2022

2022 Summer Newsletter

Nova Southeastern University

Office of Suicide and Violence Prevention

Nova Southeastern University

SUMMER 2022 NEWSLETTER

Director: Scott Poland, EdD
Post Doctoral Resident: Juliette Hubbard, PsyD
Graduate Assistants: Christina Castellana, B.S., & Katlyn Bagarella, B.A.

Keeping Our Community Safe

In this Issue

Events and Highlights

5/10/22: Invited session at the 7th Annual Behavioral Health Conference held by the United Way of Broward. "Suicide Prevention, Intervention, and Potvention: est Practices for Behavioral Health and Social Services"

5/19/22: Presentation at the 2022 Higher Education Suicide Prevention Coalition (HESPC) and Prevent Suicide PA (PSPA) Conference "Bringing It All Together" - "The First Year Experience: Outcomes from Required Suicide Prevention and Awareness for all Freshmen at Nova Southeastern University (NSU)

6/8-9/22: Invited sessions on school violence, school safety, and suicide prevention for the Arkansas School Psychology Association in Jonesboro, Arkansas

6/14/22: Webinar - Lessons Learned from School Shootings

6/15/22: School violence and school safety for the Pembroke Pines police department

6/21/22: Invited sessions for MT. Behavioral Institute in Bozeman, MT

- Session 1: School violence and school safety
- Session 2: Youth suicide prevention

6/30/22: Testimony to the Montana State Legislature on the important role of schools in youth suicide prevention

Upcoming Events!

8/31/22 @ 7:00 PM on Zoom - Session on suicide prevention for individuals with justice system involvement. Collaboration with Forensic Advocates for Reintegration and Rehabilitation

9/5 - 9/9/22 from 12-2pm - Tabling in the Maltz Lobby for Suicide Prevention Week

10/8/2022 - NAMI Walks Your Way Broward at Nova Southeastern University

11/13/22 - AFSP Out of Darkness Walk at Nova Southeastern University

NSU Campus Safety

At NSU, our priority is the safety of our students, faculty, staff, and visitors.

- In case of an emergency, a mass notification system (NSU Alert) will be sent to notify the NSU community of any confirmed significant emergency or dangerous situation involving an immediate threat to the health or safety of NSU students or employees on campus. To sign up for these messages visit nova.edu/emergency.
- Blue-Light Emergency Phones are located throughout each NSU campus! Press the red EMERGENCY button (or black CALL button) and wait for the dispatcher to answer. Then, explain the reason for your call. A blue light will flash so that personnel can more easily find you.
- On-campus Safety Escorts are available 24/7 by calling the NSU Public Safety hotline. A uniformed NSU Public Safety officer will meet you and accompany you to your destination.
- Remember, in case of an emergency call 9-1-1.
- To access NSU's Campus Safety Handbook go to: https://www.nova.edu/publicsafety/forms/campus_safety_handbook.pdf

If you see something, please say something!

NSU PUBLIC SAFETY HOTLINE (NOVALERT)
(954) 262-8999 (AVAILABLE 24/7)

NSU EMERGENCY HOTLINE
800-256-5065

Download the SaferWatch app to report tips, suspicious activity, and nonemergencies directly to NSU Public Safety.

Community Violence

Christina Castellana, B.S.

Of the myriad factors which affect the well-being of our communities, violence has captured the concern of researchers, politicians, and civilians alike. Community violence affects the well-being of individuals and communities in numerous ways. “Community violence is a broad concept,” explains Dr. Christopher Layne, clinical director for the Child and Adolescent Traumatic Stress Program (CATSP) clinic and an associate professor at Nova Southeastern University in Fort Lauderdale, Florida, “it encompasses violence that is found in the broader community as well as domestic violence.” While domestic violence plays a critical role, researchers often conceptualize community violence as the exposure to acts of interpersonal violence committed by individuals who are not intimately related, generally in public areas outside the home (Community Violence Prevention, 2021). Although some types of traumas are accidental, community violence is an intentional attempt to hurt one or more people (Community Violence, 2018). Common types of community violence affecting youth include both individual and group conflicts, such as bullying, fights among gangs or groups, and shootings in public areas, such as schools and on the streets (Community Violence Prevention, 2021). Community violence can also include sexual assault, burglary, mugging, the sound of gunshots, drug abuse, racial tension, and other forms of social disorder (Hamblen & Goguen, 2015). Though an individual can be directly impacted by community violence, its indirect victims are more numerous, and may be affected because they’re bystanders, witnesses, or even anxious about the potential of violence (Cooley-Strickland et al., 2009).

(Crime Free Future)

Community violence can also include sexual assault, burglary, mugging, the sound of gunshots, drug abuse, racial tension, and other forms of social disorder (Hamblen & Goguen, 2015). Though an individual can be directly impacted by community violence, its indirect victims are more numerous, and may be affected because they’re bystanders, witnesses, or even anxious about the potential of violence (Cooley-Strickland et al., 2009).

According to Dr. Layne, “Everyone is at risk for community violence.” That risk is realized for millions of individuals, families, schools, and communities affected each year (Community Violence Prevention, 2021). Children are especially impacted by community violence. One study showed that more than 40% of youths surveyed (N=2248) reported exposure to a shooting or stabbing in the past year, and 74% reported feeling unsafe in one of more common environmental contexts (Schwab-Stone et al., 1995). Another study showed that over 80% of children living in urban areas have witnessed community violence and that as many as 70% of them report being victims of community violence (Cooley-Strickland et al., 2009).

There are various risk factors surrounding exposure to community violence. One prominent risk factor is having a low socioeconomic status (SES). Dr. Layne included that "children and families who live in low socio-economic, disadvantaged neighborhoods tend to be at disproportionately high risk for various types of community violence."Research supports this assertion, with many studies indicating that higher rates of exposure to violence happen in poorer neighborhoods (Buka et al., 2001). Other community-level risk factors may include low community cohesion, urbanization, and inner-city living (Krug et al., 2002). Troubled family life (e.g. estranged or alienated family members, abuse, neglect, substance use, or minimal parental involvement) may also influence this troubling phenomenon (Krug et al., 2002). There are also individual risk factors for community violence, including gender, age, race, and ethnicity(Buka et al., 2001).For example, several studies have found that males are more likely than females to be victims and witnesses of violent acts (Selner-O'Hagan et al., 1998; Singer et al. 1995). Additionally, the research suggests that the prevalence of exposure to violence increases with age; however, even the youngest age-groups in these studies may be witnesses to community violence (Shahinfar et al., 2000).

(NCTSN)

There are many prolonged effects of community violence. One study looked at higher levels of externalizing disorders, internalizing disorders, and posttraumatic stress disorder (PTSD) among inner city youth in a meta-analysis that assessed outcomes from 114 studies. The study found that directly experiencing violence was associated with greater externalizing and internalizing symptoms compared to witnessing violence. Another study, which included an urban sample of 615 teenagers, found that exposure to violence prospectively predicted an increase in all symptoms assessed, including internalizing, externalizing, PTSD, and dissociative symptoms. Gender made a difference in the outcome of this study in that boys experienced more violence than girls.
However, compared to boys, girls who experienced violence were more likely to experience dissociation, but not the other symptoms (Zona & Milan, 2011). Other effects of both witnessing and experiencing community violence include depression, dissociation, aggression, substance abuse, and poor academic achievement in children (Buka et al., 2001; Schwartz &Gorman, 2003). Clinicians should be mindful of the association between exposure to community violence and mental health symptoms when treating or assessing clients. Dr. Layne recalled instances where individuals "exposed to some pretty severe episodes of community violence," were later assessed with severe PTSD.

Community violence can be prevented by strengthening, empowering, and engaging children to keep them safe and healthy. Approaches should be aimed at reducing factors associated with at-risk, problematic behaviors, and strengthen protective factors, such as higher levels of parental involvement, directed towards at-risk populations within the community.

Intervention programs should target individuals already engaged in at-risk behaviors. Evidence-based youth violence prevention and intervention strategies should build youth's skills and competencies to choose non-violent, safe behaviors, foster safe and nurturing relationships between the youth and their caregivers, improve and sustain a safe physical environment in communities, and facilitate the social cohesion and collective efficacy of the community. Possible psychotherapy interventions may include cognitive-behavioral therapy (CBT) and/or contingency management approaches (Alderden, 2017). Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a manualized intervention that includes elements of CBT. It includes exposure, relaxation training, strategies for cognitive coping, contingency management, processing traumatic memories, and solving social problems. In addition to CBITS, CBITS-plus-family comprises regular CBITAS plus intervention modules offered to children's parents. This intervention's focus on effective parenting can enhance child adjustment by enhancing parent engagement, parent-child communication, and other positive parent- and family- coping strategies. Another possible intervention is mindfulness-based stress reduction (MBSR), which provides intensive training in mindfulness meditation with the goal to ameliorate the negative effects of stress and reduce trauma-associated symptoms (Ali-Saleh et al., 2020).

Community violence affects a wide-range of individuals, through a variety of traumatic and violent experiences. Existing research, as well as the experience of experts like Dr. Layne, provide a wealth of information for clinicians to utilize when treating and assessing those who have been exposed to community violence. Given the sheer breadth of this phenomenon, it is important for clinicians to understand the risk factors that operate at the individual, family, and community levels. Additionally, understanding the interventions that may ameliorate risk and strengthen protective factors are critical in treating those affected individuals. Furthermore, as our knowledge base increases with regard to the effects and consequences of exposure to community violence, it will be important to expand our efforts in finding ways to prevent community violence and its effects.

**References on page # 16

Refugee Status and Suicide Risk: Cultural Considerations for Practitioners

Stevie Schapiro, B.A.

Each year, millions of people are forced to leave their homes, fearing persecution and conflict. Annually, only 385,000 are able to return home (United Nations, n.d.). Given the current Russian-Ukrainian conflict, this year alone, 12 million Ukranians have fled their homes and have become refugees in neighboring countries such as Poland, Romania, and Russia (BBC, 2022). After enduring traumatic experiences and/or stressful life events (i.e., war and torture, hazardous journeys, harsh circumstances in refugee camps and separation from family members [Tinghög, 2009]), refugees are reported to have a high prevalence of common mental disorders, particularly post-traumatic stress disorder (Bogic et al., 2015; Tinghög et al., 2017). Of critical importance, mental health diagnoses, including post-traumatic stress disorder (PTSD), have been linked to increases in suicidal behavior, suicide attempts, and completed suicide (Ferrada-Noli et al., 1998; van Heeringen, 2012).

Given the scope and severity of this issue, those individuals working with refugees should take special care in understanding and treating mental health concerns.

In the course of fleeing their homes, many refugees experience traumatic or stressful events which place them at greater risk for adverse outcomes. Specific risk factors for self harm and suicide in the refugee population include the exposure of traumatic events on the journey to the host country, the adjustments that come with post-migration (e.g., psychosocial acculturation problems and ethnical discrimination), and leaving behind family (Amin et al., 2021). The impact on refugee populations can be devastating. For example, research on Bhutanese refugees demonstrated that refugees are dying by suicide at a rate nearly 2x that of the general U.S. population. In addition to an increase in suicide and self-harm, , these same risk factors can influence the prevalence of other mental health disorders (Giacco, Laxhman, & Priebe, 2018). For instance, one study comparing a refugee population in economically developed western countries found a prevalence of PTSD 10x higher than in the general population (Fazel, Wheeler, & Danesh, 2005; Amiri 2020). Further investigation has discovered that these disorders are more common when refugees do not socially integrate and feel a sense of exclusion from the society within the host country (Giacco, Laxhman, & Priebe, 2018).

Although regional variations exist, internationally, suicide is the 15th most common cause of death (Hollander et al., 2020), causing one million deaths annually (World Health Organization, n.d.a., n.d.b.) As previously noted, certain risk factors may amplify suicide risk in refugee populations. However, clinicians should be aware of the complexities of treatment when working with refugees experiencing suicidal thoughts. When it comes to seeking help, refugees in other cultures may experience cultural and structural barriers including financial strain, unstable accommodations, and lack of trust in authority figures (Byrow et al., 2020). Because refugees may be hesitant to approach clinicians regarding mental health difficulties, individuals working with this population may need to detect as well as to support refugees as they enter and acclimate to the host country. Currently, the surge of Ukranian refugees has increased the demand for general mental health support in addition to specialized help for those exposed to trauma and those at risk for suicide.

(Pew Research Center)

Due to the factors described above , it is crucial for mental health practitioners to seek cultural competence and understanding in order to appropriately treat refugee populations. Research done by Jorm, Ross, and Colucci (2018) indicated that clinicians should ask directly if an individual has suicidal thoughts, if the individual has positive things in life worth living, and ensure that the suicidal individual does not have access to means for suicide.

It is vital that practitioners are mindful of possible cultural considerations (i.e., providing psychoeducation, building intentional rapport, having awareness of cultural competencies) that may impact an individual's response to the topic of suicide and mental health supports in general (i.e., social norms, mistrust in health care providers and previous adverse experiences). Moreso, warning signs for suicide may appear differently in refugee populations. These may include the individual describing the feeling they are stuck between both cultures, expressing failure, or endorsing the idea that they would have been better off in their home country (Jorm, Ross, & Colucci, 2018). Additionally, clinicians should take special care to seek clarification regarding language and to research cultural norms regarding suicide within the refugee's country of origin.

Other considerations for treating refugee populations include proper and frequent screening by additional supportive figures such as local gatekeepers including traditional healers, elders, and religious leaders (Schinina et al., 2011). Furthermore, it is essential to enlist leaders within and outside the refugee community to promote connection within the displaced community. Programs and infrastructure put in place by host nations may also be important in ameliorating suicide risk. By creating an infrastructure for refugees to depend on, they can treat their stressors and prevent the development of any potential or untreated mental illness, which is the most reported risk factor for suicide attempts (Schinina et al., 2011). Additionally, the need to belong, is an intrinsic motivation for the human emotional need to associate with a group and be accepted by the members (Schneider and Kwan, 2013). Consequently, having a supportive network of organizations and resources to welcome refugees may serve as an important protective factor for loneliness, decreasing the risk for suicide (Van Orden et al., 2010).

(Wilson Center)

The recent conflict in Ukraine has further spotlighted the mental health needs of refugee communities. In 2018, Ukraine was selected by the World Health Organization's (WHO) Special Initiative for Mental Health, a program to assess mental health needs, to improve mental health policy, and to expand services. Despite the growing public interest in mental health, COVID-19 and now the Russia-Ukraine war have curbed these health priorities. Previously considered a country with a high burden of mental illness, with suicide as the second leading cause of disability burden; this population is expected to be even more in need of psychological support (Yale Institute for Global Health, 2021).

In the case for Ukrainian refugees, who may be right in your neighborhood, knowing the culture and experiences endured these past few months will assist in creating understanding as well as rapport. Due to the increased rate of suicide within the refugee population, meaningful coordinated care is essential to ensure hope. Training and knowledge in suicide is helpful, but even showing up for individuals by providing donations or funding can aid in the transitions demanded of them to save their lives. Check your local Ukrainian churches for direct ways to help the community. As Mahatma Gandhi said best, "peace between countries must rest on the solid foundation of love between individuals".

**References on page # 16

Interested in Volunteering?

LOCAL OPPORTUNITIES

Ukrainian Orthodox Church Miami
info@ukrainianorthodox.church
More info on volunteering call: 954-680-2008 or 954-649-0834
Direct Contact: Irene White, whiteirene89@yahoo.com

Host a family in South Florida: https://www.bnaiaviv.org/host-family.html

Volunteer form: https://docs.google.com/forms/d/e/1FAIpQLSdZue3y5Hh26IMGcA6Wn7yqGdeEX9BGQMYlq9s7DoFw5VULGA/viewform

GENERAL OPPORTUNITIES

- ***United Help Ukraine***
- ***Revived Soldiers Ukraine***
- ***Sunflower for Peace***
- ***UNICEF***
- ***International COmmittee of the Red Cross***

The Impact of Intergenerational Violence

By: Leeron Nahmias, B.S., and Sitara Rambarran, B.S.

Violence seldom, if ever, occurs within a vacuum. Most times, those individuals exposed to or affected by violence will interact with others as friends, spouses, or parents. A blaring question researchers currently have is: “What happens in the parent-child relationship when those traumatized children become parents?” (Glaus et al., 2022). The term “intergenerational violence” implies transmission across generations, hence, this concept suggests that children exposed to violence are likely to show violent behavior as they grow up. Family violence can be defined as as physical, sexual, or emotional abuse or aggression directed against an intimate partner or child in the family. While exposure to violence is central, biological and environmental factors are also key components delineating the perpetual cycle enacted in intergenerational trauma.Aside from violence in adulthood, the literature demonstrates that adults who have histories of childhood trauma display greater somatization, dissociative symptoms, and affect dysregulation (Glaus et al., 2022), which may lead to further difficulties in parenting.

The Centers for Disease Control and Prevention (CDC) estimate that over their lifetimes, approximately 1 in 4 women and 1 in 10 men experience physical violence, sexual violence, or stalking, and more than 43 million women and 38 million men experience psychological aggression (CDC, n.d.). The U.S. Department of Health & Human Services reports that in 2019 there were approximately 656,000 victims of child abuse and neglect in the U.S., which is a rate of 8.9 victims per 1,000 children. Certain ethnic groups such as American Indians and African Americans had even higher rates, and children under 1 year of age had a rate of victimization equal to 25.7 per 1,000 children (U.S. Department of Health and Human Services, 2019). In light of the ongoing pandemic, evidence suggests that the incidents of family violence have increased during the isolation, increased stress, and lock-downs (Usher, 2020).

“My dad. He taught me how to fight like a guy, fight like he does. I don’t smack, pinch or pull hair. I fist fight. No, he’s taught me how to fight my whole life.” (Giordano 2010, p. 144, as cited in Besemer, 2017).

Some prominent theories regarding intergenerational violence include social learning (teaching and co-offending), genetic mechanisms, intergenerational exposure to multiple risk factors and/or mediation through environmental risk factors, and official (police and justice) bias (Besemer, 2017). A combination of these mechanisms can explain the occurrence of intergenerational violence. Social learning can happen in several ways, either through observation and imitation of role models or through observed attitudes. Bandura (1973; 1977) posits that parents are important role models and suggests that if parents are violent, children will copy this violence. In some cases, parents may even offend with their children (e.g.,...). Regarding the question of "what happens when children who are exposed to violence and abuse become parents?" It is possible that children are more likely to commit violence when they have witnessed their parents engage in unlawful behaviors.

There may be confounding factors which make it appear that children of alleged criminals will engage in criminal behavior more frequently. For example, official justice systems, such as the police and the courts, might be biased against known criminal families. As a result, officials may pay more attention to these families, which means that children in those families are more likely to be arrested and thus appear in official statistics more often. It is expected that this official bias is similar for children of violent and non-violent criminal parents who offend with similar frequency (Besemer, 2017). It is also possible that children develop similar attitudes to those of their parents and are more likely to engage in unlawful behavior if their parents portray a greater motivation to break rather than to follow the law. When these children grow up, they are likely to model similar behaviors and attitudes to their own children. Official bias has not been studied for intergenerational transmission of violence specifically. For general crime, previous studies showed that sons of offenders were at higher risk of having a conviction compared to their peers with similar levels of self-reported offending but no convicted parents (Farrington, 2011).

Criminal behavior has biological and environmental components. Genetically speaking, violence may have a stronger or different biological basis than other types of criminal behavior (Brennan & Raine, 1997). Since these neurological bases are often inherited, violence might have a stronger intergenerational transmission than other types of criminal behavior. Specifically, arson and robbery have been shown to be resembled more strongly among family members than other offenses (Besemer, 2017). With that in mind, environmental risk factors such as low socio-economic status (SES), low family income, poor housing, large family size, becoming teen parents, parental conflict, and having a violent parent must also be considered. Children who are raised in such environments often have to grow up faster than the average child. They may have to take on non-traditional roles within their families such as helping raise younger siblings, taking on the role of protector to shield younger siblings from parental violence, or make sacrifices to provide for their family, all of which add immense pressure to a developing child. Parents may work multiple jobs which means they may not be able to spend as much time as they'd like to with their children, may miss milestones in their child's life, or be less involved in a child's life overall.

The added pressure on the child and uninvolved, potentially violent parenting, may lead the child to engage in antisocial behaviors with the intention of providing for their family. According to this perspective, crime is not directly transmitted from parents to children but through a "larger cycle of deprivation and antisocial behavior" (Farrington, 2011). These factors are not meant to justify violence or crime; however, understanding where the perpetual cycle begins is imperative to understanding how to intervene. Furthermore, not all children who grow up with such factors engage in antisocial behaviors, and not all parents in such cases are violent.

Although exposure to violence affects all SES groups, youth from lower SES backgrounds tend to have increased exposure and likelihood of suffering from detrimental future outcomes (APA, n.d.). Family functioning is influenced by social context (Public Safety Canada, n.d.), and families with few resources and who live in underprivileged areas have more difficulty providing their children with an upbringing that will keep them away from deviant and at-risk behavior (Public Safety Canada, n.d.). Studies have concluded that violent offenders are indistinguishable from frequent offenders in terms of risk factors (Farrington, 2011). Hence, one would expect transmission through risk factors to be similar for violent parents.

Treatment to address traumatic events that impact individuals and generations to come is key and pertinent to the healing process.Treatment for breaking this cycle can be as simple as educating the public to understand the way that their trauma, past or present, affects their families but may also include training for front line professionals to help them in working with traumatized members of the community (Coy, 2019).

There are various modalities of therapy that can be employed when working with an individual who has been affected by intergenerational trauma. Once such modality, Narrative Exposure Therapy (NET),is a therapeutic model that focuses on treating clients who have experienced complex or multiple traumatic experiences. The method is often used in group or community settings to assist clients with challenges due to complex trauma. Another possibility is the Intergenerational Trauma Treatment Model (ITTM), which focuses on complex trauma specifically for children and their parents/caregivers. ITTM is designed to treat the unresolved trauma impact from childhood in parents/caregivers prior to engaging the child in treatment. ITTM treats two generations at once, increasing the functioning of both child and parent. Clinicians may also wish to use Trauma-Focused Cognitive Behavioral Therapy (TF-CBT),an evidence-based treatment modality for children and adolescents who have symptoms related to trauma. This method of treatment combines psychoeducation and cognitive techniques to teach children and adolescents how to express themselves, learn cognitive coping skills to deal with stressors, develop relaxation techniques, create and process trauma narratives, and manage behaviors that could be detrimental to their overall mental health (White, 2022).

"While trauma can come in many forms, providers of mental health or legal services need to be especially aware of trauma that is ongoing and has intergenerational consequences."-Judith McMullen (Marquette University Law School Faculty Blog)

Understanding the underlying mechanisms of intergenerational violence is necessary in order to break the cycle. The impact of intergenerational violence affects not only the victims, but also the surrounding community and their future families. From a psychological perspective, there is a need for a treatment modality that considers the family system, how dysregulation may have occurred, and emotion regulation strategies that can be taught across all factors including age, ethnicity, and SES. From a community level, education is of utmost importance and can lead to development of resources rather than stigma for victims of the perpetual cycle. Educating parents, teachers, officials, and other community members can provide support to both victims and perpetrators of intergenerational violence. Perpetrators of intergenerational violence may not be aware that what they are doing is wrong and in some cases, violence is all they know. Building trust, support, and resources can help mitigate the biological and environmental risk factors known to exacerbate familial and generational violence. Most importantly, we cannot judge but unite to empower those affected with the knowledge that at any given moment they have the power to say this is not how the story is going to end; the generational narrative can be changed.

** References on page 17

(Centers for Disease Control and Prevention "Fast Facts: Preventing Intimate Partner Violence")

Best Practices in School Shooting Prevention

By: Christina Castellana, B.S., and Gabriela Kostzer, B.S.

School shootings can be defined as an event in which a perpetrator utilizes a firearm on school campus to intentionally execute or injure others, including shootings that result in deaths and injuries (Poland & Ferguson, 2021). Statistically, school shootings are a rare event in the United States in that they represent less than one percent of the homicides among children between the ages of 5 and 18 years old. However, school shootings can be a real and frightening part of school violence in this country. Each attack has lasting effects on the students, school, surrounding community, and nation as a whole (Schuster, n.d.). Over the last three decades, significant efforts have been made toward the implementation of school shooting prevention strategies (Poland & Ferguson, 2021).

School shootings in the United States have been documented dating back to the 1970s. However, it was not until 1999 that the tragedy at Columbine High School spread fear throughout the nation (Poland & Ferguson, 2021). Since then, there has been an increase in the number of school shootings throughout the United States (Table 1.1). Most recently, 19 children and 2 adults were killed in a shooting at Robb Elementary School in Uvalde County on May 24, 2022 (Astudillo & Ocner, 2022).

In response to school shootings, many schools aim to increase their security measures. This may include the use of student ID badges or security cameras or even the use of metal detectors. Among the many options, the quickest and most economical prevention measure to implement is restriction of access or access control. Access control involves limiting the access that someone can gain from outside of the school. It may include measures such as locked doors, one point of entry, gated campuses, or the requirement of visitor screenings and badges. Despite the widespread use of restriction of access, there is limited evidence to prove the effectiveness of access control in increasing school safety (Poland & Ferguson, 2021). For example, at Sandy Hook Elementary the doors were locked, but the perpetrator was able to enter the school through a window adjacent to the door (Sandy Hooky Advisory Commission, 2015).

When a school shooting occurs, the media and the public may focus disproportionately on the controversial issue of gun control This may be because of the highly lethal nature of firearms.. However, there is a lack of evidence for the effectiveness of gun control laws and policies as means for school shooting prevention. (Poland & Ferguson, 2021).

Table 1.1 Number of school shootings by decade

Decade	Number of school shootings
1966 to 1975	3
1976 to 1985	8
1986 to 1995	14
1996 to 2005	18
2006 to 2015	19

Adapted from Langman (2016)

While gun violence remains a significant public health concern, research suggests that policies and research regarding gun violence will need to be multifaceted, including policies on design, advertising, manufacturing, distribution, and purchase in order to be effective (American Psychological Association, 2013). Another popular prevention measure is the use of School Resource Officers(SRO). A 2021 study examined the association between the presence of an armed officer on scene and the severity of shootings in kindergarten through 12th grade between 1980 and 2019. The results demonstrated that armed guards were not associated with significant reduction in rates of injuries. Supporters of SROs believe that the presence of security personnel will stop individuals from attacking school settings (Poland & Ferguson, 2021). However, research is limited, and the few studies completed have focused broadly on the effectiveness of SROs in reducing school crime, rather than school shootings (James & McCallion, 2013). Jonson (2017) reported that the role of SROs varies from school to school, ranging from strict disciplinarian to a service-oriented approach. This range may impact the student body and staff perspectives of the SROs.

An additional area of discussion is the execution of active shooter drills. Active shooter drills go by many names, such as intruder crisis drills and school lockdown drills, but they all have the purpose of preparing children and adolescents in case there is an active shooter on campus. Today, 96% of schools have employed active assailant protocols. Sixteen states specifically require lockdown, intruder, or active shooter drills in grades kindergarten through twelfth grade (Bonanno, McConnaughey & Mincin, 2021). The National Child Traumatic Stress Network (NCTSN), informed by the recommendations of the National Association of School Psychologists (NASP), has released points to consider for before, during, and after a drill occurs specific to students, teachers, and parents (Griffin, 2019). Some of these suggestions include developmentally appropriate language when discussing drills, coping techniques, buddy systems, proper staff training, informing parents of drill schedules, praise during drills for students, posters around the classrooms with instructions, clear alerts to parents that a drill is currently occurring, etc. Additionally, NCTSN recommends that safety drills must incorporate a lockdown response and an "option-based" approach. An "option-based" approach involves different courses of action that one may take when confronted by an active shooter/intruder. NCTSN also recommends that all drills are announced, therefore, in a case of an emergency, teachers and students do not become desensitized to unannounced drills and under-respond.

Along with the NCTSN, the federal government has released recommendations through Homeland Security and the Federal Bureau of Investigation, however, these are recommendations, not requirements. Therefore, states, counties, and schools can choose their own active shooter drills and protocols.This meaning, there are variations in what is taught to students and teachers. There is no uniformity in the implementation of these drills nor the education surrounding them. Thus, if a student or teacher transfers schools, counties, or states, they may not be as prepared or knowledgeable regarding what to do in an active shooter emergency in their new setting. One federally recommended protocol for active shooter drills is called, RUN. HIDE. FIGHT. It is a formal training that outlines steps in the case of an active shooter (Federal Bureau of Investigation, n.d.). "RUN: Wherever you go, be aware of alternate exits. HIDE: If there is no safe escape route, find a good hiding place. Quickly and cautiously evacuate in a direction away from the attacker. FIGHT: Fight only as a last resort. STOP THE BLEED: A victim can die of uncontrolled blood loss in 5 minutes or less" (Federal Bureau of Investigation).

(Olympic College)

Another popular and recommended multi-option training approach is ALICE: Alert, Lockdown, Inform, Counter, Evacuate. This approach teaches students to hide, but also swarm and throw objects at the assailant and flee as soon as possible. The most extreme protocols include first responders and actors imitating school shooting events with airsoft guns and fake blood (Bonanno, McConnaughey & Mincin, 2021). Despite these many recommendations, we continue to see a lack of uniformity across the country.

(Cape News, 2016)

Among the many recommendations for best practices for the prevention of school shootings, threat assessment continues to receive strong support across experts. Threat assessment is a comprehensive evaluation of the intentions of an individual who may pose a threat to an organization, including how they might cause harm, and their motivation and ability to carry out the task (Clifton & Brooks, 2013).Threat assessments can have a significant impact in the context of school shootings.

Analyses of school shooters have demonstrated that most exhibit behavioral signs prior to their attacks, and many reveal their plans to others. There have also been a number of cases in which peers assist the school shooter, either directly or indirectly. This emphasizes the fact that in the majority of school shootings, there is a window of prevention (Poland & Ferguson, 2021).

The ways in which schools are attempting to increase and maintain safety vary across states and their districts. However, there is consensus regarding the way schools should respond to a school shooting: be prepared for a crisis. The best form of crisis response in the aftermath of a school shooting is one that has been planned. This should include an emphasis on acting instead of reacting (Poland et al., 2017). Best practices for crisis intervention include a multidisciplinary approach that addresses the physical, psychological, and emotional needs of everyone impacted by the tragedy (Poland & Ferguson, 2021). The best practices for prevention include school safety planning, which should be a collaborative, multidisciplinary, and comprehensive approach including individuals from the school setting and the broader community (Poland & Ferguson, 2021).

** References on page 17

National Suicide Prevenetion Hotline

CALL OR TEXT:

988

In 2005 the first 10 digit National Suicide Prevention Hotline was created (800-273-8255). More than 200 local crisis centers across the country make up the nationwide network, which has received more than 20 million calls since it launched 17 years ago (Kuta, 2022). Starting July 16, 2022, all calls and texts made to the three digit number 988, will be directed to the existing National Suicide Prevention Hotline. The Federal Communication Commission (FCC) adopted this number to be easy to remember, like 911, in the hope to make it easier for individuals in crisis to access the help they need and decrease the stigma surrounding suicide and mental health issues (Kuta, 2022).

References

Community Violence

Alderden, M. (2017, June 21). Illinois Criminal Justice Information Authority. ICJIA. Retrieved May 12, 2022, from https://icjia.illinois.gov/researchhub/articles/community-violence-prevention-intervention-and-suppression

Ali-Saleh Darawshy, N., Gewirtz, A. & Marsalis, S. (2020) Psychological Intervention and Prevention Programs for Child and Adolescent Exposure to Community Violence: A Systematic Review. Clin Child Fam Psychol Rev 23, 365–378. https://doi.org/10.1007/s10567-020-00315-3

Buka, S. L., Stichick, T. L., Birdthistle, I., & Earls, F. J. (2001). Youth exposure to violence: prevalence, risks, and consequences. American Journal of Orthopsychiatry, 71(3), 298.

Community Violence Prevention. (2021, October 18). Centers for Disease Control and Prevention. Retrieved May 3, 2022, from https://www.cdc.gov/violenceprevention/communityviolence/index.html

Community Violence. (2018, May 25). The National Child Traumatic Stress Network. Retrieved May 3, 2022, from https://www.nctsn.org/what-is-child-trauma/trauma-types/community-violence

Cooley-Strickland, M., Quille, T. J., Griffin, R. S., Stuart, E. A., Bradshaw, C. P., & Furr-Holden, D. (2009). Community violence and youth: affect, behavior, substance use, and academics. Clinical child and family psychology review, 12(2), 127–156. https://doi.org/10.1007/s10567-009-0051-6

Fowler, P. J., Tompsett, C. J., Braciszewski, J. M., Jacques-Tiura, A. J., & Baltes, B. B. (2009). Community violence: A meta-analysis on the effect of exposure and mental health outcomes of children and adolescents. Development and Psychopathology, 21(01), 227-259.

Hamblen, J. & Goguen, C. (2015). Community violence. Retrieved from http://www.ptsd.va.gov/professional/trauma/other/community-violence.asp

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. The Lancet, 360(9339), 1083-1088.

Schwab-Stone, M. E., Ayers, T. S., Kasprow, W., Voyce, C., Barone, C., Shriver, T., & Weissberg, R. P. (1995). No safe haven: A study of violence exposure in an urban community. Journal of the American Academy of Child & Adolescent Psychiatry, 34(10), 1343-1352.

Schwartz, D., & Gorman, A. H. (2003). Community violence exposure and children's academic functioning. Journal of Educational Psychology, 95(1), 163.

Selner-O'Hagan, M. B. , Kindlon, D. J. , Buka, S. L. , Rauden-bush, S. W. , & Earls, F. J. (1998). Assessing exposure to violence in urban youth. Journal of Child Psychology and Psychiatry, 39, 215–224.

Shahinfar, A. , Fox, N. A. , & Leavitt, L. A. (2000). Preschool children's exposure to violence: Relation of behavior problems to parent and child reports. American Journal of Orthopsychiatry, 70, 115–125.

Singer, M. I. , Anglin, T. M. , Song, L. , & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. Journal of the American Medical Association, 273, 477–482.

Zona, K., & Milan, S. (2011). Gender differences in the longitudinal impact of exposure to violence on mental health in urban youth. Journal of Youth and Adolescence, 40(12), 1674-1690.

Refugee Status and Suicide Risk: Cultural Considerations for Practitioners

Amin, R., Helgesson, M., Runeson, B., Tinghög, P., Mehlum, L., Qin, P., ... & Mittendorfer-Rutz, E. (2021). Suicide attempt and suicide in refugees in Sweden–a nationwide population-based cohort study. Psychological medicine, 51(2), 254-263.

Amiri, S. (2020). Prevalence of suicide in immigrants/refugees: a systematic review and meta-analysis. Archives of suicide research, 1-36.

Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: a systematic literature review. BMC international health and human rights, 15(1), 1-41.

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: a systematic review. Clinical Psychology Review, 75, 101812.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. The Lancet, 365(9467), 1309-1314.

Ferrada-Noli, M., Asberg, M., Ormstad, K., Lundin, T., & Sundbom, E. (1998). Suicidal behavior after severe trauma. Part 1: PTSD diagnoses, psychiatric comorbidity, and assessments of suicidal behavior. Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies, 11(1), 103-112.

Giacco, D., Laxhman, N., & Priebe, S. (2018, May). Prevalence of and risk factors for mental disorders in refugees. In Seminars in cell & developmental biology (Vol. 77, pp. 144-152). Academic Press.

Hollander, A. C., Pitman, A., Sjöqvist, H., Lewis, G., Magnusson, C., Kirkbride, J. B., & Dalman, C. (2020). Suicide risk among refugees compared with non-refugee migrants and the Swedish-born majority population. The British Journal of Psychiatry, 217(6), 686-692.

"How many Ukrainian refugees are there and where have they gone?" BBC News, July 4, 2022. https://www.bbc.com/news/world-60555472

Jorm, A. F., Ross, A. M., & Colucci, E. (2018). Cross-cultural generalizability of suicide first aid actions: an analysis of agreement across expert consensus studies from a range of countries and cultures. BMC psychiatry, 18(1), 1-8.

Reinhard, S., Dang, A., & Matesva, M. Mental Health in Ukraine. https://medicine.yale.edu/yigh/students/case-competition/2021YIGHCase_Final_407033_46325_v1.pdf

Schininà, G., Sharma, S., Gorbacheva, O., & Mishra, A. K. (2011). Who am I? Assessment of Psychosocial needs and suicide risk factors among Bhutanese refugees in Nepal and after the third country resettlement. International Organization for Migration (IOM).

Schneider, M. L., & Kwan, B. M. (2013). Psychological need satisfaction, intrinsic motivation and affective response to exercise in adolescents. Psychology of sport and exercise, 14(5), 776-785.

Tinghög, P. (2009). Migration, stress and mental ill health: post-migration factors and experiences in the Swedish context(Doctoral dissertation, Linköping University Electronic Press).

Tinghög, P., Malm, A., Arwidson, C., Sigvardsdotter, E., Lundin, A., & Saboonchi, F. (2017). Prevalence of mental ill health, traumas and postmigration stress among refugees from Syria resettled in Sweden after 2011: a population-based survey. BMJ open, 7(12), e018899.

van Heeringen, K. (2012). Stress-diathesis model of suicidal behavior. The neurobiological basis of suicide, 51, 113.

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. Psychological review, 117(2), 575.

World Health Organization (June 17, 2021). Suicide. Retrieved from https://www.who.int/news-room/fact-sheets/detail/suicide

The Impact of Intergenerational Violence

American Psychological Association. (n.d.). Violence & Socioeconomic Status. American Psychological Association. Retrieved June 9, 2022, from https://www.apa.org/pi/ses/resources/publications/violence
Bandura, A. (1973). Aggression: a Social Learning Analysis. Englewood Cliffs, NJ: Prentice Hall.
Bandura, A. (1977). Social Learning Theory. Englewood Cliffs, NJ: Prentice Hall.
Besemer, S.(2017). Intergenerational Transmission of Violence. The Encyclopedia of Juvenile Delinquency and Justice.10.1002/9781118524275.ejdj0064/abstract
Brennan, P. A.,& Raine, A. (1997). "Biosocial Bases of Antisocial Behavior: Psychophysiological, Neurological, and Cognitive Factors." Clinical Psychology Review 17: 589–604
Canada, P. S. (2018, January 31). Family-based risk and protective factors and their effects on juvenile delinquency: What do we know? Public Safety Canada. Retrieved June 9, 2022, from https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/wht-knw/index-en.aspx
Coy, E. (1967, January 1). Breaking the cycle – intergenerational trauma. Breaking the Cycle – Intergenerational Trauma | Danielle Rousseau. Retrieved June 9, 2022, from https://sites.bu.edu/daniellerousseau/2019/04/28/breaking-the-cycle-intergenerational-trauma/
Department of Health, Us Services Administration for Children, Human Administration on Children Youth, Families Children, Families. (2019). Child Maltreatment 2019. Retrieved from:https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2019.pdf
Farrington, D. P. (2011). "Families and Crime." In Crime and Public Policy, edited by James Q Wilson and Joan Petersilia, 130–57. New York: Oxford University press.
Glaus, J., Moser, D. A., Rusconi Serpa, S., Jouabli, S., Turri, F., Plessen, K. J., & Schechter, D. S. (2022). Families With Violence Exposure and the Intergenerational Transmission of Somatization. Frontiers in Psychiatry, 13, 214.https://doi.org/10.3389/FPSYT.2022.820652/BIBTEX
McMullen, G. J. (n.d.) Interrupting the Intergenerational Trauma of Family Violence – Marquette University Law School Faculty Blog. Retrieved from: https://law.marquette.edu/facultyblog/2021/11/interrupting-the-intergenerational-trauma-of-family-violence/
Ph.D., W. by: D. K.-W.; MD, R. by: K. F. (n.d.). Intergenerational trauma: What it is; how to heal. Choosing Therapy. Retrieved June 9, 2022, from https://www.choosingtherapy.com/intergenerational-trauma/
Usher, K., Bhullar, N., Durkin, J., Gyamfi, N., & Jackson, D. (2020). Family violence and COVID-19: Increased vulnerability and reduced options for support. International journal of mental health nursing, 29(4), 549–552.https://doi.org/10.1111/inm.12735

Best Practices in School Shooting Prevention

American Psychological Association. (2013). Gun violence: Prediction, prevention, and policy. Retrieved from http://www.apa.org/pubs/info/ reports/gun-violence-prevention.aspx
Astudillo, C., & Oxner, R. (2022, May 28). What we know, minute by minute, about how the Uvalde shooting and police response unfolded. The Texas Tribune. Retrieved June 20, 2022, from https://www.texastribune.org/2022/05/27/uvalde-texas-school-shooting-timeline/
Bonanno, R., McConnaughey, S., & Mincin, J. (2021). Children's experiences with school lockdown drills: A pilot study. Children & Schools, 43(3), 175–185. https://doi.org/10.1093/cs/cdab012
Clifton, S., & Brooks, D. (2013). Security risk management. Security Science , 51– 80. https://doi. org/10.1016/B978-0-12-394436-8.00003-5
FBI. (2020, September 21). Run. hide. fight. FBI. Retrieved December 14, 2021, from https://www.fbi.gov/video-repository/run-hide-fight-092120.mp4/view.
Griffin, D. A. (2019, February 21). Creating school active shooter/intruder drills. The National Child Traumatic Stress Network. Retrieved June 20, 2022, from https://www.nctsn.org/resources/creating-school-active-shooter-intruder-drills
James, N., & McCallion, G. (2013). School resources officers: Law enforcement officers in schools . Congressional Research Service.
Jonson, C. L. (2017). Preventing school shootings: The effectiveness of safety measures. Victims & Offenders, 12 (6), 956– 973. https://doi.org/10.1080/15564886.2017.1307293
McDevitt, J., & Panniello, J. (2005). National assessment of school resource officer programs: Survey of students in three large SRO programs . http://www.ncjrs.gov/pdffiles1/nij/ grants/209270.pdf
Peterson, J., Densley, J., & Erickson, G. (2021). Presence of armed school officials and fatal and Nonfatal gunshot injuries during mass school SHOOTINGS, United States, 1980– 2019. JAMA Network Open, 4 (2). https://doi.org/10.1001/jamanetworkopen.2020.37394
Poland, S., & Ferguson, S. (2021). Lessons learned from school shootings: Perspectives from the United States of America. Springer.
Poland, S., Conte, B., VanHasselt, V., & Bourke, M. (2017). School violence (Chapter). In Handbook of behavioral criminology: Contemporary strategies and issues . Springer.
Sandy Hook Advisory Commission. (2015). The National Child Traumatic Stress Network .https://www.nctsn.org/resources/final-report-of-the-sandy-hook
Schuster , B. (n.d.). Preventing, preparing for critical incidence in schools. Retrieved June 7, 2022, from https://www.ojp.gov/pdffiles1/nij/225765.pdf

National Suicide Prevention Hotline

Kuta, S. (2022, June 13). Beginning in Mid-July, dial 988 for the Mental Health Hotline. Smithsonian.com. Retrieved July 18, 2022, from https://www.smithsonianmag.com/smart-news/beginning-in-mid-july-dial-988-for-the-mental-health-hotline-180980241/

(The Inspired Classroom)

Thank you to the Summer 2022 SVP Newsletter Contributors!

Scott Poland, Ed.D., Director
Juliette Hubbard, Psy.D., Editor, Post Doctoral Resident
Christina Castellana, B.S., Graduate Assistant
Katlyn Bagarella, B.A., Graduate Assistant
Stevie Schapiro, B.A.
Leeron Nahmias, B.S.
Sitara Rambarran, B.S.
Gabriela Kostzer, B.S.

If you are interested in joining the **SVP Crew**, please contact Dr. Hubbard at jh2688@nova.edu.

Respond to the QR code for a chance to win a Starbucks gift card!

Suicide & Violence Prevention Resources

Center for Student Counseling and Well-Being
954-424-6911 (available 24/7)
www.nova.edu/healthcare/student-services/student-counseling.html

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

National Suicide Prevention Lifeline
1-800-273-TALK (8255) or 1-800-SUICIDE
www.suicidepreventionlifeline.org
Veterans: Press "1" or Text 838255
Chat: www.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/211FirstCallforHelp/contact.html

Palm Beach 2-1-1 Help Line
2-1-1 or 561-383-1111 or 211Palmbeach.org

Jewish Community Services of South Florida
305-358-HELP (4357); 305-644-9449 (TTY)
www.jcsfl.org/programs/contact-center/

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

The Jed Foundation (JED)
www.jedfoundation.org Suicide

Prevention Resource Center
www.sprc.org

Suicide Awareness Voices of Education
www.save.org

The Depression Center
www.depressioncenter.net

Yellow Ribbon International
www.yellowribbon.org

Florida Initiative for Suicide Prevention
www.fisponline.org

Florida Suicide Prevention Coalition
www.floridasuicideprevention.org

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

American Association of Suicidology
www.suicidology.org

American Association for Suicide Prevention
www.afsp.org

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