popular in that area. And obviously, firearms are not common and popular in Japan and South Korea, but they have other vulnerabilities that speak to their suicide risk. In the book, I talked about some culturally-based phenomena that one could speculate might be fueling their suicide rates, although I certainly can't see the data conclusively say this to be the case. For example, in Japan, historically, dating back to Samurais, honor killings, and kamikazes, there's been a notion seen in a lot of collectivist cultures that it's an honorable thing, if you are a liability to others, to sacrifice yourself for the greater good or for the benefit of the group. So taken to an extreme, and the researcher Thomas Joiner argues this quite a bit in his paper, the extent to which humans aligned with other sort of species that tend to lower their own importance relative to the group. This sort of collectivist cultural belief, which is so distinct from that of the individualistic cultures you see a lot in the West, could make suicide a more likely outcome for individuals who are suffering. So the decisional balance of, "Do I do this or not?" is different for someone who might see it as the honorable thing to do. There's also issues of shifting dynamics. In South Korea, there has been a pretty abrupt shift from a collectivist culture to more of an individualistic one. This change aligns pretty well with when their suicide rates started to surge upwards and has impacted the elderly quite a bit also, because we see less caretaking of older relatives and more older relatives consequently having to reenter the workforce and sort of a fundamental shift in their identity and their quality of life and what they're able to do and how they view their worth and their connection to others, which again fuels into suicidal desire. So the argument in the book that I'm making isn't that without guns there's no suicide anywhere in the world or even in the US, but the US has a gun culture that makes people more capable of dying by suicide than they otherwise would be. And so if we limited access to firearms, the suicide rate would crater, just as it has with other methods when we've applied that same principle across the globe. In time, some other means may replace firearms, but it probably will not be as lethal, then we would just apply the same principles to that method.

**[SP]: Michael, those are really great points. I worked on the suicide prevention plan for the schools in Montana and as you know, state like Montana, Wyoming, and Alaska are always like number one, two and three for suicide rates. So do you think in a state like Montana, for example, the suicide rate would go down drastically if the guns weren't so available?**

[MA]: Yes. What I'll tell you, from just having an email exchange with our folks in Montana who were actively working to try and lobby to pass an extreme risk protection order, which is not the most powerful form of protective legislation but a new one that's more palatable to conservative states. Are you guys familiar with those laws?

**[SP] Yes.**

[MA]: The extreme risk protection orders, for anybody who is not familiar, are laws where family members or law enforcement (there's some variability from state to state), can petition a court to temporarily remove firearm access for someone who is deemed at imminent risk to self

or others, introducing due process, which feels less like someone coming to take the guns and more like going through a process of risk being established with temporary reduced access. Those are actually passing, not just in liberal, low gun ownership states, but in red states, Montana being one that's considering this in the very near term. I think I feel certain that if gun access was dramatically lowered, the suicide rate would be dramatically lowered. Obviously you want to focus lowering risk only for folks who are at risk for suicide, but that's hard to do. So Joe Franklin at Florida State published, I think, the scariest study in the history since that research shows that we're no better now at prospectively predicting who's going to die by suicide than we were in the 1950's, being slightly better than a coin flip. So, interventions that focus only on lowering access to those we know are at risk relies on the principle that we're any good at understanding who's at risk, which we're not, meaning we're going to miss most of the folks who are. Therefore it's not hurtful to implement those policies, but it is not the most efficient or beneficial.

**[SP]: Great point. As you know, we train clinicians here. Could you weigh in and talk a little bit about the importance of direct discussions about means restriction with suicidal patients and clients?**

[MA]: Yes. I think it's massively important. We have talked about an arc in our training clinic here at USM, although we're going to be doing a training in a month or so that will further intensify our procedures for that. I think it's vital and that people are hesitant to do it, because if you don't own a firearm or haven't used one, it's uncomfortable talking about it. People may also be worried about appearing political or offending others. I'm doing a clinical trial right now where we talk to conservative gun-owning members of the military about means restriction and we found that if you're not a jerk about it and not just telling people what they have to do, they are actually pretty responsive to this. It isn't nearly as hard as we hear it would be. It's just dramatic. Separating an individual from the method that they are intending on using for suicide is the most powerful tool we have to keep suicidal people alive, and I don't think there's a close second. So, our hesitancy to do that is fairly negligent on our part, and it's universal across all healthcare settings. It's not just clinical psychologists who are sort of failing in this regard, but I think that there has been a movement shift, particularly in emergency medicine, that has been promoting the importance of doing this [means restriction].

**[SP]: I think you just gave us a great quote to highlight in this article. Also, I've been frustrated that states don't really have or enforce child access prevention laws, and adults are rarely held accountable if their child uses their gun to die by suicide.**

[MA]: Yeah. You know it is obviously a small percentage of it, but it is eminent. People talk a lot about smart-gun technology, for instance, as a way to address this as a non-legislative approach, in addition to the child safety laws you're referencing. I'm generally not a huge fan of that because a lot of folks die using their own handgun, right? So the smart-gun isn't really protecting many, with some exceptions. So in addition to the laws that I agree with, need to be enforced more readily, there's technologies that make it very difficult for a child to use their parent's gun. Also, it would reduce death from firearms. I mean, there's a lot of ancillary benefits to it, but it wouldn't have a huge impact on the suicide rate overall, I don't think. Because again, most folks are dying using their own guns and so there's no protection built into smart-guns for that. But it would have an impact on youth suicide, because children can't own guns. It's not legal. They wouldn't have a smart gun that is programmed to work for them.

**[KH]: Great Point. Dr. Anestis, what can an individual do on a small scale to reduce the risk of suicide deaths by firearms in the community?**

[MA]: Overall or are you talking about clinicians?

**[KH]: Both.**

[MA]: Yeah, sure. So in a clinical intervention, you can talk openly about this. Day to day life, however, doesn't allow for any conversations you hear or see about firearms to be about anything related to suicide, for the most part. Two out of every three gun deaths in the U.S. involve suicide. But suicide is only involved in maybe 1% of the conversations about firearms, and when it is, it's usually done in an inaccurate way. So by infusing any conversation you see or hear about it, whether that's online or face to face with a discussion of suicide does have the potential to change cultural norms. I think that writing to your elected representatives and telling them about the data is always a good idea. One of the things we see so frequently in our studies is that a lot of the folks who store their firearms unsafely and who are unwilling to chang, endorse extremely high level of confidence in incorrect beliefs. They think there is no connection between firearms and suicide, about ownership, about storage practices, and people don't tend to feel motivated to make behavioral changes about things they think don't matter. So we don't create the urgency. We don't create the market for this sort of behavioral change until we introduce incentives by getting people to understand the reality of how these variables relate to one another. So I think that part of it is just banging the drum, being loud, learning to understand the cultural lens of gun owners, and making sure that every conversation about

suicide isn't a conversation about the second amendment, because the next time someone convinces someone else to change their mind on that topic will be the first. And so if you make this conversation about that, you lose the conversation about suicide prevention. In a culturally-competent manner, learning to talk to someone about how guns work and how they can stay safe and understanding that you may leave the conversation still fundamentally disagreeing with them about the pros and cons of gun ownership. But if your goal is to keep them alive, it doesn't matter whether you guys agree about the rules of firearms in America, it matters whether or not they store their firearms safely.

**[SP]: Great points. And I know probably over your entire career you've been battling the people who say, 'Oh, they would just find another way'.**

[MA]: Yes. That is the number one most common account. That's the one that's more common than Japan and South Korea. I mean, look, that makes a lot of sense intuitively and it's just fundamentally incorrect. It's such an obvious question that people have investigated it for decades, and it's universally found that it is not the case. It's just not how suicide works. One of the big problems is people just don't understand how suicide works. In addition to having the demographics wrong in their head, they think it's easy and they call it the coward's way out. It's not. It's incredibly difficult, and any obstacle you put between someone and doing it makes it that much harder and less likely to do it. People don't just find another way. If they did, then all the examples of means safety and reduced suicide rates throughout history would be unexplained, whether we're talking about detoxifying gas in the UK and their suicide rates dropping 40%, or removing the most lethal pesticides in Sri Lanka and their rate dropping by 50%, or not letting young soldiers in the IDF bring their firearms home on the weekends and seeing their suicide rates drop by 40%. You wouldn't see the overall rates drop like this if they just found another way. You would see the method-specific rate drop and the overall rate would stay the same because, as they said, they would just find another way. Simple math says that argument is wrong, even though it's appealing. But even if people in our current political climate are willing to look at that much unambiguous evidence and say, "I still don't believe it," the fact of the matter remains that firearms are more lethal than any other method. And so if they did find another way, they're far more likely to survive. Again, 75% of survivors of suicide attempts don't go on to attempt again, so by preventing them from using a firearm and that specific method, you'd still probably save their life forever, even if they did swap methods, which by the way, they probably won't do.

**[SP]: Great points.**

[MA]: This is kind of related to my last question, "What can we do on a large scale to reduce the risk of suicide death by firearms"? Well, it's multi-faceted. I think it would have to be a combination of local and national efforts, as well as a combination of legislative approaches like universal back-ground checks, mandatory waiting periods, extreme risk protection orders, permit to purchase laws. I think it would be those, as well as campaigns to get folks to always store their firearms safely. By that we mean unloaded, separate from ammunition, in a locked location (e.g., a gun safe or a lock box). And ideally also using something like a trigger lock or a cable lock. And then also recognizing that in times of crisis, for themselves or anyone else who has access to that firearm, finding a legal way to temporarily store it away from home (e.g., with law enforcement or a buddy, if that's legal in that area, at a gun shop, at a shooting range). There are options everywhere that vary from place to place. And so getting people to embrace that sort of multifaceted approach is a big part of that. That's going to require some cultural changes and some leadership that involves a backbone amongst the elected officials. None of that, however, will be as successful as firearms just not being around, but there's no question that if safely stored, a firearm will be much safer [in terms of reducing suicide risk] but also far more dangerous than one that isn't there in the first place. But they're going to be here. In the US, we have more firearms than people. So even if we institute a buyback program right now, we're not going to get rid of all of them. Working from a pragmatic standpoint, as somebody who lives and works in South Mississippi, I think it is working to find common ground with gun owners, making them not feel like outsiders are coming in and telling them what to do, but changing cultural practices in storage and getting people to understand the association between guns and suicide so that they make informed, rational decisions to keep themselves safe. We're also working on legislative approaches that are actually quite popular amongst gun owners, just not with the gun lobbyists. Things like background checks will help supplement those sort of behavioral changes the people are making.

> "I want people to see the hope and understand that there's a clear path to it"

**[SP]: What kind of feedback have you gotten on your important book, *Guns and Suicide*?**

[MA]: I really haven't gotten a lot of negative feedback. Most of the negative feedback comes

from trolls or like literally Internet bots (like Twitter bots). In areas like the Internet, sure people say all sorts of nasty stuff. But again, we have a clinical trial going on and we are up to 71 participants out of the 232 we'll be doing over the next couple of years. And so far, every single person has said they'd recommend the protocol to their fellow service members. We've got a 92% retention from baseline to three months and 100% from three months to six months. So, if this information was really offensive, I don't think we'd be getting that. I think they'd be leaving. Sure, we're paying them, but they wouldn't recommend it. They still just get their money, and they'd probably leave and not keep coming back, but I really don't get a lot of negative feedback. I think when people make assumptions about what I'm saying, they sort of cringe and maybe tune me out a little bit, but I've learned how to lead off my conversations with folks with some comments that will sort of assuage their fears so they know that I'm not coming in to do what folks will refer to as a 'gun grab,' no matter what my political views happen to be (and they're probably quite different than those folks'). It's readily apparent that I'm not from Mississippi the second I start talking, but I think that I can get people to put their guard down a little bit and they typically find what I'm saying inoffensive. Even if they don't buy into it and don't change their behavior, ultimately we're at least changing the receptiveness to the message; there's a space to talk about it even if we haven't figured out how to talk about it just right.

**[SP]: Well, clearly you're trying to educate them on the fact that means matter.**

[MA]: Yes. It's a message no one was looking to buy, which makes it a tougher sell.

**[KH]: One of my questions is, "What do you hope your readers take away from this book"?**

[MA]: I hope that they take away that what we've been doing is a lot of admirable work that I wouldn't argue is the top in suicide prevention, but what we've been doing has just been focusing on why people want to die, without any consideration to whether or not they can, and if we don't shift away from that, we're going to continue to see increases in suicide rates every single year. So, in a lot of ways, that sounds dire, not hopeful, but I think that common sense, common ground, solutions exist if people are willing to step forward, have difficult conversations, not let this be pushed to the background, and not let folks like the gun lobbyists take control of the narrative. I think gun owners actually value safety quite a bit, and that's why we had such great success in reducing rates of accidental homicide and accidental firearm deaths. We just haven't made a space for suicide in that conversation, because people were unaware of the scope of the problem. I want people to see the hope and to understand that there's a pretty clear path to it, but it's going to require a sustained and massively increased frequency of the conversation about firearms and suicide.

**[SP]: How do you counter the argument that if a gun owner locks up and secures his gun, it wouldn't be readily accessible to protect his family?**

[MA]: That's a tougher one. Those are by far the hardest folks to sell on this, and it's a pretty big sum of the population here, as well as in different areas of the country. For example, you go out to Wyoming and that mentality exists, but there's also a lot of folks who own longer guns for shooting or hunting. In Mississippi, a lot of folks own handguns and they own them for protection in the home, so when I say safe storage and I explain what I mean, to them, that sounds like unsafe storage, because they need their gun on the ready. In fact, NRA sponsored concealed carry classes and firearm safety classes directly to encourage that exact form of storage. And so they've been trained to do this very thing. It's tougher, and so we look at mean safety as a spectrum of safety. Ideally, I'd want someone to do all the stuff I told you about. We talk to them about what steps are there that they might be wanting to do or any steps they can take. Could it be unloaded? Could there at least be not one in the chamber? Are you willing to put it in a gun safe? If you're not willing to do a gun safe, could you at least use one of the lock boxes that is bio-metric? You can keep the lock box by your bedside table, all you have to do is put your finger on it and it recognizes your finger print. Can you at least do that? And if they're not willing to change any of those practices, we at least get them talking about the circumstances where it might not be a great idea to have a gun readily available. Some folks will talk about being intoxicated and then folks eventually sometimes circle around to "is somebody suicidal?" and they're like, "yeah, maybe that isn't a good time to have a gun around," and at least make a plan: "Well if I do start to feel this way or if someone I love feels that way, maybe we would temporarily do this. Or, "Maybe I'd let my spouse store it someplace where at least I don't have all the information for it.' We find anything they are comfortable with, and we move them as far along the spectrum as we can and hope that it's enough. We don't know that it is, but it's probably safer than the alternative.

**[SP]: I loved hearing about all of those steps and all of those possibilities. It is clear you're very passionate and knowledgeable about this. Do you have any final statements that you'd like to make about this difficult topic in our country? About all the misinformation about suicide and all of the guns that are available. Any concluding thoughts?**

[MA]: I would like to conclude by just thanking you guys for being

willing to take this cause on. I am at a stage where I will accept any conversation I can have on this, because I'm of the mind that people just aren't willing to do it most of the time. So anytime somebody wants to talk about this, I feel like it's a valuable contribution. I just appreciate your willingness to do it. I am hopeful that others who hear this will do the same and that the conversation will just keep on building.

# RELIGION AND SUICIDE

## Catherine Ivey

As opposed to spirituality, which refers to personal beliefs about life or mind-body-soul connectedness, religion is a belief system with texts and practices that concern a greater power. Approximately 70% of Americans claim to have an affiliation with a religion (Religious Landscape Study, 2015). Of those, approximately 70% claim to be Christian, 22% unaffiliated, two percent Jewish, and less than one percent Hindu, Muslim, or Buddhist. Many religions have been studied and associated with many physical and mental health benefits across and outside of the United States (U.S.; Jocson, Alers-Rojas, Ceballo, & Arkin 2018; Van Cappellen, Toth-Gauthier, Saroglou, & Fredrickson, 2016; and Fenelon & Danielsen, 2016). Specifically, high levels of religiosity are associated with significantly lower levels of anxiety, lower reports of depression, and lower aggression (Haney and Rollock, 2018), whereas religious involvement is associated with increased self-worth and lower depression symptoms (Krause, 2012). Religiosity has been shown to slow cognitive decline in older adults with dementia and to improve their quality of life (Oceane, Nathalie, and Claude, 2015). Research also suggests that religion can act as a strong protective factor against suicide (Gearing & Alonzo, 2018).

According to researchers Gearing and Alonzo, a majority of research concerning religion and suicide has primarily been studied in the U.S., with an emphasis on the following religions: Christianity, Judaism, Hinduism, and Islam. In 2009, these researchers synthesized the relationship between religion and suicide and found that most religions condemn or apply negative consequences to suicide. Thus, individuals who show commitment to religion are less likely die by suicide. Gearing and Alonzo suggested that conflicting values create an internal struggle within the individual that may encourage him or her to live. Furthermore, they explained that religion provides many protective factors, such as social support, lowering aggression and hostility, and encouraging interpersonally appropriate behaviors. Gearing and Alonzo specified that individuals with "lower moral and religious objections compared to those with religious faith are more likely to have more suicide attempts, as those with religious faith find more reasons to live" (p. 2482). Specific to age, youth with previous suicide attempts or ideation find their strength of faith the biggest predictor of living. Yet, the findings for older adults (65 and older), were such that church attendance was the biggest protective factor against suicide attempts. Regarding gender, the risk for religious women compared to men is lowered by five times. However, other literature suggests this may be due to the associated factors such as prayer, beliefs, and social support rather than attendance alone. It is important to note that affiliation and attendance for adults is not found to lower suicide ideation, just attempts. Findings are also not specific to an individual's religion. Overall, what remains unclear is whether it is the role of social support or the true strength of religious affiliation that protects individuals from attempts or ideation. (Gearing & Alonzo, 2018)

As mentioned, research suggests that church attendance can function as a protective factor against suicide attempts. According to Kleiman (2018), this may be associated with an individual's participation in activities and not due to the individual's specific affiliation with religion. Additionally, Walker, Salami, Carter, and Flowers (2018) found that "African American adults with an individualist philosophy with self-directing coping styles is associated with high levels of suicide ideation" (p.106). However, Mason, Hu, Him, Korver, Xia, and Coniglio (2018) compared religious group members to non-religious group members in order to further discern what theory is supported in the protection against suicide related to religion. The study found that while both groups shared community, the religious group valued individual prayer as the necessary factor in growing in one's faith. This supports the theory that religion protects against suicide, because "it shapes moral and religious beliefs that object to suicide" (622). However, further research is encouraged, in order to support or negate whether religious affiliation is a variable that leads to protection in suicidal ideation and attempts.

For future research, it may be interesting to explore religions that do not provide consequences for suicide. Jongkind, van den Brink, Schaap-Jonker, van der Velde, and Braam

(2018) found that suicide ideation has a negative relationship with individuals who believe in a positive, supportive God. Furthermore, individuals who believe in a passive, distressing God show a positive relationship with suicide ideation. Moreover, exploring religion may not only provide many benefits, but this may also have important implications for how a psychologist might approach treatment.


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# SCHOOL PSYCHOLOGISTS MUST BE INVOLVED IN PLANNING AND CONDUCTING ACTIVE SHOOTER DRILLS


**Terri Erbacher and Scott Poland**


A recent 2019 headline in USA Today is a critical example of why school psychologists need to be involved in planning active shooter drills. The headline read *Terrified: Teachers, kids hit hard by shooter drills (*Dastagir, 2019). Teachers at the elementary school in Monticello, Indiana were left bruised, bleeding, and frightened after being shot execution style with plastic pellets during a drill. The *Indianapolis Star* follow-up story cited that the Indiana Teachers Association wants the use of projectiles in shooting drills banned, but the Senate Education Committee believes projectiles should be allowed so that teachers participating in the drills experience emotions and adrenaline (Herron, 2019). Articles such as these create more questions than answers. How should active shooter drills be conducted and how often? How can drills avoid traumatizing staff and students? How likely is it that a school shooting will occur and how safe are our schools? What is the critical role of school psychologists in planning and conducting these drills?

The organization Every Town USA (www.everytown.org) provided data for how many schools in the United States experienced a school shooting in each of the last two years. One school shooting is unacceptable, but it is important to know the exact incidence. In the 2016 - 17 school year, there were 14 incidents where someone was shot at school. The vast majority of those incidents were accidental. In a number of the others, a student brought a gun to school and died by suicide. The 2017-18 school year was particularly tragic as there were 33 schools that experienced a school shooting. Three of those tragic shootings received extensive national news coverage: Marshal County, Kentucky, Parkland, Florida and Santa Fe, Texas. Again, the vast majority of those 33 incidents were the accidental discharge of a weapon at school or a student suicide at school with a gun. There are currently approximately 130,000 K-12 schools in the United States. Based on the statistics for 2017-18, every K-12 school could expect to have someone shot every 3000+

years. While shootings are unlikely, this is not the perspective that students, teachers, parents, school administrators and local police have due to the extensive media coverage of school shootings. It is important that we emphasize that a school shooting is a possibility but it is not a probability. There is extensive documentation that school shootings were more frequent in the 1990's than today and approximately 98 to 99% of violent deaths of children occur outside of school in our homes and communities (Fox and Delateur, 2014).

It is very important that schools be careful not to scare children about a place where they should feel safe. Thus, it is imperative that any active shooter drill be preceded by extensive education and preparation. Drills should be carefully planned by local police and the school crisis team, and school psychologists' involvement is critical. School psychologists can help ensure drills are conducted in a trauma-informed way while attending to the developmental needs of children. With training in research and program development, school psychologists can also assist in creating pre- and posttests to assess whether students and staff felt safer after the drill. Every single student and every single staff member has their own unique history with regard to trauma, and a realistic drill likely causes unresolved issues to surface for at least a few individuals. School psychologists can be indispensable in providing support to those who are experiencing a strong reaction to an active shooter drill.

How often should an active shooter drill be conducted? This question can only be resolved after careful study. Historically, schools have conducted many fire drills, yet it has been decades since anyone was killed in a fire at a school. Active shooter drills are clearly more important today than fire drills. Recently, the state of Florida's School Safety Office recommended one active shooter drill a month at each school, but is that really best practice? Will staff and students feel safer and better prepared or will they view their school as an unsafe place? School psychologists need to be involved in not only planning active shooter drills, but also gathering data regarding the suggested frequency for effective drills and the impact these drills may have on staff and students. We outline below how drills can be traumatic for staff and students and provide an example of a very carefully planned and conducted active shooter drill which included extensive involvement from the school psychologist. We also call all school psychologists to review the excellent guide, *Best Practice Considerations for Schools in Active Shooter and Other Armed Assailant Drills* from NASP and the National Association of School Resource Officers (NASRO). This important guide was updated in April 2017.

**Are drills traumatizing?**

Another recent article in *The Atlantic* (Christakis, 2019) referred back to drills conducted in the 1950's for nuclear bombs, which led to fear in children with 60% reporting nightmares. A more recent 2018 survey by the PEW Research Foundation found that 57% of teens worry about a shooting at school. The Atlantic article suggests that in doing drills, "our efforts may exact a high price." On December 6, a Florida school initiated a lockdown saying "this is not a drill." Students sobbed, vomited and fainted while others sent goodbye messages to parents. IT WAS A DRILL and the resultant trauma was unnecessary. A detailed analysis conducted by the *Washington Post* found that over 4.1 million students experienced at least one lockdown drill in the 2017-2018 academic year, stating that, "while most kids won't suffer long-term consequences, a meaningful percentage will" (Rich & Cox, 2018). Full-scale drills can be more traumatizing, and students with prior trauma histories may be at particular risk. For example, "children who live in high-crime urban neighborhoods may be more susceptible to stress during or after lockdowns…because so many of them have been exposed to gunfire in their communities" (Rich & Cox, 2018). This only accounts for drills and not the depth and breadth of potential trauma experienced in actual lockdowns in which a school or community is threatened.

It remains true that school shootings are rare, and schools continue to be the safest place for children (Christakis, 2019, NASP, 2018, Rich & Cox, 2018). However, due to the perceived increase in school violence, some schools are staging drills that include simulated bullet wounds, students pretending to be deceased, real guns shooting blanks, and students banging on classroom doors during a lockdown drill begging to be let in (Aronowitz, 2014). These are referred to as full-scale drills and some states mandate them. There are many types of emergency drills and NASP (2018) suggests that schools clearly differentiate them and practice multiple types of planned responses from evacuations (i.e., fire drills) to lockdowns.

**Types of drills (NASP, 2018)**

*Full-Scale Lockdown:* This is used when there is imminent danger. Staff and students make rooms seem unoccupied; windows and blinds are closed, doors are locked and all sit quietly against a wall positioned away from the sightline of doors or windows. This can result in traumatic stress reactions.

*Secured Perimeter/Lockout:* All exterior doors are locked and no one may enter/leave the building. Teachers can continue with instruction, as authorized. These may be used when there is a danger outside of the school campus, such as a robbery at a nearby bank. While still unnerving, this is less stressful than a full-scale lockdown.

**Are drills needed?**

The National Association of School Psychologists (NASP, 2018) recommends that schools conduct drills to ease the stress reaction and ensure an adaptive response in the event an actual lockdown occurs. NASP stresses the importance of these drills being carefully planned and integrated into the school's crisis protocol. Cathy Kennedy-Paine, head of NASP's crisis response team, states that drilling is "essential" and that when done with

care, can protect students from physical injury in a real-life emergency (Rich & Cox, 2018). Drills provide an opportunity for students, staff, as well as first responders to practice procedures as well as identify challenges. Previously, most drills for first responders were done with no people in the building. Unfortunately, this does not allow them the opportunity to build ease in their own real-life response where students may be encountered in common areas as they work to find an armed intruder. Teachers may learn how difficult it is to control kids on their cell phones or keep children with disabilities quiet. Staff may realize some doors were not kept locked and some windows are difficult to shut. And, students may learn things like not hiding in bathroom stalls, as automatic bathroom flushes may give them away (Aronowitz, 2014). Drills are therefore encouraged by many leading organizations including NASP and NASRO, but they must be done in a manner that provides these benefits while mitigating traumatic risk.

**Case example: A trauma-informed approach**

Full scale drills should be carefully planned and thoughtfully conducted. One of the authors had the opportunity in the fall of 2018 to work with local first responders in developing a trauma-informed approach to active shooter drills. This was a collaborative effort to promote ongoing learning for the school staff, EMS Providers, Firefighters, Law Enforcement, the students, and their families. The planning team included public safety, school administration, and the school psychologist. Cooperation was also received from the County 911 Center and the PA Emergency Health Services Council. NASP (2018) stresses the importance of including the school psychologist in the planning process due to training in crisis mitigation and response. The trauma history of participants should be taken into account with accommodations provided when needed. During this full-scale drill, two students were identified by the school psychologist as having trauma histories related to guns. These students went into lockdown with their individual guidance counselors to provide a sense of comfort and safety and a place to debrief immediately upon the drill's conclusion.

NASP (2018) provides further suggestions for mitigating the potentially traumatizing effect of drills that begin with an orientation to the lockdown so that participants know what to expect. All drills should be announced in advance and school psychologists are key in ensuring effective communication to all stakeholders. Not only was this drill announced to staff and students prior to implementation, but parents were also informed. A detailed letter was sent home educating parents on the purpose of the drill and how the drill would not only help the school community, but increase the effectiveness of first responders. Interestingly, there was no increase in the rate of school absences on the day of the drill. The morning of the drill, students and staff were again reminded of the drill timing and how to respond to ensure they were ready. The principal communicated with faculty and staff through "Remind," a text messaging system, and staff were updated throughout the process. NASP suggests that the onset of the drill is stated in a clear manner such as "this is a drill." Public Safety refers to this as the advantage of plain language. Using code words such as "code red" is not recommended as some staff may forget what this means and substitutes or visitors in the building will have no idea how to respond.

The school psychologist ensured reminders of the drill were posted on the school's Twitter and Facebook feeds and the police department posted social media alerts notifying the community that there would be multiple police cars, EMS vans, and fire trucks on the scene for training. NASP (2018) stresses the importance of posting these messages "to prevent rumors of confusion in the community." The school also provided advance notice to nearby facilities and educational partners. This is exceptionally important in order that other schools do not inadvertently enact response protocols. It also allowed the neighboring preschool to choose to keep their children inside at the time of the lockdown. Finally, it was posted on the large sign on the school's front lawn that a lockdown DRILL was being conducted.

Captain Johnson, Coordinator of the local Shooter Rescue Task Force, directed the exercise. In his executive summary of this exercise, Captain Johnson stated that "in response to industry criticisms that it was taking too long to locate wounded victims in mass shooting events, public safety agencies around the country are developing protocols to introduce rapid evacuation procedures for victims." This drill was not taken lightly and first responders engaged in significant training prior to drill implementation. A safety plan was developed to mitigate training risks. This included the replacement of duty weapons with plainly obvious training replicas at an off-campus location so that no guns were near the school building.

While all students were present and practiced the lockdown, only theater students from the local community college were permitted to volunteer as actors to portray injured or deceased victims. The rationale for even needing victims was that this was a training for EMS to practice new protocols for responding to those injured while police continued to seek out the active shooter. Two classrooms of student volunteers were asked to flee their classroom in a non-dramatic fashion (no screaming, etc.) to give first responders a feel for students running toward them and through them while they are working. These senior classrooms were chosen carefully, the school psychologist debriefed them before and after the lockdown, and students were allowed the opportunity to opt out. Students seemed proud to have a role that was helping to train first responders. First responders were instructed not to have purposeful contact with any student and to function at half speed for added safety. The school psychologist also briefed teachers in detail and provided education regarding traumatic stress reactions and referral procedures should concerns arise. To further mitigate trauma potential, baseball bats were

used to mimic a sound for officers to locate and no simulated firearms were discharged at any time. It was deemed important that a sound be utilized since part of the training need for police was to seek out the source of the sound (the active shooter). It was clearly communicated to students that they would hear this sound, what it was, and the rationale for it.

Classes did great with keeping silent, as no sounds were heard from any room. This exercise was comprehensively documented through multiple professional videographers, public safety cameras, drone, and the school CCTV system. In an effort to demonstrate transparency, the training event was also covered extensively by both local television and print media, with no negative feedback. There were zero calls to the school regarding concern of parents, stakeholders, or community members. A few additional steps to be considered include providing staff with ongoing professional development on school safety and including lockdown drill information in the school handbook with both a rationale and description of procedures.

**Student Perspectives**

One student interviewed Captain Johnson for the school newspaper, reporting that this drill was particularly valuable for first responders' practice. Since that initial publication, raw video footage was shown to the State EMS Medical Director and he immediately approved its inclusion in a training course to be delivered to all paramedics and EMTs serving in the Commonwealth of Pennsylvania. As predicted in the school newspaper, the drill was also made into a one-hour television special for the Danish television program "Police Chase." The newspaper article concluded by stating that the drill showed that the school community "is all for promoting school safety." Not only were students able to practice a lockdown, but they were able to help create a training module to help first responders state-wide.

A senior student was also interviewed as he was in one of the classrooms asked to flee for the drill. He shared that he knew the drill was happening so there was no anxiety. He felt prepared as his class had been instructed on what to do. He further stated that "it was a great opportunity; it instilled in me that we, as a school, care about safety." From his perspective, the event ran smoothly and as planned. When asked what could have been done differently, he simply reiterated that students and parents were well informed. He added further insight that this event has also helped prepare him as he goes to college. For example, he feels he will know what to do, and where to hide, if something happens in a college quad. He also finds that he has become more aware of the exits at his current job and thinks carefully about what he would do if safety was threatened. This student has transferred skills learned to other settings and this makes him feel less anxious, not more. Overall, he appreciated "being a face in the movement for safety."

To conclude, the suicide prevention workshop training was a success. Students learned how to destigmatize suicidality and mental health. The facts have been presented regarding suicide, as well as the key variables that make assessments more effective. Students were encouraged to explore outside their comfort levels while achieving their objective in preventing suicide. The tools taught and implemented during the role-playing portion helped students gain clinical competence when encountering individuals suffering from suicidality. There is no doubt, the initiative these students exemplify will help save lives from suicide.

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# "Where will you be next?" The Journey of Bev Perez

**Michael Travisano III**

Bev Perez is a retired law enforcement officer who moved from the Northeastern part of the United States to Florida a year and a half ago. She is currently a member of Broward 2-1-1, an organization that connects the community with relevant resources, including when anyone calls in a crisis situation. Ms. Perez hosted a presentation at Nova Southeastern University, courtesy of the psychology graduate student organization called Mental Illness New Directions (M.I.N.D.), where she told the story of her life. She discussed what events made her contemplate and attempt dying by suicide, what helped her survive, and how she helps promote awareness of suicide to the community.

Ms. Perez recalled her time as a member of the police department in a Northeastern State. While on the force, she met another police officer who eventually became her fiancé. On March 13, 2016, a civilian man went to the police headquarters and began shooting at the station and at passers-by, attempting "suicide by cop," a term used to describe someone who acts in an intentionally threatening manner to provoke law enforcement to respond lethally. Her fiancé, who was undercover at the time, shot and killed the suspect. In the midst of the shooting, another police officer emerged from the station, spotted Miss Perez's fiancé shooting a gun. Not realizing that he was an undercover officer, he shot him to prevent any further shooting or harm to others. Ms. Perez had just arrived at the scene, and she threw herself over her fiancé, yelling to the other officer not to shoot. She told the audience that she did not remember throwing herself over him; she was only told this after the incident ended. She explained that she thinks she blocked it out of her mind. At this point during the incident, she does remember that her fiancé was trying to identify himself and was continuously repeating that he was an undercover police officer. Later, at the hospital, Ms. Perez learned that her fiancé had died.

Shortly after this incident, Ms. Perez was diagnosed with Post-Traumatic Stress Disorder (PTSD). Ms. Perez told the audience that the police department did not know how to effectively support her. She said that there was "no protocol" for helping a police officer who had experienced an incident of this nature. Ms. Perez also expressed that she did not have a positive experience with the psychiatrist she met with. She therefore concluded that neither typical therapy nor psychotropic medication was going to be helpful for her.

After suffering for some time with post-traumatic stress, depression, and anxiety, Ms. Perez strongly contemplated suicide and eventually attempted to take her own life. She stated that proceeding her surviving the attempt, the look of worry on her mother's face prevented her from attempting again. Ms. Perez said that she asked her mother, "Mom, are you mad at me?" Her mother then replied, "No, I'm sad. Because you are my daughter."

Perez then decided to move to Florida to start a new life. One difficulty she faced after her move was finding work. She stated that when she applied for service jobs at restaurants, many did not want to hire her, because employers did not see police experience as useful experiences for servers. However, she persisted and was ultimately hired as a waitress at a restaurant.

She soon met a retired New York police officer who persistently referred her to a place called the Mind-Body Center. After asking time after time for her to give it a try, Ms. Perez finally agreed. At first, she did not think it would benefit her, but before long, she realized that this center taught her "how to breathe" and be at peace with herself. She told the audience that the Mind-Body Center was "like a boot camp for your brain." It taught her how to live in the moment and be mindful. Soon after experiencing the program, she was asked to lead a group. At this group was a member of Broward 2-1-1, who convinced Ms. Perez to join the organization in an outreach position to speak to the community about suicide prevention.

Since then, Ms. Perez has become a speaker and an active member of Broward 2-1-1. She assists in spreading awareness about suicide to the community in an effort to help prevent it. Her goal is to help others realize that "it is okay to not be okay." She also works in partnership with United Way, an organization that speaks to and

with police officers about mental health. She reaches out to others who are experiencing thoughts of suicide to help them realize that they are not alone and that they too can overcome their situation.

Presently, three years after the incident, she has a home, a job, and friends. To emphasize her continuing journey of growth and new opportunities, Ms. Perez asked herself, in front of the group, "Damn, Bev, where will you be next?"

## "It Gets More Manageable with Time": The Experiences of Kirsten Fleming

**Michael Travisano III**

Kirsten Fleming is a single mother of two daughters as well as a suicide survivor. The term "suicide survivor" means that someone she knew has died by suicide. She recently gave a talk at Nova Southeastern University courtesy of the Nova Students for Prevention, Intervention, and Response to Emergencies (N.S.P.I.R.E.) psychology graduate student organization. During this presentation, she told the audience not only how she became a survivor, but also how she lives with her experience and what it has taught her.

Ms. Fleming's husband used to have what she referred to as "alcohol dependency." She had previously asked her husband not to drink in the house, and as a result, he often drank in the garage. One day, about 6 years ago, Miss Fleming heard a gun go off in garage. She thought her husband had died then, but he did not. She asked him the next day what happened, but he did not respond. Miss Fleming told the audience that before this incident, he did not have any previous suicide attempts that she was aware of. About 4 months later, on Mother's Day, Miss Fleming's husband got drunk and decided to go outside to shoot squirrels with a gun. During a conversation, one of their daughters expressed to her father that she would not be getting him anything for Father's Day because he did not get her anything for her 15th birthday. Shortly after this, he went into the computer room and came out with his gun. Ms. Fleming looked at him and asked, "What are you gonna do? Shoot us?" To this, her husband replied, "I will kill her and make you watch." He then proceeded to hold Miss Fleming and her daughter at gunpoint. Their daughter stood between the two parents. After Ms. Fleming managed to get all of her children out of the house safely, they heard a gunshot.

Ms. Fleming stated that following the incident, their two daughters required different amounts of time in order to cope with this experience. For instance, her elder daughter attended school the very next day, but her younger daughter waited a week before returning to school. As for Ms. Fleming, she explained that she used to wait until her daughters went to school and then laid down and cried in the room where her husband died. The family lived in upstate New York at the time. Since she perceived her husband's family blaming her for her husband's death, she decided to move closer to her side of the family in Florida.

Ms. Fleming described how difficult this experience was for her and her daughters. When someone from the audience asked her if stigma against mental health issues had impacted how they grieved the incident, she said that she thinks stigma hinders the grieving process. Not long after her husband's suicide, she asked her daughters, "Do you feel ashamed?" One of her daughters replied, "Yes."

Ms. Fleming asked aloud, "Why do we feel like that?" In the years that followed, both daughters developed eating disorders at one time or another.

Additionally, Ms. Fleming reported that her elder daughter previously experienced some suicidal ideation at one point and that her younger daughter was recently involuntarily hospitalized. "I think we're still grieving," Ms. Fleming told the audience.

While in Florida, Ms. Fleming joined a therapy group for suicide survivors. She revealed that she enjoys speaking to people in group settings, because she feels that hearing other people's stories helped her understand her own. However, not everyone appeared to understand this. For instance, Miss Fleming's mother once asked her, "Aren't you over it yet?" Miss Fleming said that she wished that her mother would come to group therapy one day to experience what it is like.

She communicated that "group therapy is not for everyone." Ms. Fleming's older daughter, for instance, does not enjoy attending group therapy, whereas Miss Fleming's younger daughter attends group therapy regularly alongside her mother. Both daughters are currently receiving individual therapeutic services, and they both appear to find that form of therapy helpful. Miss Fleming, however, prefers group therapy to individual therapy.

Miss Fleming appeared honest and open with her story and her experiences. Miss Fleming said that she likes speaking to members of the community in order to help raise awareness about suicide. One of her last messages to the group was that "it gets more manageable with time."

## INTRODUCING YOUR SVP TEAM:

Douglas Flemons, Ph.D., Department of Family Therapy faculty member

Scott Poland, Ed.D., College of Psychology faculty member

Elizabeth Hilsman, Psy.D., Psychology Postdoctoral Resident

Samantha Vance, B.S., Graduate Assistant

Karly Hauser, B.S., Graduate Assistant

J.R. Soria, M.S., Psychology Trainee

Catherine Ivey, B.S., School Psychology Trainee

Michael Travisano III, M.S., Psychology Trainee

Ashley Jacobson, B.S., Psychology Trainee

Thomas Ingram, M.A. Psychology Trainee

## NOVA SOUTHEASTERN UNIVERSITY'S COUNSELOR IN RESIDENCE

The Counselor-in-Residence is a counselor who lives on campus providing on-call services, such as mediation and response to emergency situations involving mental health issues, crisis situations, and emotional concerns of NSU's residential population.

Residential students can schedule an appointment with the CIR by phone, (954) 262-8911, or by email, counselorinresidence@nova.edu.

Henderson Student Counseling Center, (9540 424-6911 or (954) 262-7050, located at University Park Plaza off of University Drive, is also free of charge to students and offers excellent services to the student population.

**What should every student know?**

Students can participate in up to 10 sessions per year FOR ***FREE***!

The counseling relationship is strictly confidential. An on-call counselor is available after hours in times of crisis.

Call **(954) 424-6911** to make an appointment!

# Suicide & Violence Prevention Resources

**Henderson Student Counseling**
954-424-6911
nova.edu/healthcare/student-services/student-counseling.html

**NSU Wellness** (mental health services for NSU employees)
1-877-398-5816; TTY: 800-338-2039
nova.edu/hr/index.html

**National Suicide Prevention Lifeline**
1-800-273-TALK (8255) or 1-800-SUICIDE
suicidepreventionlifeline.org
**Veterans**: Press "1" or Text 838255
**Chat:** suicidepreventionlifeline.org/chat
**TTY:** 1-800-799-4889

**Crisis Text Line**
**Text:** "Home" to 741741

**Mobile Crisis Response Teams** (for on-site crisis assessment)
**Broward** (Henderson):
954-463-0911
**Palm Beach**:
North: 561-383-5777
South: 561-637-2102
**Miami-Dade** (Miami Behavioral):
305-774-3627
**Broward 2-1-1 Help Line**
2-1-1 or 954-537-0211
211-broward.org
**Chat:** https://secure5.revation.com/211-broward/contact.html
**Palm Beach 2-1-1 Help Line**
2-1-1 or 561-383-1111
211palmbeach.org
**Jewish Community Services of South Florida**
305-358-HELP (4357); 305-644-9449 (TTY)
jcsfl.org/programs/contact-center/

**Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Locators**
samhsa.gov/find-help

**The Jed Foundation (JED)**
jedfoundation.org

**Suicide Prevention Resource Center**
sprc.org

**Suicide Awareness Voices of Education**
save.org

**The Depression Center**
depressioncenter.net

**Yellow Ribbon International**
yellowribbon.org

**Florida Initiative for Suicide Prevention**
fisponline.org

**Florida Suicide Prevention Coalition**
floridasuicideprevention.org

**National Center for Injury Prevention and Control**
cdc.gov/ncipc/dvp/suicide

**American Association of Suicidology**
suicidology.org

**American Association for Suicide Prevention**
afsp.org

**Florida Department of Children and Families Suicide Prevention**
myflfamilies.com/service-programs/mental-health/suicide-prevention

## SVP Newsletter Contributors

Stefany Marcus, Psy.D.
Samantha Vance, B.S
Karly Hauser, B.S
Samantha Guy, M.S
Catherine Ivey, B.S
Michael Travisano III, M.S
Scott Poland, Ed.D
Douglas Flemons, Ph.D.

Graduate students looking to write articles on the topics of suicide and violence prevention are encouraged to contact us.

Elizabeth Hilsman, Psy.D.
Eh731@nova.edu

## SVP Presentations

The office of Suicide and Violence Prevention has provided 300+ presentations to various departments at NSU.

SVP has presented to over 6,000 NSU faculty, staff, and students, on a variety of topics related to suicide and violence training, management, and mental health struggles.

Use this link to request a presentation:
http://www.nova.edu/webforms/suicidepreventio n/presentation-requests/index.html