

Suicide and Violence Prevention Newsletters

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2020

## 2020 Spring/Summer Newsletter

Nova Southeastern University

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# OFFICE OF SUICIDE & VIOLENCE PREVENTION

NOVA SOUTHEASTERN UNIVERSITY

Newsletter – Spring/Summer 2020

*Dr. Scott Poland & Dr. Douglas Flemons, Directors*

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## SUICIDE CONTAGION AND CLUSTERS-PART 2: WHAT CAN A SCHOOL PSYCHOLOGIST DO?

**By Marina Niznik, Scott Poland & Richard Lieberman**

In Part 1 of this series (Lieberman, Poland, & Niznik, 2019), we discussed the phenomenon of contagion and identified adolescents as the most susceptible age group for imitating suicidal behavior. Beyond specifically suicidal behavior, we may be underestimating the full impact of being exposed to a death by suicide—a contention supported by Cerel and colleagues (2018), who found that of approximately 135 people exposed to a death by suicide, as many as 30% found it to be a life-changing event. Ultimately, the primary goal of postvention is to identify those now at risk and prevent the next suicide. Part 2 of this series focuses on limiting contagion and highlights the many potential roles of the school psychologist in suicide postvention. Frequently-asked questions (FAQ) are addressed in a special section at the end of the article.

Postvention is defined as an intervention after a suicide. The term was coined by Schneidman (1973), whose basic view was, “the largest public health problem is neither the prevention of suicide nor the management of suicide attempts, but the alleviation of the effects of stress in the survivors whose lives are forever altered.” Research has shown

### UPCOMING EVENTS:

*Dr. Scott Poland has recorded a webinar on suicide prevention as part of NSU College of Psychology's series of webinars on helping children and families cope during the COVID-19 pandemic.*

*Recordings and future webinars can be accessed for free at:*

**[www.nova.edu/sharkchats](http://www.nova.edu/sharkchats)**

**See Page 7 for more information regarding COVID-19 and suicide.**

that postvention efforts in the schools are often too short in duration and focus on too few children. While many districts have policies established for intervening with suicidal students, few spell out a process for postvention or how they will intervene in the aftermath of a student death by suicide. School psychologists play a critical role in guiding district policies and procedures, identifying and alleviating the distress of suicidal, bereaved individuals, reducing the risk of imitative suicidal behavior, and promoting the healthy recovery of the impacted community (see FAQ 1).

We have assisted many school districts in the aftermath of point clusters (multiple student deaths by suicide, in geographical proximity, over a short period of time), and in each case the local school psychologist spearheaded the comprehensive district response. Working in collaboration with administrators and other school mental health personnel (such as counselors, social workers, and nurses), school psychologists provided guidance, resources, and ultimately, leadership. They helped their communities see this was not a school problem but a serious community crisis that required commitment and determination to respond (see FAQ 2). The remainder of this article provides suggestions regarding some of the key roles and actions that may be taken by school psychologists in these situations.

### **Immediate Actions**

Respond immediately when a student suicide occurs. Confirm the facts and gather information. Verify that the death was by suicide, preferably by talking directly to the student's parents, law enforcement, or coroner. Work closely with the school administration and community resources to recognize the possibility of contagion and to identify students most at risk. Students at risk may include: students who were close to the student who died, students who have previously considered or attempted suicide, students who have been exposed to the suicide and have other risk factors, students who have major life events occurring, and students exposed via social media.

Mobilize a crisis response team (assist the principal in establishing this team before the crisis occurs!). Collaborate with team members to determine the impact of the crisis and advise the principal on how to proceed. Notify key district and community partners to increase screening and support of affected students.

Reach out to the family. Offer to accompany your principal to the home. Express sympathy and offer

support. Identify the victim's siblings and friends who may need assistance. Discuss the school's postvention response. Identify details about the death that could be shared with outsiders. Discuss funeral arrangements and whether the family wants school personnel or students to attend. Communicate directly to parents and students, balancing the family's wishes for privacy and needs of the students (see FAQ 3). Utilize the *After a Suicide: Toolkit for Schools (2nd ed.)* for templates of statements for parents and students and share with your principal.

### **Next Steps**

Triage staff first and notify them in person, if possible. Allow grieving staff to be relieved from the classroom. Conduct a faculty planning session to review the referral process and staff role in postvention. Remind staff that how they respond has a great impact on potential traumatization, particularly in young children. Share resources for students who need additional support. Share crisis hotline information via the school's social media page, and send out information about safe messaging via the commonly-used social media sites directly to adolescents. Post relevant support information, such as text line or crisis hotline numbers in visible locations for students and staff.

Conduct educational/psychological sessions (see FAQ 4). Avoid large assemblies or large groups (See Toolkit, p. 30) where students cannot ask questions or be easily monitored for their reactions (see FAQ 5). Provide support to students in small groups or in classrooms. Share facts, dispel rumors, allow students to share, and then normalize a wide range of reactions, and look for students who may be showing signs that they are significantly impacted.

Identify and screen students for suicidal ideation/behavior. Conduct primary screening and triage students utilizing three factors: those physically proximal to the event, those emotionally proximal, and those with preexisting vulnerabilities. Train or refamiliarize faculty members, parents, and students on how to recognize warning signs and identify support services. Have mental health providers screen for suicidal ideation/behavior. Conduct secondary screening with students who may present an elevated risk for suicidal behavior or have been affected by the suicide to determine if interventions are necessary. Some exposed students will have sufficient ability to cope. Notify parents/guardians of those assessed with suicidal risk and recommend community-based mental health services as needed. Coordinate with community providers with appropriate signed releases to do so.

Assess high-risk students for suicidal ideation or behavior. "All school mental health professionals have the ethical and practical responsibility to conduct suicide risk assessment" (Singer, Erbacher, & Rosen, 2018, p. 8). Suicide risk assessment is an essential role of the school psychologist in suicide intervention and requires specialized training (Lieberman et al., 2014). Risk assessment includes: identifying suicidal ideation, intent, and plan; assessing for risk and protective factors; assessing for access to lethal means and experience with self-injury to address habituation to pain; and creating a risk formulation. Many districts that we have consulted with have utilized the Columbia Suicide Severity Rating Scale for assessment.

Provide individual and group counseling to affected peers. Provide or refer students for individual counseling. This can include school-based counseling, safety planning, or referral to community agencies or mental health practitioners for treatment. Safety planning should include triggers, warning signs, thoughts, moods, coping strategies, agreement to remove access to means, and steps to take for help in a crisis. Parents should be involved in safety planning (Singer et al., 2018). Provide for students reentering from hospitalization (see FAQ 6).

### **Ensure Safe Messaging**

Be aware of policies and procedures on social media sites. Appoint a Social Media Manager to assist the Public Information Manager. Utilize students as "cultural brokers" to help faculty and staff understand their use of social media. Train students in a gatekeeper role, and specifically identify what suicide risk looks like when communicated via social media. Have staff monitor social networks and provide safe messaging when important (this will require that districts not completely block these networks). Have parents get involved in their child's use of social media.

Support opportunities for memorialization. Assist your school district in developing memorialization policies (see FAQ 7 and consult the memorialization pages of the Toolkit for a host of suggestions). Encourage funeral participation with support from the family. Contribute to a suicide prevention effort in the community. Develop living memorials or primary prevention programs that will help students cope. Monitor all off campus memorial sites (see FAQ 8).

Ensure responsible media reporting and safe messaging (see FAQ 9). Educate everyone about safe messaging by adopting the phrase "died by

suicide" to replace "committed suicide." Work with news reporters to inform, limit details, and share the resources listed at the end of this article. Educate students on safe messaging on social media. Encourage parents, staff, community members, and the students themselves to monitor communication that is concerning and to take action to get help for adolescents in need (via a trusted adult, crisis hotlines, crisis text lines, etc.).

### **Plan for the Long Term**

Follow up with all referred students in the days, weeks, and months that follow, particularly with siblings and relatives of the victim. Be mindful of planning for anniversaries, birthdays, and graduation. Debrief and evaluate the response. Collect data throughout the postvention on students referred, parent notifications, and student hospitalizations. Evaluate these data and update procedures.

Remember that postvention leads back to prevention. Implement evidence-based mental health promotion programs beginning in elementary school so that communication and seeking support for mental health is something that is accepted, encouraged, and supported. Train staff annually on how to respond to students seeking assistance. Have clear procedures in place with identified staff roles for getting students help. Update mental health and suicide prevention resources. Train peers, using gatekeeper programs such as Signs of Suicide (SOS) or Question/Persuade/Refer on how to respond when a peer needs assistance. Involve parents in all aspects of suicide prevention including policy development and gatekeeper training. Implement an evidence-based suicide prevention curriculum such as SOS, Sources of Strength, or Riding the Waves (see FAQ 10).

Engage your community. Implement a comprehensive suicide prevention program that includes the entire community, including school officials, law enforcement officers, emergency room directors, funeral directors, clergy, public health administrators, representatives from mental health agencies, technology experts, and adolescents. Communicate with other schools in the district or geographic area (including feeder schools) and groups with whom the student was involved (e.g., clubs, sports teams, jobs, and religious organizations) that can help support survivors and identify potential contagion. Ensure that school personnel, parents, and community members are monitoring social media and other forms of preferred communication among adolescents and empowering students to reach

out for help and get help for their friends and classmates.

### Resources

Utilize the newly released and updated, *After a Suicide: Toolkit for Schools, Second Edition* (2018), which is available at [www.afsp.org](http://www.afsp.org) and [www.sprc.org](http://www.sprc.org). This resource was created in collaboration with suicide experts, school personnel, clinicians, and crisis responders, and provides guidance and tools to assist with postvention efforts in the schools that aim to provide support to students and staff and prevent additional trauma and deaths. The importance of community collaboration and partnership, well established prior to a crisis, is emphasized to enable good working relationships when necessary.

Be familiar with recommendations from the Centers for Disease Control (CDC) and the World Health Organization. The CDC (1988) recommends the preselection of a suicide task force, made up of trained and experienced gatekeepers from various helping professions, to assemble when an adolescent suicide has occurred and to oversee the implementation of the community-based postvention plan. Tasks include organizing local gatekeepers who may not all be familiar with the cluster phenomenon or the postvention plan; helping professionals to review the anticipated reactions from peer survivors so that they can swiftly, uniformly, and effectively respond; creating a statement within 24 hours of the suicide to be shared with gatekeepers, schools, churches, teen organizations, and news sources in order to control what is reported and to advertise public forums and emergent resources; and frequently reconvening while the cluster remains active to discuss any new developments and to review the postvention plans.

More information from the CDC and the WHO may be found on their websites.

Ten FAQ's From the Field Answered

#### 1. **What is the one essential resource I need if a student in my school dies by suicide?**

If you do one thing after reading this series, we hope it is to download *After a Suicide: Toolkit for Schools, Second Edition* from the Suicide Prevention Resource Center and American Foundation for Suicide Prevention. It is easily accessed, completely electronic, and, at a time when you will find it hardest to think, it will provide you with best practice suggestions on how to proceed. Arrange to review the Toolkit with your principal in "prevention/

preparedness" mode, particularly the section on "Crisis Response." You could also share the "Helping Students Cope" section to highlight mental health services you provide.

#### 2. **What have you learned from consulting with school districts that have experienced point clusters?**

Realized they were in it for the long haul (minimum of 2 years). Created an intradistrict suicide prevention task force to inform their school boards in establishing best practice policies and procedures. Collaborated with and assisted in developing county-level task forces to consolidate suicide prevention resources and data tracking in the community. Provided specialized training to mental health personnel in suicide risk assessment, parent notification, collaborating with law enforcement and community mental health agencies, and safety and reentry planning for students returning from hospitalization. Created district-level suicide prevention/wellness coordinator positions to implement primary prevention programs such as Signs of Suicide: Depression Screening Program; Sources of Strength; and Riding the Waves. Coped with contagion due to unsafe messaging in television and other news media.

#### 3. **What if the parents do not want the cause of the death of their child to be acknowledged as a suicide?**

We have faced this situation many times and sometimes we have been successful in explaining to parents that no one will be theorizing about the reasons that their child died by suicide. In fact, the reasons for their suicide have died with them, but if we can simply acknowledge that the death was a suicide, this gives us an opportunity to talk truthfully with all staff and students about their important role in preventing further suicides. If the parents do not give permission to disclose the cause of the death, then the school crisis team is encouraged to read in the Toolkit the sample templates for student and parent communications that address this situation. It will be up to the crisis team and administration to determine whether or not to adapt the template letter, which essentially states that the parents have asked that the cause of their child's death not be disclosed but still emphasizes that suicide is a leading cause of death for students and that everyone needs to know

what to look for and what to do if someone is suicidal. It is worthwhile to mention there are two other templates for letters, one for when the parent is cooperative with the team in acknowledging the suicide and another for when you do not know if the victim's death was accidental or intentional.

4. **What are the most common questions that students ask in the aftermath of a suicide?**

Students always want to know why the suicide occurred, and it is important for the school psychologist to emphasize, "The answers have died with him/her and we will never know why, which is why it is so hard to grieve." Students often asked directly about the method that was used to die by suicide. We have found it best to simply acknowledge the method if it is factually known but not to dwell on any graphic details. Always focus the conversation back to helping students. Students also often ask why God did not stop him or her. We do not claim to be religious experts; however, numerous members of the clergy have stated, "Unfortunately, God could not stop him or her, but God has embraced them in whatever afterlife you believe in. But God is sad that they did not stay on this earth and do God's work over their natural lifetime." We like this approach, because it emphasizes that the victim has been embraced but was not chosen at a young age to die.

5. **Why don't you support an assembly after a suicide?** We very much believe that suicide prevention must be discussed with students and a death by suicide acknowledged, but in a classroom or an even smaller group setting. An assembly is dramatic and glamorizes the suicide, students will be reluctant to ask questions, and school staff will not be able to ascertain how individual students are coping with the tragedy.

6. **What do you do when the parent just drops the student off at school the day after their hospitalization? Can you tell the first period teacher?** This question comes up frequently and is known in "prevention phase" as reentry planning. In a perfect world, the parent would accompany the student back and meet with the psychologist to share the records from the hospital and develop a safety plan that includes trusted adults at school. Additional components of reentry planning include: Monitor the student to ensure that no bullying takes place as a result of hospitalization.

Collaborate with members of the team and determine which staff members, including teachers, need to be apprised of the situation to ensure the student's safety. Do not deny entry to any student standing at the front door of the school. They are much better served at school then alone at home. Check in frequently the first few weeks, particularly if monitoring medications.

7. **What is the key recommendation in the Toolkit about memorials?**

The Toolkit strongly recommends that school districts establish one policy that treats all deaths the same, regardless of the cause of death. The school psychologist could advocate for such a policy while in prevention phase before a death by suicide occurs.

8. **What if students arrive at school the day after the suicide with T-shirts with a picture of the deceased, and they want to wear them at school?**

This is the scenario that we have encountered quite often, and the Toolkit stresses the importance of being compassionate and understanding that students are expressing the loss of their friends through wearing the T-shirt. We believe it is best to allow the T-shirt for that first school day and then meet with students, remind them of the school's dress regulations, and guide them toward more appropriate prevention and memorialization activities referenced in the Toolkit.

9. **What are some examples of the safest messages that I can communicate to my students, staff, and parents?**

Suicide and the grief that follows a death by suicide are complex and no one person, no one thing, is ever to blame. Additional safe messages include: While some suicides cannot be prevented, most can. Everyone plays a role in suicide prevention. There are evidence-based treatments for all the risk factors of youth suicide. Kids are resilient, and they can get better.

10. **What are some available applications to help me with suicide assessment and safety planning?**

One application to assist with suicide assessment is SUICIDE SAFE from SAMHSA. Three applications to assist with safety planning are: Virtual Hope Box; A Friend Asks from the Jason Foundation; and My3, developed with funding from the California Mental Health Services Act (<http://my3app.org>).

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## COVID-19 AND SUICIDE

By Scott Poland & Elizabeth Hilsman

In the midst of this international crisis caused by the COVID-19 pandemic, there has never been a more important time for people to know the warning signs of suicide and to be comfortable reaching out for help.

This situation is still developing, and we will be following it closely. What we can say at this time is that experts are making dire forecasts for the suicide rate to increase in the coming months. According to the American Association of Suicidology, the suicide rate is already the highest it has been in 50 years. Dramatic rises are predicted as people feel more anxious, powerless, and isolated while facing trauma and grief.

Past research shows us that suicide rates have increased after stock market crashes. Unemployment rates and financial hardships have skyrocketed in our country in the past few months, suggesting a major risk factor for suicide rates to go up.

Who might be most at risk? We believe it is likely to be those with preexisting mental health and medical conditions; those experiencing grief due to the loss of a loved one; those exposed to pain, suffering, and trauma, such as first responders and healthcare workers; and those experiencing extreme financial losses.

Are there increased risks for kids? While some students may feel some reductions in some social or academic stresses now that virtual school has replaced campus life, we do believe they will be at higher risk if they have untreated or undertreated mental illness, have lost a loved one to the virus, or are now living in poverty.

As we note all of these risk factors, we want to emphasize that *suicide is preventable*. This is the time to know the warning signs of suicide and how to get help, to increase funding for suicide prevention, to increase education about and reduce the stigma of seeking help for mental health concerns, and for increasing prevention and intervention efforts for students who are in distance learning (see Comprehensive School Suicide Prevention in a Time of Distance Learning at [www.nasponline.org](http://www.nasponline.org) and resources from the American Foundation for Suicide Prevention at [www.afsp.org](http://www.afsp.org)). Communities can pull together at this time to share resources and strengths.

We will address the pandemic more fully in the next edition of our newsletter.

Stay safe and be well,  
Scott Poland & Elizabeth Hilsman

## WHY KIDS KILL AUTHOR INTERVIEW WITH PETER LANGMAN, PH.D.

By Dr. Scott Poland & Pamela Hirsch, M.S.

*Dr. Scott Poland (SP) and NSU doctoral student Pamela Hirsch, M.S. (PH) interviewed Peter Langman, Ph.D., psychologist, national expert, and author of Why Kids Kill: Inside the Mind of School Shooters and School Shooters: Understanding High School, College and Adult Perpetrators. Dr. Langman's website, <https://schoolshooters.info>, is an excellent resource for anyone trying to make school safer. It contains extensive information, including a "Prevention" page with close to 50 documents on threat assessment, warning signs, and violence prevention.*

### **What got you interested in school violence and characteristics of school shooters? (SP)**

As you will recall, April 20, 1999 was the attack on Columbine High School. I was doing my internship in a psychiatric hospital, which is part of the KidsPeace spectrum of care. Just ten days after Columbine, we had a 16-year-old boy admitted, because he had a hit list and was engaging in some very strange and disturbing behavior. People saw him as a potential Columbine-type risk. So it was only ten days post-Columbine when the first potential school shooter came through the doors, and I was assigned the case. It wasn't long before there was another potential school shooter, and another one, and after my internship, I got hired and was there for over 12 years. I saw a pretty steady stream of these kids coming through our doors.

### **When did you start to develop your idea about the three types? (SP)**

I was working on the typology by 2006. I still remember it exactly. It was the summer of 2006 that the Jefferson County Sheriff's Office released about 22,000 pages on Columbine. Included in that were the journals of Harris and Klebold. Before that release of documents, I was not even going to include Dylan Klebold in my first book, because I didn't know what to say about him. Once the documents came out, suddenly I was able to make sense of Dylan.

### **What did you use for your foundation as you were developing the three types? Were there previous**

### **works that influenced you? (SP)**

No, it was early on, and there was no literature on the typology of school shooters, evaluating for school shooting risk, and so on. Columbine was hardly the first school shooting or the first in the '90's. There were a lot, including the previous academic year of '97-'98. But the literature in the field hadn't really caught up with the phenomenon. So the early work by the Secret Service, the Department of Education, and the FBI were identifying characteristics of the perpetrators, but they were not dividing them into categories. I think going back to my very first case, the 16-year-old boy who came in after Columbine, I remember struggling with that individual trying to figure it out. Is this person psychotic? Is he psychopathic? He was not a cooperative client. That made it challenging. I remember even with that first case trying to figure out, what am I dealing with here? I was trying to make sense of the presentation, and what struck me as I was seeing the kids in the hospital and also the cases that happened across the country from '99 on was not how similar the perpetrators or would-be perpetrators were but how different they were. I was realizing there were significant differences in who they were and how they got to that point, even if the end point looked like it was the same thing—a school shooting. Why they were doing it and the path they took to get there tended to be very different from the next guy, and out of that emerged the recognition that I'm dealing with different types of people here.

### **I know you used the term "focusing on their life histories" in trying to understand these rampage acts. (SP)**

I think life history is important. Sometimes it's important because, like with the traumatized shooters, it's been so devastating in so many ways, multiple types of abuse, chaotic, violent upbringings, and so on. In other cases, what's striking about their life history is how "normal" or "typical" they seem to be and then trying to make sense of how someone from, as far as we can tell, a stable and intact, loving and supportive family gets to the point where mass murder seems like a good idea. Again, that's where psychopathy or

psychosis might come into play.

**What kind of feedback have you received about your books, especially from school personnel? (SP)**

It seems that school personnel are very eager for the information that I've accumulated. When I travel to a school district, often they've had no training in who school shooters are and what the pre-attack behaviors are that they should be looking out for. Often, they don't seem to know anything beyond what they've heard from the media. My impression is that people are very hungry for someone to make sense of what seems like an incomprehensible phenomenon.

**What other resources would you like to see in schools for these kids? (PH)**

From a standpoint of preventing a school shooting, the number one thing is they need people trained in threat assessment. There are several components in putting in an effective threat assessment process. One is a threat assessment team that needs in-depth training. Second, train all the staff, regardless of position, in a basic introduction to warning signs and what to do when they see potential warning signs. And three, educate the students about warning signs, help them think through their potential ambivalence about reporting on a classmate or not, differentiating "ratting someone out" or "snitching" or "tattling" on someone from reporting a safety concern to save people's lives. These are two very different things, but it may be hard for students to take that step. You should have an anonymous reporting system in place to make it easy for students to come forward with what they know. If anyone knows what's about to happen, it's probably the students, but you have to have the relationships in place and have the system in place to make it as easy as possible for them to report what they know when it comes to safety concerns.

**What are the warning signs that you think that a school psychologist should look for? (PH)**

You might not be hearing things directly from the students in question if you're the psychologist. You might be hearing from the classmates what is called "leakage," when the perpetrators disclose their intentions to their peers, and it is often very direct and explicit. They will say, "I'm going to bring a gun to school and kill people." They will announce it to their friends or brag about it to their friends. They will warn a friend to stay away,

because they don't want that particular friend to get hurt. So they will say, "Don't come to school on Monday. This is what I'm going to do, and I don't want you to be there." They might invite a friend to join them in the attack, and often the kid will say no, but if he doesn't report that invitation, you're not going to prevent the attack.

The problem with all this leakage that is so explicit is that people don't take it seriously. Especially when they are young perpetrators. There have been perpetrators of mass attacks from 11 years old and up. When they're that young and that small, it may be hard for anyone to take them seriously. They think the kid is just shooting their mouth off, so they don't report it. Administrators can get caught in that too. They might look at the cute 11- or 12-year-old boy—it usually is a boy, but not always—and think, "This kid is not a mass murderer, because I know the boy, I know his parents, I taught his older brothers and sisters." It is easy to convince ourselves that we're not facing what we don't want to believe were facing. It's easy to rationalize not taking action both for students and staff. So that's a big barrier—getting people to report things, and if they are reported, getting the staff to take them seriously.

Another thing to look out for is that sometimes they threaten people. There was a student who said, "When I come back with a rifle, you're going to be the one I shoot." He told that to a peer, but the peer did not report that. There have been other cases like that where direct threats to students have been ignored. One shooter told his ex-girlfriend, "I'm going to put a bullet through your head." She didn't take it seriously, so she didn't tell anyone, and, sure enough, the kid came back and tracked her down and put a bullet through her head.

**We've had this recommendation for threat assessment teams in schools for nearly 20 years. What do you think has held schools back from forming and training these important teams? (SP)**

I don't work in the school system, so I might not be the best person to answer that. For some reason, it seems like schools across the nation jumped on board with responding to an attack and doing lockdown drills, doing drills on surviving an active shooter, emergency response, and having plans on how to evacuate and where to meet and so on, but they're not doing the same thing with the preventive piece. I've talked to people who've said, "Oh we have school safety covered, we do lockdown drills," as if that's all you need to do. They don't understand the distinction between

proactive threat assessment to prevent the attack in the first place versus reactive lockdowns and emergency procedures. I am not sure how or why, but since Columbine, people seem to be focused on reacting to the event rather than preventing the event.

**I agree with you. One of the Sandy Hook parents said, "School safety focuses too much on the moment of the shooting and not on preventing it in the first place." (SP)**

Yes, and I wonder if that goes back to the repeated misstatement that, "it's impossible to predict violence." I wonder if people feel like it happens out of the blue, and you can't predict it or see it coming, that the best you can do is respond to it. This is a major misconception when it comes to attacks like these. A lot of people make the distinction between preventing violence and predicting violence.

**As a psychologist, are there any particular instruments for assessing violence that you prefer and recommend? (SP)**

I don't, at this point, do violence risk assessments. There are some instruments out there, but I can't recommend one over the other. There is a fascinating article by Dr. Brian Van Brunt that I have on my website on the "Prevention" page. He creates a scenario or two, then uses four different instruments to see how each one would rate the risk of violence based on the information available in those scenarios.

**In reading your books, it got me thinking about the events that have happened closer to us, and I wanted to know your thoughts about Nikolas Cruz. Which category might he be placed in? (PH)**

This is a tough case, and it's still being sorted out. If I had to put him in a category, I tend to lean toward psychopathic personality. This is someone who throughout his life has had problems with impulse control, aggression, violence, lack of empathy. That would seem to be a reasonable perspective on him. If you read his interrogation post-attack, however, he also talked about voices and demons. I don't know if those are valid and legitimate symptoms he is reporting or things he's coming up with after the attack. There may be some evidence that he had some prior to the attack. That's a hint of possible psychotic symptoms, but in the overall picture, they don't seem as significant as his apparent psychopathic traits. One thing I should

say is that people are not limited to one category only. There have been multiple shooters who seem to have traits of two of the categories, so that's also possible. He could have been primarily psychopathic with an aspect of psychosis, if those reported symptoms were legitimate.

**Due to his claims and the other evidence of mental health factors, are kids like this fully responsible? At what point are they no longer responsible? (PH)**

That's more of a legal question, getting into the 'not guilty by reason of insanity,' defense, which is a separate issue. This does get into some very difficult issues of responsibility. There was a 12-year-old shooter who may have had some brain damage and was perhaps on the autism spectrum. He committed a school shooting. He also killed himself, so he never came to trial, but when you have someone that young with obvious intellectual deficits, how does the court view that? That becomes a very tricky issue. Kip Kinkel, who committed a school shooting at age 15, was diagnosed with schizophrenia after his attack. He remains in prison, and the ethics of putting a mentally ill teenager in prison for life have been discussed in law journals.

**What do you think about the fact that a number of districts are arming staff other than resource officers? What's your take on that? (SP)**

I think that's a problematic approach for multiple reasons. Even if you're skilled with a firearm shooting at a target, that has very little relevance to handling a firearm in a crisis situation. It's very easy to make a mistake. When your heart is pumping and the adrenaline is flowing and your hand is shaking, to even get your gun out and aim it, especially with hundreds of students running wildly and maybe people bumping into you, it would be easy for a teacher to hit the wrong person. In fact, there is a study of New York City police officers who engage in firing against a suspect on the streets of New York. Even trained police officers miss their target 82% of the time. If they're trained and it's that hard to hit a target in a crisis situation, you have to ask where those bullets are going. It obviously would be very devastating for teachers with the best of intentions to wound or kill a student or colleague. That's one big concern. Another is when police show up in that situation, if the first thing they see is a teacher pointing a gun at a student, the police may likely shoot the teacher. They may not know who the assailant is, and that teacher may be gunned down by mistake. There are other concerns

too, but those are just some examples of what can go wrong with what seems like a good idea. When we start thinking of how this can really play out, it becomes more problematic.

**What are the key things you would say to a principal or a superintendent to prevent a school shooting? (SP)**

I would say implement a threat assessment system. Don't just have people trained once and think they're ready to go. Have ongoing training, maybe monthly meetings. How are you going to stay fresh with the materials? You need to have table-top scenarios and have ongoing meetings, discuss articles. You have to stay on top of the subject matter.

**Your first book was all about high school and middle school age shooters. With the second one, you included college shooters. Do you see any significant differences? (SP)**

The second book includes college age as well as what I call aberrant adult shooters. I've got 24 shooters who committed attacks on middle schools or elementary schools where they were current or former students, and I've got 24 college and aberrant adult shooters. There are some differences. You know the stresses that put a 40-something-year-old perpetrator on the path of violence may be different than a 16-year-old perpetrator. What you see with the older shooters is a lot more financial distress seeming to be a major issue. You don't see that with the teenage shooters. You also see a higher rate of psychosis among the older shooters, which makes sense, because the average age of onset of schizophrenia is usually late teens or early 20's for males. So it would make sense that you won't see as many psychotic shooters at a younger age. You do see some other differences. You see far more traumatized shooters among the secondary school shooters; they're virtually nonexistent among college and adult perpetrators. The typology is still relevant, but how that plays out in terms of the demographics of the population is different.

**One thing that I think is missing, from my personal opinion, is that if a kid doesn't have a gun, they don't shoot anybody. That is not what is being focused on, at least not enough, in my opinion, safeguarding guns from troubled and impulsive, mentally-ill kids. (SP)**

I've looked into this, and in most cases with a juvenile shooter, they are just using guns from within

the family. They are not buying guns illegally on the street. They are just taking guns that belong to their parents or grandparents or other relatives in most of the cases. It's not a matter of firearm law as much as firearm safety within the home, just using common sense to keep your kids from having access to your weapons.

**You've cranked out two great books. What are you working on now? What's your next project? (SP)**

I'm currently working on another book all about warning signs of school shootings written for diverse professionals in education, law enforcement, and mental health. My last two books focused on the psychology of the perpetrators. This new book takes the accumulated knowledge of many years of studying this and focuses on their pre-attack behavior, the warning signs, and what people should be looking for.

**Well, anything else you'd like to say to us today? (SP)**

My general message is that these attacks can be prevented, and they are often prevented and we tend not to hear about that. Often people do come forward. Often it is students, but it can be family members or school personnel who pick up on the warning signs. That is the good news—that we can and are preventing these attacks. Another message is that people are growing up to be paranoid about walking into a school, whether you're a student or a teacher or administrator. School shootings, especially the rampage attacks like Parkland, are still statistically extraordinarily rare, and we need to be prepared without being panic-stricken. When I speak to school audiences, I often start with a slide that says, "Prepare, don't panic." I try to put this issue in context for them, because there is so much misinformation from media coverage that people seem to think that it's not a matter of if but when it happens. Just to put it in context, even if we had a Parkland attack every month of the year, so we were having 12 rampage attacks like Parkland every year (which we're not, nowhere near that), there are over 120,000 schools in this nation. So at the rate of 12 a year, on average, any particular school could expect to have such an attack once every 10,000 years.

**You're absolutely correct, and that's something that has really gotten lost with all of the media coverage of school shootings. It has scared parents, and they're pushing schools to do things that may not make much sense. (SP)**

Right. Schools feel obligated to do something. There's this panic about it often, but that means that they're not necessarily taking the time to think it through and to figure out how real is the danger and how can we best spend the funds that we have to prevent the danger. I've seen statistics that more students are killed in school parking lot traffic accidents than are killed in school shootings. There is no upsurge in public concern about school parking lots, and yet they are more dangerous than school shootings in terms of students killed each year. There is so much in the way of discrepancy between the reality of danger and the perception of danger. I could go on and on, but, again, in terms of putting it in context, when I'm presenting to school audiences, I will tell them that when you drive up to school and walk from your car into the school building, you've just gone from the most dangerous place you will be all day, your vehicle, into what is probably the safest place you'll be all

day, the school. Traffic fatalities are something like 1300 times higher than school homicides—more than 1,000 times more frequent. You're also probably ten times more likely to be hit by lightning than to be killed in a school shooting. I try to put this in context for people in all kinds of ways. Going back to suicide, because I've done work on suicide prevention too, most schools will never have a rampage shooting in our lifetime, but it's safe to say that every middle school and high school has students at risk of suicide, probably every day, and yet there is no equivalent upsurge in awareness and concern about student suicide. That's because it's much more of a not-so-public event, so it doesn't get the same media coverage. So, let's prepare our staff and students to recognize the warning signs to prevent school shootings, but let's not forget all of the other risk factors for students, especially suicide.

## HELPING SURVIVORS OF SCHOOL SHOOTINGS: ADVICE FOR PARENTS AND HEALTHCARE PROVIDORS

**By: Carolina Vega Suarez, M.S. & Ashley Jacobson, B.A.**

*Dr. Jessica Ruiz and Dr. Kasi Patterson, licensed clinical psychologists, work with Behavioral Health Associates of Broward at Goodman Jewish Family Services in Davie, Florida. Both psychologists have experience providing psychotherapy for individuals who have a history of trauma, including school shooting survivors. We spoke with Dr. Ruiz and Dr. Patterson about the effects of a school shooting on survivors, family members, and clinicians.*

School shootings are traumatic events that impact communities in a way that changes individuals' lives forever. This type of traumatic event could result in psychological problems that range from acute distress symptoms to a Posttraumatic Stress Disorder (PTSD) diagnosis. If symptoms are not addressed, it places individuals at an increased risk for suicide. Therefore, being informed about the mental health consequences following a traumatic event, signs of difficulties, and when to seek help could lead to better outcomes for everyone affected.

The most prevalent sign caregivers and teachers should look out for in children who either experienced or witnessed a school shooting is any type of behavioral change. Dr. Ruiz explained that sometimes children have a "difficult time putting their feelings into words," and show increasing irritability. Moreover, she highlighted the importance of monitoring the child's academic progress, as it could suggest a sign of distress. Finally, she indicated that social withdrawal is a major component in the development of psychological symptoms after a traumatic event. On the other hand, Dr. Patterson reported that children may exhibit changes in mood, sleeping, and eating habits, and change within their peer relationships. Therefore, if caregivers or teachers notice any behavioral change, it is important to check in with the child to provide insight and to establish honest, open, and safe communication.

Some of the most common psychological symptoms for survivors according to Dr. Ruiz include

intense fear, shock responses, dissociation and detachment. Additionally, Dr. Patterson indicated other common psychological symptoms such as difficulty with intrusive thoughts, nightmares, difficulty with interpersonal relationships, and survivors' guilt. He indicated that often when survivors experience this guilt, they may ask, "*Why me? Why was I spared? And now that I have been spared, what do I do with this opportunity? How do I keep alive the memory of my peers who were not so fortunate?*" which raises questions about seeking treatment.

When it comes to the appropriate time to search for professional help, Dr. Ruiz suggested that around one week after the traumatic event is a good time to evaluate lingering symptoms and their effects. However, she noted that immediately after the event occurs, the child should be provided with resources and support to talk to someone if needed. On the other hand, Dr. Patterson suggested that "even if signs and/or symptoms are not immediately noticeable," seeking treatment "as soon as possible" could be helpful, as it could assist the child with processing the traumatic event. As he explained, once an event occurs, a memory can be inappropriately stored, thus making it essential that the individual receives professional services at the earliest possible time in order to process and store that memory appropriately.

Crucial to know is that surviving a school shooting places an individual at risk of having suicidal ideation and attempts. The three most critical symptoms for an increased suicidal risk are isolation, a sense of hopelessness, and "survivors' guilt." According to Dr. Patterson, hopelessness could be one of the most dangerous aspects associated with suicide, as a client might feel stuck and with no progress noted over time. Additionally, individuals may refrain from socializing with their peer groups and communities and may distance themselves from their families, increasing loneliness. Furthermore, as explained by Dr. Ruiz, individuals who experience survivors' guilt often feel as though they could have or should have done something different, which could lead to feeling a lack of control and negative cognitions. These behaviors and thoughts can exacerbate the individual's

symptoms and develop into suicidal thoughts and attempts. When PTSD symptoms worsen, an individual is more likely to experience "cognitive mood shifts," such as, "*I'm always going to feel this, and this is never going to change,*" per Dr. Ruiz. These types of cognitive changes may lead to thoughts of suicide or even worse, to suicide attempts.

In the aftermath of a school shooting, it is natural for children to be curious and to have the desire to discuss the event with other people. Therefore, as previously mentioned, establishing honest and open communication with responsible adults is vital. Both Dr. Ruiz and Dr. Patterson agreed that it could be more helpful to discuss issues of safety, resilience, and coping strategies rather than focusing on the details of the event, such as people injured or killed. However, family members should be cautious not to overload the child with information, as it could aggravate the problem. According to Dr. Ruiz, some of the helpful questions that caregivers could ask their children to promote good communication and feelings of safety are, "*What are your thoughts?*" and, "*What is your school doing in terms of safety?*" Moreover, the discussion of the event will depend on the child's age and maturity. For instance, Dr. Patterson explained that with a younger child, caregivers could talk about safe people to reach out to, while with an adolescent, caregivers could talk about political actions. Also, it is advised that family members disconnect or "take a holiday" from social media, as it could retraumatize the survivor and his or her family.

When it comes to the most effective treatment approach, Dr. Ruiz and Dr. Patterson suggested any type of trauma-informed care, such as Eye Movement Desensitization Reprocessing (EMDR) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Nevertheless, what makes therapy effective is a good therapeutic relationship, which according to Dr. Patterson means a "good fit between the person sitting on the couch and the person sitting in the chair," or, as Dr. Ruiz described, "making the client feel comfortable," despite their discomfort and suffering. In other words, it is recommended that clinicians implement

evidenced-based and trauma-focused interventions but modify them to the client's needs and preferences in order to achieve more effective outcomes.

Ultimately, working with survivors of a shooting is complex and challenging for healthcare providers. It requires compassion, empathy, openness, understanding, as well as training and experience

providing trauma-informed care. Clinicians may face difficulties when treating survivors of a shooting, such as burnout and "re-living the trauma with the client," according to Dr. Ruiz. Therefore, some of the recommendations provided by Dr. Patterson include consultation with colleagues and good self-care, both physically and mentally, to avoid exhaustion, feeling emotionally drained, and to provide the best possible care.

## Kevin Hines Shares Lessons from His Suicide Attempt

By Claudia Rodriguez, M.S. & Patrick Pyott

Built in 1937 with a length of 1.7 miles and looming 220 feet above the San Francisco Bay is an engineering marvel – the Golden Gate Bridge. Since the bridge's opening, 1,700 people have leaped from its railing with the intention of dying by suicide. With such a high number of jumps, only 36 people are known to have survived the plunge. One such person is Kevin Hines. Hines, 38, came to Nova Southeastern University as a guest speaker for NSPIRE & MIND on February 20<sup>th</sup>, 2020, to share his story. Beginning with his first psychotic break at seventeen, Hines described his journey to his suicide attempt at nineteen, the knowledge he gained from this traumatic experience, and resources he shares around the world.

At seventeen-and-a-half years old, Hines described himself as a "theatre kid." During a performance, Hines experienced his first psychotic break on stage in front of 1,200 audience members. Hines recounted his "brain breaking" as thoughts of danger entered his mind. Hines's psychotic mental state led him to perceive that all 1,200 people in front of him wanted to end his life. Immediately, Hines ran to his theatre director for help, and his mother picked him up. After this experience, Hines went to a psychiatrist who diagnosed him with bipolar disorder and prescribed medication to treat his symptoms.

As time progressed, Hines described that on September 24, 2000, auditory and visual hallucinations about death dominated his perception of reality. He did not communicate

what he was experiencing, because the voice in his head echoed, "Who would listen?" Hines secretly wrote out his suicide notes. Ambivalent about dying and wanting to feel less alone in his pain, he had problems directly expressing to another person the distress he was in, in spite of his father's efforts to talk to him and to encourage him to spend the day together. Unbeknownst to his father, Hines had dropped all of his college courses except for his English class, but he went to campus to see a professor one last time.

On a bus leaving campus, he sat towards the back and cried profusely, hoping another rider would ask if he was okay or if he needed help. His hopes sank when another passenger dismissively said, "Hey, what's wrong with that kid?" Hines, in his talk, described this uncaring attitude as a problem in our society. As he reached the end of the line at the Golden Gate Bridge, Hines was hopeful that the bus driver would see his pain and reach out to help, but instead, he heard a cold response of, "Come on kid, I've gotta go." Hines said that he exited the bus fighting his psychosis, thinking, "I have to die, but I don't want to."

After getting off the bus, Hines walked the whole length of the Golden Gate Bridge still hoping someone would stop him and ask if he was okay. As he made this 1.7 mile walk across the bridge, the voices in his head kept telling him to die. As he reached the end of the bridge, he remembered that someone walked up to him. He thought, "This is it, the person who is going to stop me and save

me," but it wasn't; he was simply asked to take a picture. He reached the end of the bridge, stood over the edge, looked down, and jumped.

Hines recalled that the very moment he jumped, he knew he had made a mistake. He completely regretted his decision. In four seconds, he traveled 220 feet, plunging into the frigid San Francisco Bay waters, shattering three vertebrae, missing his spinal cord by millimeters. By this time, his body was fully submerged underwater, and Hines recalled being unable to swim or breathe. He knew he was drowning, but he also knew that he wanted to live. He remembered thinking, "I can't die here." As he tried to swim and reach the surface, he remembered feeling something swimming under him. "A shark?" he thought. Then he lost consciousness. He didn't regain it until the coastguard rescued him, and he was air-lifted to a nearby hospital. What Hines would find out months after his recovery, was that the moment he jumped, a man on the bridge saw him. This man immediately called the Coast Guard, which is why they were able to get to him so fast. As the man on the bridge waited to make sure Hines was rescued, he noticed the same thing Hines felt swimming under him. It was not a shark. It was a sea lion that held Hines up to the water's surface to stop him from drowning. The action of this sea lion caused Hines not to drown and gave the Coast Guard more time to reach and save him.

Today, Hines is an activist for mental health and suicide prevention. He mentioned that he regrets jumping off the Golden Gate Bridge to die by suicide, and yet he still struggles with bipolar disorder and thoughts of suicide. He said, "Suicidal thoughts plague me, but they are never going to take me." The difference between September 24, 2000 and today is that Hines is now proactive when he does have suicidal thoughts and uses the safety plan he has in place. He knows he needs to talk to his wife and family about what he is thinking and feeling. He has a list of activities he makes himself accomplish every day to combat his unhelpful thoughts. He also has the phone numbers of professionals and crisis lines he can contact at any time for help. Additionally, Hines now goes to therapy and is in treatment for his Bipolar Disorder. As he puts it, "Don't let pain defeat you. Let it build you brick by brick." Hines has done just that. He has made it his life's mission to improve the lives of and attitudes toward people with mental illness with his #BeHereTomorrow campaign. As he says, "Be here tomorrow... and every day after that."

If you would like more information about Kevin Hines, visit <http://www.kevinhinesstory.com>, his YouTube channel that focuses on mental health, or watch his documentary film, *Suicide: The Ripple Effect*.

**"Don't let pain defeat you. Let it  
build you brick by brick." *Kevin Hines***

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## SVP Presentations

The office of Suicide and Violence Prevention has provided 300+ presentations to various departments at NSU as well as many outreach presentations in our community.

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

To request a presentation, email [svp@nova.edu](mailto:svp@nova.edu) or use the form at our website [www.nova.edu/suicideprevention](http://www.nova.edu/suicideprevention).

# Suicide & Violence Prevention Resources

## **Henderson Student Counseling**

954-424-6911 (available 24/7)

[nova.edu/healthcare/student-services/student-counseling.html](http://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](http://nova.edu/hr/index.html)

## **National Suicide Prevention Lifeline**

1-800-273-TALK (8255) or 1-800-SUICIDE

[suicidepreventionlifeline.org](http://suicidepreventionlifeline.org)

**Veterans:** Press "1" or Text 838255

**Chat:** [suicidepreventionlifeline.org/chat](http://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](http://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](http://211palmbeach.org)

## **NSU Student CARE Team**

Non-crisis prevention & early intervention

954-262-7482, [nsucareteam@nova.edu](mailto:nsucareteam@nova.edu)

[www.nova.edu/studentcare](http://www.nova.edu/studentcare)

## **Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Locators**

[samhsa.gov/find-help](http://samhsa.gov/find-help)

## **The Jed Foundation (JED)**

[jedfoundation.org](http://jedfoundation.org)

## **Suicide Prevention Resource Center**

[sprc.org](http://sprc.org)

## **Suicide Awareness Voices of Education**

[save.org](http://save.org)

## **The Depression Center**

[depressioncenter.net](http://depressioncenter.net)

## **Yellow Ribbon International**

[yellowribbon.org](http://yellowribbon.org)

## **Florida Initiative for Suicide Prevention**

[fisponline.org](http://fisponline.org)

## **Florida Suicide Prevention Coalition**

[floridasuicideprevention.org](http://floridasuicideprevention.org)

## **National Center for Injury Prevention and Control**

[cdc.gov/ncipc/dvp/suicide](http://cdc.gov/ncipc/dvp/suicide)

## **American Association of Suicidology**

[suicidology.org](http://suicidology.org)

## **American Association for Suicide Prevention**

[afsp.org](http://afsp.org)

## **Florida Department of Children and Families Suicide Prevention**

[myflfamilies.com/service-programs/mental-health/suicide-prevention](http://myflfamilies.com/service-programs/mental-health/suicide-prevention)