Interview with Ralph E. (Gene) Cash, Ph.D., ABPP

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The SVP Newsletter for this quarter is focusing on suicide awareness and prevention particularly for the LGBTQ population. I know that you've been actively involved in suicide prevention for many years.

Many years, yes.

Can you tell me a little bit about your involvement in suicide awareness and prevention?

Well, in general, my particular interest – obviously all psychologists should be interested in suicide prevention and intervention because they're going to be faced with it at some points during their careers – but, my particular interest was piqued by the fact that two of my brothers died by suicide. And that fact, as one might expect, was very difficult for me but also motivated me to learn more about suicide and suicide prevention and to try to become more actively involved in suicide prevention. During the 23 years that I was in private practice full time, I dealt with many suicidal clients. And I believe that I helped almost all of them sufficiently. There's one who died by suicide during the time that I was treating her. And that was, of course, difficult. But I sought help from a colleague and support from a colleague and that got me through it. I was determined to learn as much as I could and to be effective in suicide prevention and intervention. In part, that's how I got to know Scott Poland, because of our connections within the National Association of School Psychologists in that way. Since then, I have written some articles and done some presentations on suicide prevention and I'm currently a member of the Florida Suicide Prevention Counsel – Florida Counsel for Suicide Prevention I think is the name of it. That's a state organization that's responsible for planning and implementing the state suicide prevention program. And I do lots of presentations on suicide prevention. I'm also very interested in the connection between bullying and suicide. And because of my wife's being an allergist she and I have done a number of presentations on food allergy and bullying. And food allergy kids, students, have a particular vulnerability not only because bullying can lead to suicide but also because bullying can cause anaphylactic reactions which could lead to death. So, I've been involved in those ways and I would like to spend more time in suicide prevention and intervention and theorizing and writing but I have a wide variety of interests as you probably know, Hillary, so I try to juggle and keep a lot of things in the air at once.

So you're always delving into different areas that you're interested while keeping this on the backburner at least as an interest.

I am, I am. I'm probably too curious for my own good.

And it sounds like you got your start in your interest in suicide prevention the same way that a lot of suicidologists get their starts by having a relative or close one die by suicide.

Sure. Yeah. There are many, many people in our country – there are many, many people in the world – who have lost a loved one or more than one loved one by suicide. And those people are

always changed, and changed forever. And the fact is that when one loses a family member to suicide that person or the people in that family are six times more likely to attempt suicide themselves. I was determined that that was not going to be my fate. And was determined that instead because of those losses of two brothers I was going to try to make a difference in suicide prevention and intervention. So yes, that certainly intensified my interest. I was already interested in suicide prevention because I was a psychologist.

So these losses enhanced that interest – Intensified it.

Right.

I'm sure you're aware that the prevalence rates for suicide have been substantially increasing over the past couple of decades, particularly for youth between the ages of 10 and 14. So, as a seasoned psychologist who has worked in the school setting throughout your career, how do you determine the risk for suicide in schools?

Well, how I determine it and how other school personnel determine it are two different things I believe. And part of the reason for that belief is because I've done a number of talks to school psychologists across the country about suicide prevention and I urge them to ask. You know that the American Association of Suicidology has a motto: "You must ask!" and "IS PATH WARM?" And I encourage them to ask and there's often resistance. Not necessarily asking to someone to whom they deem clearly at risk for suicide about suicide. School psychologists tend to be good at that. But they tend not to be good at asking every kid with whim they come into contact with in a professional way about their suicide risk. I think that's a mistake. I wish they would I ask. I encourage them to ask. I explain why it's important and explain that that's one of the best ways we have of knowing. Now, obviously there are screening tools that we can use and there are other kinds of ancillary data that we can use to determine who has risk *factors* – demographic data and so forth – but the bottom line is there's no substitute in my opinion for looking someone directly in the eye and very calmly and matter of factly asking, "Have you thought about harming yourself or killing yourself?" And trying to normalize it by saying, "Lots of people do. Have those thoughts occurred to you?" And then progressing from there. Now, will everybody tell you the truth? No. I don't think everybody tells you the truth about anything. But, you're more likely to get a direct answer if you ask directly and in a very calm, non-judgmental, non-threatening way.

And that's a great point that you're not going to know unless you ask. And it seems like school are just ill-equipped or ill-prepared to effectively handle situations where students are at risk for suicide. What kinds of suggestions would you have for school systems and individual schools for promoting awareness of suicide risk and prevention?

Well the first thing, the first recommendation that I have, is to ensure that every school – to the extent possible – that every school has at least one person in the school, whose a go-to person because they have special expertise in suicide prevention. Very often that person could be the school psychologist but unfortunately in some ways school psychologists are itinerant professionals in schools and so generally they have multiple schools to which they are assigned. As a result, they aren't always there. Now, they can be on-call and being on-call may very well

be sufficient in some circumstances although if there's a long wait between when they're called and when they're able to get there that can be a problem. There are other mental health professionals in schools – school counselors and school social workers – hopefully have sufficient training in suicide prevention. Not all of them do but they could and so my first recommendation would be to ensure that every school has somebody who can be a go-to person because of the nature of their mental health and suicide prevention training. Secondly, that that person – perhaps in collaboration with others who work to train all school personal, all employees, and I'm not just talking about teachers. I'm also talking about custodial personnel, I'm talking about school safety officers, and so forth to be their eyes and ears. To look out for students who may very well be distress, who may be experiencing some life crisis who may be problematic in some way. Teachers, for example, often can learn about a student's morbid thinking through essays that the student writes or personal conversations and so forth. Those things should be taken seriously and the school personnel should be trained what to look for and to whom to go if they have a concern about a student. So that's another thing. In addition, I believe that it's very helpful, and the research supports this, it's very helpful to train students and parents to be our eyes and ears as well. It's very important to work with parents to de-stigmatize the process of asking students about suicide and thinking about suicidal behavior because one of the biggest impediments to having effective suicide prevention in schools are, I think a relatively small minority of parents who are opposed to that for reasons that have to do with the stigma associated with mental health issues and perhaps suicide in particular. So, if we do effective training for not only all school personnel but also students to be our eyes and ears because very often when a person is feeling suicidal a peer will be the first one to know. And families. Families hopefully can be taught that it's not wrong, in fact it's right, to ask students about suicidality and to be aware of that and that the idea that students would think about that is not only not wrong but it's really very common and that it's very important for us to work together as a whole school community for suicide prevention.

So helping the school community be more comfortable with assessing for suicide – asking about it – as well as removing that stigma and letting them know it's okay to have those feelings, that you just need to identify a person to go to to talk about it.

Correct. Right, now I don't think we can remove the stigma but I think we can lessen it and I don't think that we've always done a very good job of that. In fact I know that we haven't done a very good job of that as a nation as a whole because the suicide rate per 100,000, which is the usual way that we specify it – is slightly above what it was in 1900. So, for a 116 years we haven't done a very good job of reducing it.

That's a scary number.

It is a scary number.

That's a lot of time and we just haven't gotten anywhere with it, we haven't done enough to lessen the risk.

Correct.

Earlier you mention that children with asthma that they are at increased risk for bullying and I think that holds true

Actually I said food allergies

Oh, I'm sorry. Food allergies

Asthma too.

So earlier you mentioned that children with food allergies are at increased risk for bullying. We also know that the research indicates that sexual minority youth are also at increased risk for bullying, which also increases their risk for suicide. What other factors contribute to the increased risk of suicide for LGBTQ youth?

Bullying. I think that you alluded to that. Negative self-image or self-concept. And that may be in part a result of bullying but it also in part a result of our society's not being very accepting of differences. And that concerns me a great deal about the rhetoric in the presidential election this year. I don't think that the rhetoric was very accepting in general. It wasn't very accepting of minorities – people with differences or people who have different sexual orientation, different gender identity, or people who are vulnerable – vulnerable minorities in our culture and in our society. But, in general, as a culture and as a society, we have not been very accepting of minority groups, whoever that may be. And that's especially true of people who are different in their sexual orientation or their gender identification. Recently we made some progress. I'm afraid that we may go backwards. But, more directly relevant to your question, I think that stigma and societal attitudes in general are contributory. I think that self-blame and self-loathing are contributory. I think that parental non-acceptance is contributory. I think that the, that non-acceptance from broader or extended family is contributory. I think sometimes religious intolerance is contributory. There are many, many things that, in my view, contribute to those who are perceived as different in their sexual orientation or gender identification as being outcasts in our society or being marginalized in our society. And any time somebody is marginalized they are more likely to be depressed and more likely to be vulnerable to ideas or thoughts about suicide.

So there's a confluence of factors that all come into play that make it so that this particular population is at increased risk, especially when they're feeling marginalized both at school and at home.

Yes.

And so thinking about the risk factors that we were discussing in light of the climate right now, what do you think the field of suicide prevention needs to do to reduce the risk of increased suicide for sexual minority youth and those whose gender identification is nonconforming?

Well I think that a big part of that has to be a societal shift in attitude and I perceived us and I believe lots of people within minority communities perceived us as a society as a whole as

making progress in that regard. Progress in the sense that the Supreme Court said gay marriage is legal. Progress in the sense that the President said, "You know you should be able to use the bathroom where you feel comfortable based on your gender identity not necessarily your biological birth record." And so those kinds of powerful statements from people in powerful positions or from our country as a whole communicated to those who are part of sexual or gender minority "Okay, you're people too." You are valued in our society. You have a right to your feelings and your hopes and your dreams and your aspirations too. You have a right to love whom you love. You have a right to use the bathroom where you want to and so forth. And that kind of message has the potential for reducing suicidal feelings, depression, negative affect, internalizing symptoms if you will in general. I hope that we don't reverse that. Now anything else? Yeah. I think that as individuals the way that we treat people whom we perceive to be different has the potential to make a difference. If we treat certain people as outcasts just on a day to day basis when we meet them and when we talk to them then that's going to be hurtful. That's going to increase risk. If we as individuals make it our business to treat people as valuable whoever they are and whatever their circumstances then that has the potential to make a positive and to reduce risk.

So it's just really society at large needs to change the way that they're viewing and thinking about people in order for us to…

Yes, but at the last here I was talking not about society as a global whole. 'Cause it's too easy to say society needs to change and not take personal responsibility for that.

That's an excellent point that it needs to be on the individual level.

I think that each of us needs now especially when those in power may not change. It's incumbent upon each of us to say, "It's *my* responsibility to be fair. It's *my* responsibility to be kind. It's *my* responsibility to be inclusive. It's my responsibility to get rid of my biases."

So on the individual level we need to change so that society in general can then change.

That's right. And I think it was Margaret Mead who said, "Never doubt that a small group of committed individuals can change the world. It's the only thing that ever has."

And I know you were talking about this earlier with school personnel not being comfortable with asking about suicidal ideation directly. We also know that many beginning clinicians have this anxiety and fear surrounding suicide assessment. And when they're thinking about encountering these clients who are suicidal – who may endorse suicidal ideation – they are kind of like a deer in the headlights at times. So what kind of advice do you have for beginning clinicians in working with suicidal clients?

Well first my advice is get trained. And obviously that should be the responsibility of mental health programs – that is graduate programs for mental health providers. Not just psychologists. All mental health providers should be taught specifically best practices in suicide prevention and in interviewing those who may be suicidal and in exploring for suicidal ideation, plan, intent, and so forth. But not all programs do that. Or not all programs do that effectively. And so I think that

it also would be wise for those who are going to programs well no let me rephrase that. I think it would be wise for every student in a mental health profession or in training for a mental health profession to seek out extra training in suicide prevention and in assessment of suicidal or potentially suicidal patients and so forth. And that training may or may not be offered by their school, but the more training a person gets the more likely it is that they're going to be able to apply that training in difficult situations.

And what should that training consist of specifically would you say?

Okay, well, first it should consist of knowledge and recognition of risk factors. It should consist of ways to do screening that are effective and evidence-based. It should consist of knowing how to ask, what to ask, and what to do once you ask and have determined that somebody's at risk. It should consist of discussion of the applicable laws about involuntary commitment if that's necessary, about referring to appropriate placements or appropriate treatment facilities if necessary and it should consist of training in how to be sensitive to and how to respond to a person who's at risk for suicide in the therapeutic situation. And certainly it should consist of how specifically to develop a safety plan for a person one has recognized as being a suicidal risk.

Thinking about the fact that not even all psychology and mental health graduate programs do train their students sufficiently in suicide assessment and prevention, what steps do you think that our field as a whole needs to take to ensure that the students are receiving adequate training?

One of the steps we're trying to move in the direction of here at Nova Southeastern that is the use of simulated – I prefer to call them simulated patients, Dr. Valley-Gray prefers to call them standardized patients – I call them simulated because they're not standardized yet. But the research and I've done some of it myself but in general the research indicates that there's no substitute for experience in dealing with someone who is suicidal. And those students who demonstrate the greatest efficacy using scales of efficacy in intervening are those who have actually experienced working with suicidal patients or clients. Obviously, dealing with a suicidal patient or client may not be the wisest thing for the patient or client when a student is inexperienced. And so, I think that the use of simulated or standardized patients who can out very convincingly – and I have seen some of them act out *very* convincingly – the role of someone who's suicidal can give students that experience without the attendant risk. And I think we ought to be doing that in psychology and I think that as an alternative experienced supervisors should demonstrate to students how to do that and then observe them in the process if doing it. That poses problems obviously. We're going to be observing students more because of APA requirements and I don't think that's a bad thing but we have to figure out how to do it so that it doesn't interfere with the therapeutic process. That's why I think that standardized patients might be a wise way to incorporate actual experience for students without actual risk for students or for the client.

So, really, until you get faced with that situation – whether it's through a simulated patient or an actual client that you're seeing – you're not going to really be prepared until you've experienced it.

Right. It's kind of like saying, "Well we'll teach you about sky diving. Now go and do it."

So not the best method. And as you know we're fortunate here at NSU to have the office of suicide and violence prevention. Do you have any suggestions for us to ensure that our efforts to promote safety are even more effective?

I'm pausing because I have a lot of ideas and I'm trying to figure out some hierarchy of ideas here.

It's okay. Take your time.

I'll tell you one thing that bothers me. One thing that could help prevent a loss of life here – not because of violence, not because of suicide – but something that could be really important that's allowed in Florida that we don't do. We should have available in every building on our campus non-student specific epinephrine auto-injectors in case somebody has an anaphylactic reaction. Those could be used to save a life. But that's not specifically about suicide and violence prevention and so then the questions becomes, "Well, what are effective ways to try to prevent suicide and to try to prevent violence?" The most effective ways are preventative methods. We talked about training before. We talked about some of the things that would make a difference in making sure that *all* students and that *all* school personnel – and when I say all school personnel I'm talking about undergraduate and graduate training in colleges and universities too – are the eyes and ears of the professionals or the experts. And that we should know to whom to go. And so here on NSU's campus we have a couple of people who head up the suicide and violence prevention program and they have some helpers and so we have a pretty good idea of whom to go and I understand that there's a committee to that functions for the university to help students with various kinds of emotional difficulties. But we should do universal training of the students and of the faculty members. Not only for suicide prevention but also for violence prevention. Understanding the risk factors for violence and understanding what to do if a student or for that matter some employee of the university is possibly at risk for either suicide or violence or a combination of the two and sometimes the combinations are… I'd like to say something here about politics and the press that we're getting. And I don't mean the media press I mean the push that we're getting from legislators and from policy makers at various levels to have people armed on campus to allow guns on university campuses and schools and so forth. I think that's a huge mistake. Having more guns does not mean having more safety. And in fact having fewer guns we know from actions and the data collected about them in places like Australia and Belgium leads to *greater* safety. So our obsession with arming our populous is antithetical in my opinion to suicide and violence prevention.

And the last question that I have for you is, in general, where do you see the field of suicide prevention going?

Well I hope it goes more in the direction that Thomas Joiner, for example, is trying to take us. And that is in the direction of developing perhaps competing sophisticated theories of why suicide happens and systematically testing those theories using research because when we make the most progress in an area is when we have a comprehensive theory that actually works. And you've heard that old saying, "In theory, theory and practice are the same. In practice, they're

not." And that usually happens because the theory is inadequate. I think that Joiner's theory is a pretty good one, but it requires more empirical data to support it. I see lots of studies done on suicide prevention that are essentially atheoretical. They'll say, "Okay, we'll look to see if *this* is a risk factor. By golly it is." Well, where does that fit into the whole prospect? The bottom line is that as mental health professionals and psychologists tend to be some of the very best trained mental health professionals in the country and in the world. We're still not good at predicting who will take his or her life by suicide – who will die by suicide. And we should be getting better at that. And I think that the only way that we can do it is by having comprehensive theories and testing those theories so that we end up with a very effective theoretical approach that is predictive. And until we do that and I think that we'll be kind of fumbling around in the dark. There are some people who do really good work in this regard. But as a whole we're not doing a very good job. And I think that doing more research on a theoretical basis will help to demystify and de-stigmatize the area as well.

Is that research that you're interested in doing yourself?

Well I'm interested in doing it. What's the right way to put it? At least now, there's so much to do and so little time.

Alright. Well thank you for taking the time to meet with me today and answer all of my questions. Do you have any other parting advice?

Yep. To paraphrase Schneiderman, Suicide is inherently an irrational act. Never kill yourself while you're suicidal.