EVERYONE HAS A ROLE IN SUICIDE PREVENTION

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Articles in this issue:

The Suicide and Violence Prevention Office

www.nova.edu/suicideprevention

svp_crew

Our office is dedicated to promoting best practices suicide prevention at Nova Southeastern University and throughout the community. We provide trainings, disseminate research, and work with graduate trainees and students in all disciplines as well as community professionals.

Visit our office!

Our office is located in Maltz, cubicle 1071E. Feel free to take stickers and suicide and violence prevention resources!

Forever Frosty Foundation

minds can mend

For more information: https://www.foreverfrosty.org/

You can also check out our Forever Frosty Corner, which honors the Forever Frosty Foundation, established by Damiann Bilotta and Bobby Hendel after the tragic loss of their son, Asher, who died by suicide in 2014. The Forever Frosty Foundation is dedicated to supporting teens with mental health programs and covering therapy costs. It provides reduced fees and financial assistance so that every young person can access the mental health care they need. When you visit the Forever Frosty Corner, be sure to pick up a blue heart for yourself or someone you know, and sign the Frosty Feelings Journal.

Join SVP

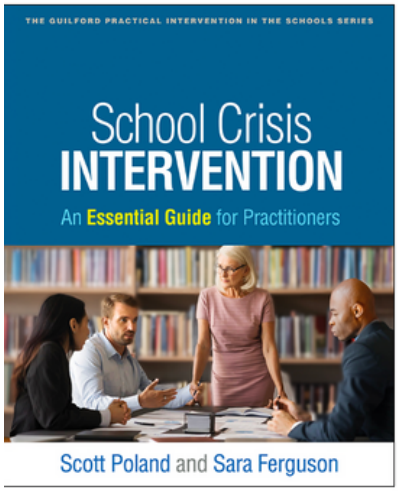
Interested in joining SVP crew or writing for next edition of our semesterly newsletter? Contact Dr. Hubbard at jh2688@nova.edu or Dr. Poland at spoland@nova.edu.

Reminders

"If you need to talk, the 988 Lifeline is here."

Call or Text 988 or chat at 988lifeline.org to access the suicide and crisis lifeline. Support from trained counselors is available 24/7! Language interpreters can be provided. Services are available in Spanish and for Deaf, Hard of Hearing, or Hearing Loss ASL Users.

See the following links for more information: https://988lifeline.org/es/servicios-en-espanol/ https://988lifeline.org/help-yourself/for-deaf-hard-of-hearing/



Dr. Poland and Dr. Sara Ferguson, a former post-doctoral resident for SVP and an alumni from the NSU clinical psychology program, completed their second book together. This is the eighth book Dr. Poland has authored or co-authored on school crisis intervention from 1989 to 2025. The book, published by the Guilford Press, provides many practical examples of school crisis intervention.

Highlights

- EMAGS + SVP volunteered to help clean up the MSD memorial garden.
- Kate Fitzpatrick and Taylor Tejera presented on Black youth suicide at the Florida Suicide Prevention Coalition Conference.
- Dr. Hubbard and Dr. Poland presented on mass violence in America at Nicklaus Children’s Hospital.
- Dr. Poland presented with Dr. Marina Niznik on understanding self-injury for the international school counseling association.
- Dr. Poland presented at the NSU regional campus in Tampa on youth mental health in the digital age.
- Dr. Poland along with the Maryland Department of Health Suicide Prevention Office presented a two-part webinar on Maryland Action Plan for Suicide for K-12 schools.

See the Sun-SENTINNEL ARTICLE: https://www.sun-sentinel.com/2025/02/13/remembering-the-parkland-17-community-events-are-set-for-friday/

Stories that Heal

By Allison Kleinfield

How Reading Positively Impacts Mental Health

In a world full of chaos, a good book can be the perfect mental escape. But for many, books are more than just entertainment-they offer comfort, healing, and even a path to self-discovery. Research by Dr. David Lewis (2009) found that reading for as little as six minutes a day can decrease stress levels up to 60% (Vallie, 2024). This is due to its ability to slow heart rate, ease muscle tension, and shift the mind into a relaxed state. Evidently, reading has been shown to be more effective at reducing stress than drinking tea, listening to music, taking a walk, or even playing video games.

Beyond stress relief, reading has long-term cognitive benefits. Studies show that individuals who continue reading later in life experience 32% less mental decline, while those who rarely read decline 48% faster than average. For teenagers, reading plays a key role in academic success, social engagement, and personal development-helping them gain deeper insights into relationships, values, and identity. As the National Alliance on Mental Illness (NAMI) states, "Great writing has the power to make connections, expand people's worldviews, and deepen our understanding of critical issues, such as trauma" (Maddox, 2020).

The Science Behind Reading and the Brain

A 2013 fMRI study led by Professor Gregory Berns (2003) explored how reading physically affects the brain. The study found that reading a novel activates the left temporal cortex, the brain region responsible for language comprehension, as well as the primary sensorimotor region, which is associated with movement and physical sensation. This suggests that reading tricks the brain into feeling as though it is physically experiencing the events of a novel-a phenomenon known as embodied cognition. In other words, when we read about a character running, fighting, or feeling emotions, our brains simulate those experiences, allowing us to mentally "step into their shoes."

To examine the long-term effects of reading, researchers scanned the brains of 21 undergraduate students over nine nights as they read sections of the 2003 thriller Pompeii by Robert Harris. The scans continued for five additional days after they finished the book. Results showed heightened connectivity in the temporal cortex (linked to language) and the central sulcus (linked to movement and sensation). This enhanced brain activity lasted for several days, suggesting that reading has a lasting impact on cognitive function and emotional processing.

An Author's Perspective: The Power of Storytelling

By Allison Kleinfield

I was fortunate enough to attend a book launch hosted by Rochelle Weinstein, author of What You Do to Me, When We Let Go, This is Not How it Ends, Where We Fall, Somebody's Daughter, The Mourning After, What We Leave Behind, and her newest release, We are Made of Stars. As I looked around the room, I couldn't help but notice the impact that Weinstein's books had on each and every person in attendance, including myself. Her novels dive into the complexities of human emotions and relationships, addressing topics such as loss, grief, secrets, acceptance, and healing. Weinstein emphasizes self-discovery, forgiveness, and the journey toward healing, often portraying how characters navigate their challenges to find hope and resilience. I had the pleasure of sitting down with Rochelle Weinstein to hear her thoughts on literature and mental health:

Allison: "In what ways do you believe that your books have helped others overcome their own difficulties?"

Weinstein: "It's fair to say we've all experienced struggles and challenges in our lives. As an author, I take what I know and have learned and fictionalize it. There's always a lesson."

Allison: "Do you see writing as a therapeutic process for yourself, and if so, how?"

Weinstein: "Interestingly, I was a prolific journal writer from the ages of 11 - 25. Once I started writing fiction, I abandoned the journals and let loose through my stories. Writing is cathartic and healing for me and even better when a reader tells me how I've touched their life."

Allison: "In Where We Fall, you explore depression and bipolar disorder-what inspired you to include mental health themes in your novels?"

Weinstein: "I speak very candidly about my experience with an anxiety disorder as a young girl. I put in the work and made major changes to my life. Socials and such show only part of my story, but I climbed a pretty high mountain to get to where I am. If I can help one person out there, why not?"

Allison: "What role do you think fiction plays in reducing stigma around mental health topics like grief, trauma, and anxiety?"

Weinstein: "I'm a voracious reader and I'm seeing more and more novels highlighting mental health issues. I see you Emma Noyes and Matt Haig. It's encouraging to see the stigma dissipate. I always preach: if you have diabetes, you take insulin. Why do we treat the brain differently? For what its worth, therapy and medication saved my life. The darkest time gave me the most blessings and made me who I am today."

To learn more about Rochelle Weinstein, visit: http://www.rochelleweinstein.com

Join a book club!

Alvin Sherman Library Happy Hour Book club:
https://libguides.nova.edu/bookclub

Broward County's Public Library- Director's Book Club
https://www.broward.org/Library/Events/Pages/DirectorsBookClub.aspx

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Burnout in Healthcare: Perspectives in the Field

By Janan Abu Shaban, Gabriela Avila Fioranelli, Priyanka Ramanathan, and Trisha Ravigopal

Interview Questions:

1. What has been your experience so far working in psych?
    a. Have you ever experienced burnout, or have you witnessed any of your healthcare colleagues suffer from it? What was that like?
2. What coping strategies do you use to manage the heavy nature of your workload?
3. What do you look out for in your colleagues in terms of suicide prevention (SP)? Students?
    a. What can you do to intervene with your friends and colleagues?
4. Can you provide an example of a story that really stuck with you?
5. What resources/initiatives does your institution provide in relation to SP?
    a. Wellness programs, policy changes, etc.
6. How do you think burnout affects the quality of patient care? Any examples?
7. Thoughts on mistreatment in medical training? What can we do to change the system?

Burnout and psychological distress among healthcare professionals have reached crisis levels, with growing evidence linking clinician well-being to patient safety, quality of care, and the sustainability of healthcare systems. Burnout—marked by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment—is particularly prevalent among physicians, trainees, and those in emotionally intensive specialties. It not only contributes to medical errors and reduced empathy but also increases the risk for depression, substance use, and suicide (Dyrbye et al, 2017). A recent national burnout survey demonstrated that 45% of physicians report at least one symptom of burnout, and factors such as time pressure, lack of control, lack of communication or trust, and the fast-paced nature of the work contribute to its development (American Medical Association, 2024).

To further explore these issues from a lived experience perspective, we conducted a series of interviews with a medical student, a psychiatry resident, and physician-educators at Nova Southeastern University. Our aim was to better understand how burnout and suicide risk are perceived and managed in real-world academic and clinical settings. Our conversations focused on early warning signs, coping strategies, institutional resources, and the cultural shifts needed to support mental health across all levels of medical training and practice. We were fortunate enough to sit down with Dr. Ushimbra Buford, Dr. Shane Williams, Medical Student Jeremy Paparozzi, and a fourth-year psychiatry resident, to hear their unique takes on burnout at various levels of physician training.

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Dr. Ushimbra Buford is a board certified psychiatrist in general adult psychiatry as well as child and adolescent psychiatry. He describes working in psychiatry as very rewarding, and has assumed many roles (resident, fellow, program director, community provider, and more). Dr. Shane Williams is a family medicine physician and one of our beloved professors. From making sure his students have the best experience both inside and outside of the classroom, Dr. Williams is the kind of professor who does not just teach—he listens, mentors, and reminds us that we are human before we are physicians-in-training. We also had the chance to sit down with a fourth-year psychiatry resident, who talked about the importance of human connection in his work. He shared stories from medical school through residency, reflecting on experiences with burnout and offering advice on spotting red flags in ourselves and in the people around us. Rising fourth-year medical student Jeremy Paparozzi shared his experiences after two years of preclinical education and nearly a year of clinical rotations.

"Burnout is because you feel isolated, alone, and that your actions are going to have ramifications that you won't be able to recover from," says Dr. Buford. In the healthcare field, you can often get used to only talking to sick patients, and fall into the trap of forgetting about all of the people you may have helped that you are not seeing anymore. He draws on an old expression that helps to combat that – "at the end of it all, if you've changed just one person's life, it was worth it. So doing something like this, you have changed hundreds, if not thousands of lives." Dr. Buford goes on to note the shift in mindset he has grown to adapt: "When I was younger, I used to think I was just going to work super hard until I'm 70, then I'll be able to take the success I have had and go live a nice life… Now my mentality is I work everyday, I vacation everyday. Everyday of my life, I'm going to have some fun and do things that make me happy." He emphasizes proactive measures vs reactive measures because burnout can "impair an organization." It is widespread in the healthcare setting - not just the attendings, but also the nursing staff, administration, environmental staff, and residents are impacted by it.

For the resident, burnout culminated throughout his training, especially after the loss of his grandmother and best friend while in medical school. Burnout was made worse by poor coping habits: "I'd come home, have wine and play video games." Now, he uses boundaries—like setting down a pen from his grandmother—to leave work at work. "If you don't compartmentalize, you're just a grief mop in this field."

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Although Dr. Williams' current career provides a nice balance of academic medicine and clinic work, he shared that throughout his training it was not always this way. He shared that his peak of burnout, like many other physicians, was during his intern year of residency. Working many, long, arduous hours in the hospital left little time for activities and people that he cared about, not allowing him to properly decompress. He compared the feeling to a "slow dimming of light that once fueled passion," the most difficult realization being that he was "losing joy in what [he] once loved" and forgetting to care for himself in the process. Now, well into his career, Dr. Williams has come to understand himself and the things that keep him grounded. His biggest word of advice– "leave work at work." Especially when dealing with others' emotions all day, he said that he stops responding to emails and charting at 5 p.m. and does whatever he can to separate himself from his work. He mentioned using exercise, basketball, photography, his daughter, and even tattooing to serve as his self-care.

Medical student Jeremy Paparozzi relays that he has very much enjoyed rotations and is thankful for the friendly and like-minded residents involved in his training. He actively avoids burnout by honoring his life outside of medicine, maintaining a solid support system, and valuing the unique opportunity he gets to make a lasting impact in the lives of others. Dr. Buford echoes these sentiments, stressing the importance of building resiliency factors with four core components: exercise, nutrition, good sleep, and social engagement. Resiliency is just as important as pathology, yet often overlooked – "When I became a program director… I would say, as opposed to being a firefighter to show up when your house is burning down, we are going to learn to be architects, teach people how to build fire resistant houses that would be a little more difficult to burn down."

Burnout does not always announce itself—it creeps in quietly. "It usually begins with sleep problems," the resident said. Over time, it turns into irritability, missed deadlines, and eventually apathy. "The end stage is when you stop caring—about your patients, your job, even yourself." The resident recounts some of the hardships he watched his peers face: "We had residents pass out from not eating." Early warning signs, such as social withdrawal, were there – they just hid it well.

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As a medical student, Jeremy Paparozzi has noticed some of these early signs of burnout among his peers. He recalled watching his typically sociable close friend crack under the pressure of taxing exams– "with board exams on the horizon, this person was very clearly not engaging with us." He emphasized the importance of reaching out early to ensure others know they are not alone.

Dr. Williams described the extreme physician burnout during COVID and watching his best friend, a nocturnist who worked overtime, suffer during this time. He experienced a slow decline in joy and his overall presence. He was not partaking in the activities he enjoyed, and most concerningly, was not willing to discuss his feelings with friends and family. We also touched on the increased risk associated with men; the idea of having to "man up and put your head down" can lead to the silent accumulation of burnout as they fight more of a social stigma around mental health. While his friend got through this period, between unpredictable schedules and missing important life events, many physicians and those in training suffer silently- something we can try and better with conversations and coping skills.

Dr. Buford deems the most important takeaway as "if you see something, say something," and if you feel someone is in danger, you must intervene and try to get them the help they need. You do not want to live with the regret of thinking you should have said something. Warning signs to look out for can include drastic changes in function from baseline, behavior, appearance, and increasing social isolation. He explains that the power of teamwork and communication cannot be understated when it comes to burnout – "make sure that the staff members feel that they are heard – that they are not just a cog in the machine, that they are part of and have agency in the organization." Creating a sense of camaraderie and support system at work can combat stress from burnout.

It is no secret that the world of medical training heavily uses "pimping" as a learning tool, a physician expecting students to know what seasoned professionals have mastered over decades, that can become a performance of intimidation. Dr. Williams discussed that mistreatment in medical training, and the differences in educators who teach with compassion and inclusivity versus those who teach by belittling. The resident shared similar views when he emphasized the need to move away from fear-based training environments. "Fear of disappointment is okay—but not fear of punishment. Good programs listen. The system's not perfect, but it can be better. The 'it's part of the job' mentality is why so much goes unreported," he noted.

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Dr. Buford explains that throughout this career journey, there will be providers who students are so inspired by that they will want to model themselves after them, but the opposite can be just as true. "Both are powerful," he says, explaining that lessons learned from hardship can change something in you for the better. Essentially, take the good from the bad and preserve your own mental health in the process: not every battle is worth fighting, and sometimes there can be context you just do not have.

Both medical students and residents are expected to have "superhuman endurance" and the utmost compassion when facing patients, while showing little regard to their own personal well being. Dr. Williams discussed how this can lead to a lack of humanity in one's capacity to empathize with patients – compassion requires energy, and cannot be expected when one's energy is depleted. Burnout is an important barrier to patient care we must be cognizant of, and unfortunately, "if it didn't impact patient care, it wouldn't be an issue, as sad as that is… the reason we even discuss this at all is because it increases medical errors," Dr. Buford said. For the resident, he witnessed the consequences of unchecked burnout firsthand—from small mistakes like putting a non-diabetic on sliding scale insulin to more serious ones, like mixing up patient histories due to exhaustion. In other cases, some physicians do not really seem to have the same love for the profession, and "when we don't remember burnout exists, the quality of care goes down and we treat people like lab values," Jeremy commented.

Therefore, Dr. Williams discussed the importance of "recharging" and how there is currently a "huge cultural shift" that is essentially up to our generation to advocate for the wellness of our future physicians. For example, employee assistance programs have been in place in many institutions, which provides faculty with access to counselors, healthcare, and other helpful resources. As a residency program director, Dr. Buford would encourage his residents to coordinate their schedules so one person each week could take a half day off for self care, doctor's appointments, or just a much needed break. In contrast, the Resident's program offers support through a Wellness Chief who organizes social events, nearly free therapy through strong insurance coverage, and assigned mentors at both the faculty and peer level. Even for those institutions that do not offer specific programs, there will always be public resources such as the 988 suicide and crisis hotline.

Dr. Williams acknowledged his unique position as an educator in being able to support student doctors during some of their most difficult years. He points out that "suicide comes about when you don't have an outlet" and his goal is to be that outlet for his students. He believes that it is "not fair for medical professionals to not practice what they preach" and therefore, he emphasizes an open door policy with all his students, whether that be through a smaller clinical group or during his class-wide lectures.

Burnout in Healthcare: Perspectives in the Field

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As we have learned from these interviews, burnout is a growing problem that necessitates intervention to ensure the safety and wellbeing of providers and patients. These perspectives have shed light on methods that can address mental health and provide support for those struggling with the weight of their career. Dr. Buford specifically cautions against normalizing the heartbreaking situations you are exposed to on a daily basis, and while “we are the people who are standing in the gap to deal with it,” healthcare providers and supporting staff should take care of themselves by relying on a strong team network who will look out for each other, working on building resiliency factors, and maintaining a sense of purpose that fuels motivation. It is our hope that burnout will continue to be at the forefront of important conversations to be had about wellness in healthcare providers, and current and future generations can be a part of a change for the better.

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The Role of Law Enforcement in Suicide Intervention

By Lolita Bell

In many cities and places, police officers are the first and sometimes the only responders to individuals who are facing a mental health crisis. As suicide rates continue to increase and emergency calls are surging, the role of law enformcent in suicide prevention and intervention are extremely critical. When an individual calls 911 in the midst of a mental health crisis, the police are the first to likely show up. However, many officers and law enforcement have little to no training in handling mental health crises (Dupont & Cochran, 2000). An officer that was interviewed anonymously shared, "We're trained to control a scene, but not always to de-escalate someone in emotional distress" (The Guardian, 2025).

Therefore, it is essential to address this concern. To address this gap, departments across the country have adopted Crisis Intervention Team (CIT) programs which was a model first developed in Memphis, Tennessee (Dupont & Cochran, 2000). The CIT training usually involves a 40-hour course where officers learn about mental illness, suicide risk factors, and de-escalation strategies. Furthermore, departments that implement CIT see lower injury rates for both officers and civilians and improved referral rates to mental health services according to the National Alliance on Mental Illness (NAMI, n.d.). Officer James Rivera of the Miami-Dade Police Department stated that "CIT has changed the way we interact with people in crisis. It's not just about safety anymore, it's about dignity and getting people the help they need" (NAMI, n.d.).

However, simply doing the training may not always be enough. In recent years, co-responder models have gained momentum, pairing officers with licensed mental health professionals to respond jointly to calls. This collaborative approach can reduce unnecessary arrests and hospitalizations, and improve outcomes for people experiencing severe emotional distress. A 2023 report by the Congressional Research Service found that co-responder teams were associated with a decrease in the use of force and an increase in community trust (Congress.gov, 2023).

Yet, these programs still face logistical and financial hurdles. A study recently conducted in Queensland, Australia, found the dangers of under-resourced mental health support in law enforcement. The article showed that, in one district of over 220,000 residents, a single mental health officer was available resulting in missed intervention opportunities for individuals in crisis, including one who later carried out a mass stabbing at a shopping center (The Guardian, 2025). Similarly in America, similar issues still arise. Officers report being overwhelmed, and mental health calls continue to rise. "We're stretched thin," said a California sergeant. "We need more support from mental health professionals embedded in our teams, ongoing training, and the right tools to truly make a difference" (The Guardian, 2025).

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Mental Health First Aid for Public Safety is a program which is supported by the Bureau of Justice Assistance, and are some steps in the right direction. This program provides brief but targeted training on suicide prevention and crisis response. But some experts argue that more comprehensive systemic change is needed, starting with legislation that mandates mental health partnerships and funds long-term training efforts. Therefore, as we talk more about suicide prevention in law enforcement, we can say that the badge now carries an added responsibility saving lives not just through enforcement, but through empathy.

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Silent Suffering on the Roads, Seas, and Skies: Mental Health Awareness Among Transportation Workers

By Blaise Desautels

Every day, millions of transportation workers keep our economies and our livelihoods moving. These workers consist of bus drivers, shipment personnel, truckers, air traffic controllers, train operators, and others. They deliver our mail, transport our goods, and ensure our public transit systems function efficiently. Unfortunately, recent research is suggesting suggests that many of these essential workers are silently suffering behind the wheel, in the cockpit, or along the tracks. Recent data is revealing a dilemma that has not had proper acknowledgment, which is that transportation workers face disproportionately high risks of suicide.

A systematic review and meta-analysis by Mathieu et al. (2022) found that transportation workers, specifically maritime workers who operate on ships and vessels in our seas, have a significantly higher risk of dying by suicide compared to those in the general and employed populations. In the same study, subgroup analyses found that aviation, freight, and driving transportation occupations did not have a similar significance compared to the maritime workers (Mathieu et al., 2022). The authors of the review suggested that this may be a result of the isolation that comes with being out at sea for long periods, as well as differences in educational opportunities and economic status. However, transport workers in general did show higher risks of dying by suicide compared to the general population (Mathieu et al., 2022).

This concerning pattern that is being found in transportation workers has reached different corners of the world. A study conducted by Yamauchi et al. (2018) examined suicide rates in transportation workers by the cases in which compensation was given for mental disorder or suicide. In Japan, transportation workers, led by manufacturing workers, had a higher rate of compensation due to suicide than those in the electricity, gas, heating, and water industry (Yamauchi et al., 2018). Similarly, in Canada and Australia, male road and rail drivers were identified among occupations with some of the highest suicide mortality rates (Milner et al., 2015; Mustard et al., 2010).

Transportation work frequently involves long and irregular hours, sleep disruption, and extensive time away from home, family, and limited social contact altogether (Pellegrino & Marqueze, 2019). For instance, long-haul truck drivers may be on the road for weeks at a time, sleeping in their vehicles and maintaining inconsistent schedules that disrupt their circadian rhythms. Transportation workers also face physical stressors, including exposure to loud, constant noise, such as the continuous roar of jet engines for airport ground crews, and experiencing motion sickness, which is common among ferry operators or maritime crew members in turbulent waters.

Silent Suffering on the Roads, Seas, and Skies: Mental Health Awareness Among Transportation Workers

By Blaise Desautels

Raising awareness about the mental health struggles of transportation workers is a crucial first step toward meaningful change. As discussed, individuals in this industry consistently endure a unique and often grueling combination of stressors that can severely impact their psychological well-being. These conditions are further exacerbated by stigma and limited access to mental health resources, contributing to disproportionately high suicide rates across various transportation occupations (Mathieu et al., 2022). From long-haul truck drivers separated from family for weeks at a time, to airline pilots and rail operators bearing the weight of countless lives on their shoulders, the emotional toll on these essential workers often remains invisible.

Despite this acknowledgment in literature, there remains a significant lack of general awareness and suicide prevention programs that are tailored specifically to the transportation industry (Mathieu et al., 2022). With the intense pressures that come with transportation jobs and their male-dominated nature, mental health promotion and intervention strategies should aim to be designed with the unique context of these workers in mind.

Effective prevention could involve workplace-based approaches that validate and address both the transportation culture itself, while also aiming to support individual well-being. Our transportation workers are critical to the functioning of modern society, yet their mental health needs often go unrecognized. By acknowledging the unique stressors they face and developing interventions that are both accessible and culturally sensitive, the risk of dying by suicide can hopefully be reduced and mental health can be improved in this vital workforce.

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Faith on the frontline: the role of religious/spiritual leaders in suicide prevention

By Layomi Adeojo, BA

Introduction

Over 49,000 people in the United States died by suicide in 2023; this is equivalent to one death every 11 minutes (Centers for Disease Control and Prevention [CDC], 2025). In addition to completed suicides, approximately 18 million more people seriously think about, plan for, or attempt suicide (CDC, 2025). Suicide impacts people across the lifespan — it is the second leading cause of death among adolescents and young adults, and sees its highest rates among older adults, aged 75 and older (CDC, 2024; CDC, 2025). Given this prevalence, there is an urgent need to mitigate suicide risk through prevention and early intervention strategies that strengthen protective factors against suicide.

In the literature, religion/spirituality has emerged as a protective factor against suicide (Cole-Lewis et al., 2016; Gearing & Alonzo, 2018; Lawrence et al., 2016a; Lawrence et al., 2016b; Mishra et al., 2017; Norko et al., 2017; Wu et al., 2015). Religious beliefs, spiritual practices, and faith communities all play a part in reducing suicide risk. With the aforementioned prevalence of suicide and suicidality, it is plausible that a percentage of these individuals identify with a religion, belong to a faith community, or engage in religious/spiritual practices.

Religiosity/Spirituality and Suicide Prevention

Studies have found that higher religiosity is inversely related to suicide (Mishra et al., 2017) and that religiosity has an overall protective effect on completed suicide (Wu et al., 2015). Higher religiosity — conceptualized in various ways such as religious service attendance, personal religious beliefs, and spiritual practices like prayer and meditation — is associated with lower suicidal behavior, a finding that holds true across age, gender, and race/ethnicity, to varying degrees (Gearing & Alonzo, 2018; Norko et al., 2017). One review of religion and suicide risk found that religious affiliation is protective against suicide attempts, and religious service attendance is protective against suicide attempts and possibly protective against completed suicide (Lawrence et al., 2016b). Among youth, research has found that private religious practices (e.g. prayer and meditation) are associated with less suicidal ideation, even after accounting for the impact of school connectedness and parent-family connectedness (Cole-Lewis et al., 2016).

Though the terms religion, spirituality, and faith are often interchanged in the literature, particular beliefs — such as the afterlife and tolerance of suffering — have been observed as protective against suicide (Norko et al., 2017). Similarly, having a moral objection to suicide has also been associated with lower levels of suicidal behavior (Norko et al., 2017).

Faith on the frontline: the role of religious/spiritual leaders in suicide prevention

By Layomi Adeojo, BA

This finding, however, is contingent on peoples' individual beliefs and their own understanding and interpretation of their faith's teachings. Nonetheless, this is important to note given that the five major world religions (i.e. Islam, Hinduism, Christianity, Judaism, and Buddhism) all hold a moral objection to suicide (Norko et al., 2017). While only several outrightly condemn suicide in their teachings, all five are disapproving of it. Therefore, when treating patients who identify with these faiths, it is important to know both their personal religious beliefs and their faith's view of suicide.

Despite the protective effects of religion/spirituality, not all the research is consistent with these findings. For some individuals, particularly those with a depressive or bipolar disorder, religious affiliation is associated with higher suicide risk (Gearing & Alonzo, 2018). One study found that greater religious affiliation was associated with more suicide attempts and suicidal ideation among depressed psychiatric patients (Lawrence et al., 2016a). Moreover, suicide stigma within religion cannot be overlooked. In one study interviewing church members, congregants described internal stigma (i.e. shame and negative self-image), interpersonal stigma (i.e. social rejection and discomfort), and theological stigma (i.e. negative views of suicide within the faith tradition; Mason, 2021).

Participants reported that this stigma is perpetuated by seven factors: silence/secrecy, ignorance about suicide, expectations of "having it all together," busyness of faith leaders, lack of training, divisions between faith and mental health, and expectations for religious services to make people "feel good" (Mason, 2021). Suicide stigma can potentially weaken or counteract the protective effects of religiosity/spirituality; thus, prevention efforts must also work to address and reduce this stigma in faith communities.

The Role of Faith Leaders

When considering those directly involved in suicide prevention, mental health professionals and first responders likely come to mind as people most likely to encounter a crisis situation. However, numerous professions play an important role in prevention and intervention. Among these professionals are faith leaders, or individuals who hold a position of authority within a given religious or faith community. In the research literature, these individuals are sometimes called faith healers, who have been characterized as "religious leaders who rely on the powers of God to heal disease and employ prayer, fasting, supplication and holy water as strategies to treat ailments" (Shoib et al., 2023). More broadly, faith leaders oversee communities that create spaces for people to receive counseling, spiritual healing, and social support, as well as discover hope and purpose in their lives (Shoib et al., 2023).

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While faith leaders are often the first line of defense in suicide prevention, many lack formal training in this area (Mason, 2021). This skills deficit presents an opportunity for spiritual and mental health support systems to bridge gaps and engage in collaborative suicide prevention efforts.

In a case study of a faith community in Colorado, Spencer-Thomas (2018) describes three approaches to addressing suicide risk: upstream, midstream, and downstream. Upstream prevention focuses on bolstering protective factors, including compassion and resilience, social support and connectedness, and spiritual practices that function as coping skills. Midstream intervention centers around early identification of suicidality and promotion of mental health via resources and care. Downstream crisis response focuses on responding to crises where positive religious and spiritual practices support the process of suicide bereavement. By employing these three approaches, faith leaders can build resilience in their communities, support emerging mental health challenges, and create places of refuge and healing in the aftermath of suicide attempts and completions (Spencer-Thomas, 2018).

Conclusion

Research shows that religion/spirituality holds a significant, multifaceted role in suicide prevention as a source of support and coping for people in crisis. Likewise, faith leaders are in a unique position to promote the protective factors of hope, meaning, and purpose in peoples' lives. When working with clients who deem religion/spirituality as important in their lives, mental health professionals should consider interprofessional collaboration with faith leaders to help prevent suicide and support individuals and communities affected by it. By bridging the gap between faith and mental health, helping professionals can work together to reduce mental health stigma and meet people in need with effective, early intervention.

The Quiet Epidemic: Suicide in the World of Animal Care

By Dina Alhassani, MS

When one thinks of a veterinary clinic, the associations are often warm and comforting: paw-shaped dog treats in a glass jar on the receptionist's desk, a kind technician slipping a Delectables or Inuba snack to calm a nervous pup before getting a shot or a family waiting with excitement to introduce their newly adopted kitten to their lifelong vet. These settings provide a space for healing, care, and trust — whether for annual routine exams, medical boarding before a couple's honeymoon, or end-of-life services for a beloved pet nearing the end of its life. However, what spaces for healing, care, and trust are established for the people who provide us with the same services? What about the veterinarian behind those compassionate services? Who cares for them and their loss? How does the emotional labor weigh on the very people who help us through some of the most heartbreaking losses, such as the loss of a beloved pet? As a species, we are facing a global public health crisis regarding loss of life due to suicide, with over 1 million lives lost annually - this is greater than the combined loss from war and homicide. However, this rate is up to 3.5 times for veterinarians than for other members of the general population (Zimmermann et al., 2023). One might wonder how this can be the case when one is involved in such a healing and caring practice.

Twenty years ago, this was not even being discussed; instead, it was brewing as a quiet epidemic, silently affecting those in the field, where there were arenas to provide for others, but providing for oneself was less established.

Thankfully, more and more is being done within this field. Just as in every great movement, there are people within it who recognize that something needs to be changed and start making movements to effect that change; the same happened in the veterinary field. The literature reveals that the veterinary profession is at risk due to a multitude of factors, including emotionally intense workloads, emotional exhaustion (potential for moral injury when delivering euthanasia to relatively vital animals), long hours, after-hours calls, high client expectations, and a fear of litigation (Stoewen, 2015). Additionally, a significant impact on the well-being of veterinarians was the role of compassion fatigue, resulting from prolonged exposure to both suffering and ethical dilemmas, which slowly depletes emotional reserves over time without clear boundaries. In veterinary medicine, the loss is not only personal (as the connection to an animal can be profound and formed through individual interactions); in this way, the loss becomes much more communal, affecting clients, coworkers, and entire communities (Stoewen, 2015).

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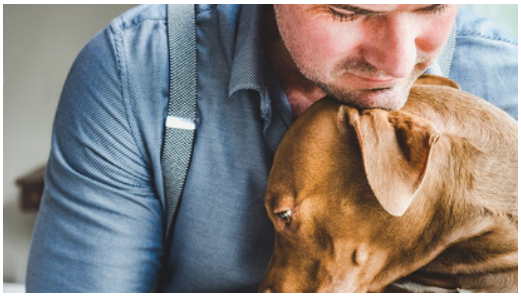
Additionally, veterinarians are often expected to rapidly shift between emotions without time for their emotional processing, switching from room to room with completely different scenarios, in some moments joyful about hearing the improvement in a pet they are treating, into other next-door rooms where traumatic experiences like administering euthanasia or delivering bad news might be needed. On the same day, a veterinarian can celebrate a new pet adoption with a family and be tasked with ending the life of an animal a family considers a member of their own.

Additionally, financial strain is quite significant on veterinarians. Despite the academic demands and considerable student debt required for veterinarians to practice, they often earn less than their human medical colleagues. This financial burden, in play with the high emotional toll, only increases the vulnerability of the profession.
Additionally, veterinarians also have access to means, like euthanasia, which can serve as a key risk factor. Veterinarians have the knowledge and access to lethal substances like euthanasia drugs, which, when combined with emotional exhaustion and financial strain, can create a deadly combination of stress, access, and intent.

Stoewen (2015) also notes how common personality traits of those within the field may contribute to the increased suicide rate within the population, such as perfectionism, high conscientiousness, and a tendency towards social withdrawal (which can be internalized and self-punishing when expectations are not met—potentially increasing the rate of depression within the population as well).

Lastly, Stoewen (2015) also notes how the stigma in the veterinarian field plays a role. Those in the veterinary field are expected to be healers and problem solvers, not those receiving help. As a result, those in the field may worry about appearing weak or incompetent if they were to admit their struggles, potentially only furthering the common characteristic of social withdrawal among veterinarians. It is key to note that these are merely factors that research suggests play a role and that every situation and individual is unique. As such, their relationship to their profession and the risk/vulnerability of dying by suicide is independent. The research suggests that these generalizations or trends within the profession can be targeted by interventions to provide systematic support for professionals.



The Quiet Epidemic: Suicide in the World of Animal Care

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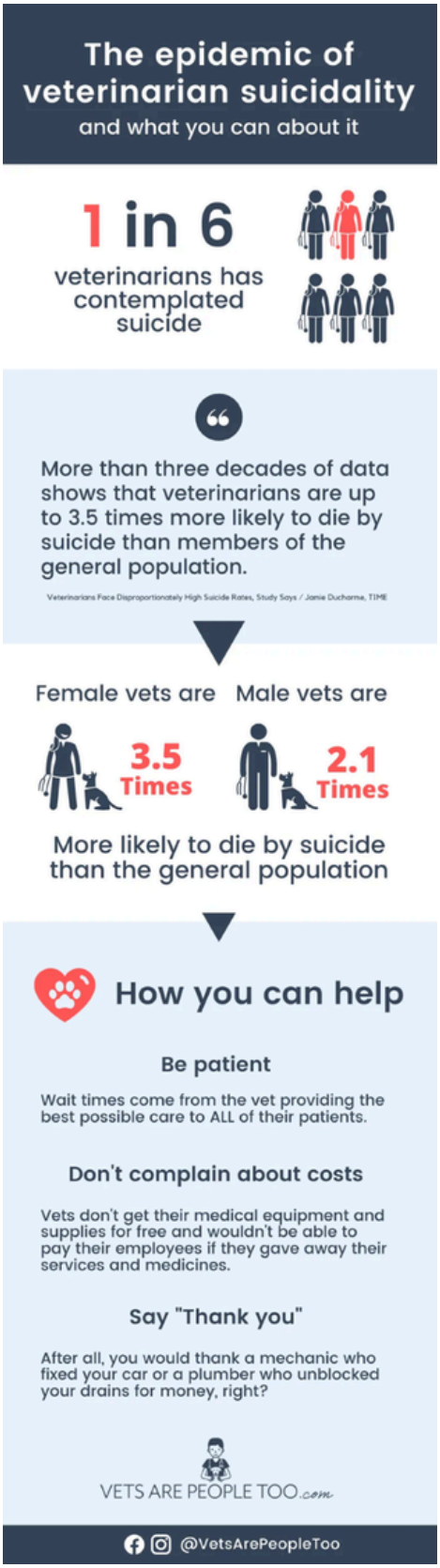
Stoewen (2015) emphasizes the three cardinal warning signs of suicide in his article, which include: 1. Clinical depression, 2. Changes in behavior, and 3. Talking about suicide. These signs must not be ignored, as they may only be the observable and visible signs of suicide. Stoewen (2015) also promotes the importance of bold compassion and systemic change that emphasizes the integration of mental health education into veterinary training (including wellness check-ins, resilience training, and access to confidential therapy, treating preventative mental health as seriously as any other clinical competency), normalization of help-seeking behavior (challenging the normative that asking for help is a sign of weakness), implementing peer support programs (adopting crisis intervention protocols, peer monitoring systems, and reflection supervision models in clinic and animal hospital settings to reduce isolation and withdrawal actions), and promotion of interdisciplinary support (intersectional collaborative work between psychologists, counselors, and social workers in veterinary wellness initiatives offering trauma-informed care, emotional processing of traumatic experiences, and preventative practice promotion for burnout prevention). As future psychologists, we can play a role in advocating for veterinarians and other healthcare professionals by amplifying their voices when possible, breaking down barriers to mental healthcare, and providing safe spaces for those who care for so many of us and our furry companions.



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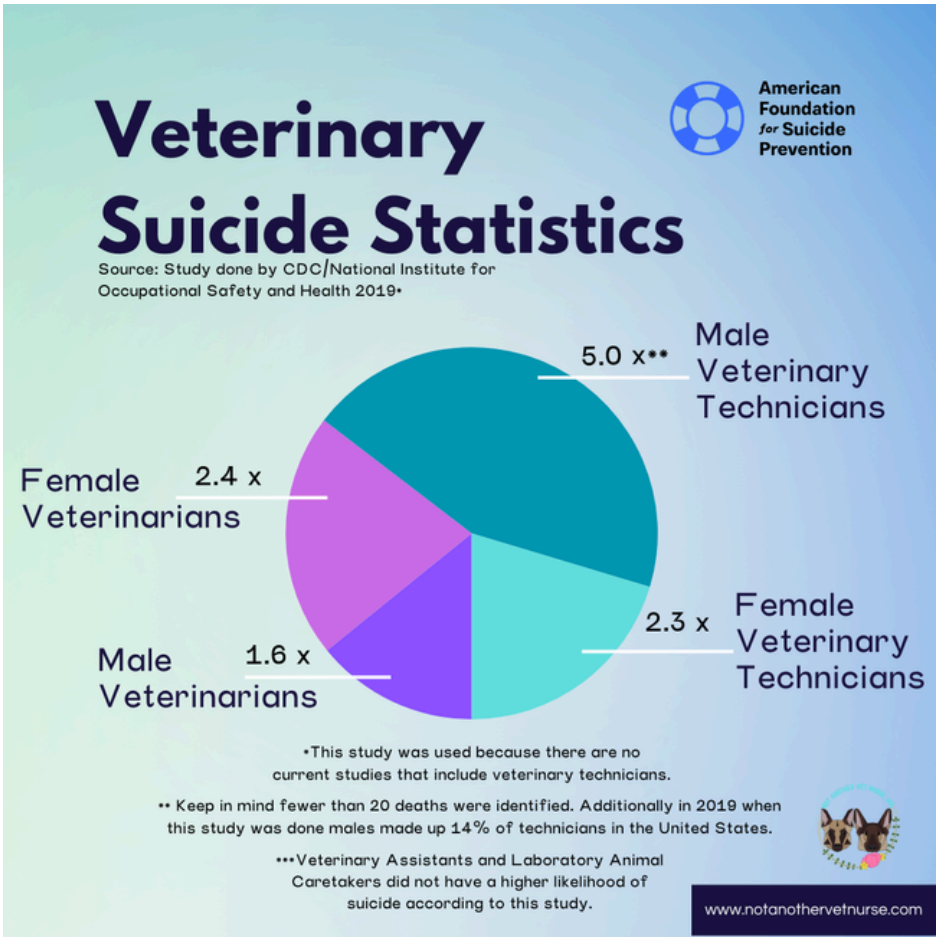
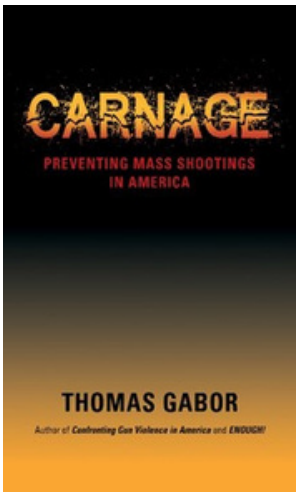


Where the Bullet Falls: An Exclusive Interview with Dr. Tom Gabor Regarding His Upcoming Graphic Novel and the Gun Violence Epidemic in America

Interview conducted by Dina Alhassani, MS & Dr. Hubbard



Dr. Tom Gabor has extensive experience in the fields of criminology and sociology, having held various roles throughout his career.

From serving as a Professor of Criminology at the University of Ottawa from 30 years (1981-2011), to serving as a member of the Editorial Committee of the Canadian Journal of Criminology and Criminal Justice for 20 years (1990- 2010), to becoming a published author of over 200 written works, to being listed among the most influential criminologists in the English-speaking world in a study published in the British Journal of Criminology, Dr. Gabor has become more and more involved in advocating for education of the gun violence epidemic that is plaguing our nation today.

Regarding his advocacy for policies to create safety and eliminate or minimize gun violence, Dr. Gabor has testified before the House of Commons Justice Committee and the Canadian Senate and has served as an expert witness in several criminal and occupational safety cases. Additionally, he is a frequent public speaker, has an extensive social media network (Facebook), appears regularly on numerous television, radio, and podcasts, and often contributes op-eds to print media.

Where the Bullet Falls: An Exclusive Interview with Dr. Tom Gabor Regarding His Upcoming Graphic Novel and the Gun Violence Epidemic in America

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Dr. Gabor strongly prioritizes education in his work for gun advocacy, working as both as a consultant to many international and national organizations, and writing and spreading awareness in his multitude of, works published or featured on outlets such as the BBC, Fortune Magazine (contributing writer), Democracy Now, LA Times, Orlando Weekly, Tampa Bay Times, Palm Beach Post, South Florida Sun-Sentinel, the Miami Herald, and numerous international publications in Canada, the UK, Australia, France, and Spain.

Regarding consultation, Dr. Gabor has left a strong footprint in the gun violence realm, providing advice to the United Nations, Lord Cullen's Inquiry on firearms policy in the United Kingdom, the Department of Justice Canada, the Canadian Firearms Centre, Palm Beach County's Criminal Justice Commission (Florida), League of Women Voters of Florida, Public Safety Canada, Canada's Border Services Agency, and the Correctional Service of Canada.

A few other inspiring accolades include listed author of the acclaimed *Confronting Gun Violence in America*, chapter contributor to the chapter on Firearms and Violent Crime to the Encyclopedia of Criminology, inducted member in the Canadian and Criminology's Who's Who, recipient of the American Society of Criminology's Gene Carte Prize for his research on Crime Displacement, and designation as an individual of "Extraordinary Ability" by the Department of Homeland Security.

Currently, Dr. Gabor serves as the President of his own Florida-based criminal justice consulting firm, Thomas Gabor, LLC. In addition, he writes frequently and has an upcoming graphic novel release, titled Gun Violence 101, which will be further discussed below.

Note on Interview Content:
This interview highlights insight from Dr. Gabor and key analysis from two of his works, one with Fred Guttenberg, titled American Carnage, and an up-and-coming graphic guide titled Gun Violence 101 - A Graphic Guide on How Gun Safety Policies Save Lives soon to be released with illustrations by Violet Lemay and Foreword by Fred Guttenberg. We were incredibly fortunate to receive exclusive pre-release access to Dr. Gabor's graphic guide, and we thank him greatly for sharing it with us and taking the time to meet with us for our newsletter.

Dina: Thank you, Dr. Hubbard, for the introduction, and thank you, Dr. Gabor, for that exclusive release—it was a huge privilege, and the work is impressive!

Dr. Hubbard: I was super excited to see that you've been doing things in a graphic guide format. I think that is so forward-thinking. I think that's one of the things that allows misinformation to spread so quickly, and graphic novels are such an accessible medium for many in the new generation. Even older people, like myself, enjoy graphic novels.

Dr. Gabor:
Yes, exactly. And we're.. trying to reach [..] young people, obviously, but also low-frequency readers. And we realize that even with the format of American Carnage, which is basic, and we have summaries at the end of each chapter, and so forth...There is a great deal of content for people to absorb. And if we want to go beyond just reaching experts in our field, we have to make it more digestible. [...] Sometimes a photograph or an illustration of some kind is worth 1,000 words.
For example, there was the one we obtained from the Kansas Historical Society, showing a sign in Dodge City from the 1800s, and Dodge City was supposed to be one of the most violent places. So, we obtained this photograph, which reinforced the point that there were some stringent gun regulations in America's history.
Some people want us to believe that the contrary is true, that, you know, we talk about the Wild West, and the regulation in many ways was more strict than it is today. So, we're not going to return when we complete all the deregulation we've been implementing in several states, particularly about permitting and other related matters. We're not returning to the roots of this country, as some people want us to believe, but instead, we have more extreme policies in many ways about the acquisition of guns and gun carrying than we did in the past. However, I'm getting ahead of myself, and I want to thank you for your feedback regarding this illustrated book. We're very excited about it. Hope to get it out there. Any support you can offer us is greatly appreciated. Alternatively, you could also ask Dina for a brief blurb of a couple of lines for marketing purposes, which would also be appreciated.

Dr. Hubbard: Absolutely. And, you know, I'll reach out to the Alvin Sherman Library and ask that they carry some copies because I think we need to have this out there.

Dina: Okay, pulled up the questions, and let's get started! Today, we'll be discussing two works: your book, American Carnage, with Fred Guttenberg, and an upcoming graphic guide titled Gun Violence 101: A Graphic Guide on How Gun Safety Policies Save Lives. Soon to be released with Violet Lime, the Illustrator, we are incredibly fortunate to have exclusive pre-release access to that graphic novel, and thank you again for sharing it with us.

Dr. Gabor: Sure.

Dina: So let's get started. To get to know you better as a person, please share one or two fun facts about yourself. They can be anything you feel comfortable sharing, such as your favorite color, type, cuisine, and so on.

Dr. Gabor: Well, I certainly like to think my wife thinks I'm a fun person. But I do like the outdoors. I enjoy walking in the wetlands here in Florida, and I was a hiker and cross-country skier when I lived up north. And I also enjoy cooking. I enjoy cooking a variety of ethnic foods, from Indian to Middle Eastern and Hungarian cuisine, as I'm of Hungarian descent. These are a couple of things that keep me centered.

Brief Moment of Sharing Excitement over Arabic Recipes

Dina: Okay, can you share a little bit about your background before becoming an author and your work in gun advocacy?

Dr. Gabor: Yes. I received my doctorate from Ohio State University. I was born in Hungary and migrated to Canada as a refugee early in my life. I grew up in Montreal, attended school, and studied sociology and criminology, both in Montreal and Ottawa, Canada. And then I went on to get my PhD in sociology at Ohio State. So, I have degrees in sociology and criminology. And then I was hired by the University of Ottawa, where I taught as a professor of criminology for 30 years.

Now, how I got into this area...one of the things that prompted me was in Canada, we had a horrific mass shooting in December of 1989, where a young man, a socially awkward young man, walked into the University of Montreal. He had frustrations with the dating scene and, in addition, work-related frustrations. He walked into a classroom at the School of Engineering at the University of Montreal asked the men to leave and proceeded to execute 14 women with an assault style weapon.

So, this shook the nation. Canada does have some mass shootings, but not the kind of numbers we're seeing here, though we didn't see those numbers here either 30 or 40 years ago. And when the liberal government came in in the early 1990s, they made it the number one priority to enact stricter legislation regarding firearms. One of the things I was asked to do was to study violence, which I had a history of doing. Still, I had no real history in terms of gun policy in particular...I had no strong feelings one way or the other, in terms of guns and their regulation and potential impact. [..] I was asked to review, as you all know, in academia, we are often asked to review the literature, specifically the research literature and the body of evidence available. And I was struck by the preponderance of evidence that I saw showing that, you know, gun ownership, increasing gun ownership will produce a net liability to society. **It tends to raise violence, not decrease violence, increase mortality, not decrease mortality, and weaker gun laws invite higher levels of violence.**

I was also honored to be asked by the United Nations to participate in the first global study of firearm regulation, which has provided me with insight into what other countries are doing. I've also conducted research in another project on licensing systems for firearms owners worldwide, across various countries.

And I was asked to serve as an expert witness after the UK in Scotland, specifically, had their sandy hook where somebody walked into an elementary school in Dublin, Scotland in 1996, and murdered 16 elementary school children and their

And I was asked to serve as an expert witness after the UK in Scotland, specifically, had their sandy hook where somebody walked into an elementary school in Dublin, Scotland in 1996, and murdered 16 elementary school children and their teacher. They had a national inquiry. The victims' families asked me to provide an expert submission. I was told that my submission had an influence on Lord Cullen, the judge overseeing this inquiry, and ultimately contributed to changing the law in the UK. So that's a career highlight for me.

And then my wife and I moved to Florida, and I've been working, especially in this area, over the last ten years. I've been more focused on this area than ever before. I am involved in other criminological work, and this book you mentioned, the graphic guide to gun safety policies. That will be my fifth book since 2016. So, I've covered a wide range from a textbook called Confronting Gun Violence in America that touches on so many different issues, a book called Enough After the Parkland, Horror, it's a book on Solutions, because I was working on another book, American Carnage, when the horror happened, and everybody was saying, "We need solutions". So, I wrote a book on solutions. I wrote a book called "Carnage on Mass Shootings," and then "American Carnage," which we're going to discuss today, and this graphic guide. So that's what I've been up to. Haven't been bored.

Dina: Yeah, five works is quite bit since 2016. It's impressive. And thank you for providing those, because unless you study the field, you can get frustrated and overwhelmed by the violent events that occur and are reported in the news. It can also be especially frustrating when you don't have the solutions and don't know the topic well enough to come up with them.

Dr. Gabor: It is a very frustrating environment today, and indeed, our national elections, without wanting to inject politics. But I mean, this is a political process at this point. Regarding specific gun laws, there are additional policies we can implement beyond changing the law. However, in my view, changing the law in certain areas is imperative. And it's really to say that it's an uphill battle right now, both in Florida and on the national scene , and changing laws in this area is an understatement.

Dina: It's essential that the work still gets done, however.

Dr. Gabor: Absolutely, we never give up because if we're giving up, first, you embolden those who don't want to see change, but also, you're giving up on our kids. How can you compromise public safety? And in my view, without the public feeling safe, I have a declaration of the right. You may have seen it at the back of the book. I've had it elsewhere to the right to live free from gun violence. That's a key part in my view. The right to feel that you can go to work, use public transportation, go to the theater, and go to the mall without the fear of getting shot. Without feeling safe, in my view, that's not freedom. So, it's not an academic issue, but one that relates very intimately, you know, is connected with our freedoms and rights and so forth. So, it's essential.

Dr. Gabor: Exactly. We thought it was essential to put that upfront in the book, in this most recent book, that the Surgeon General, just to clarify, has declared this a national crisis, gun violence. And it's also a very preventable crisis. All we have to do is look at other countries. Some people say that, oh, well, it's a cost of freedom. First of all, there are many Western countries, such as those rated higher in terms of liberty than the United States, by groups like Democracy Watch, and so forth. But it's preposterous to say that, you know, it's a cost because the United States also wasn't experiencing the number of horrors that we're seeing, say, 30 or 40 years ago, as we are now. So, it has deteriorated the situation. It can also improve. And it has nothing to do with overall freedom. It is detrimental to have all these shootings and so forth, and public safety concerns to our freedoms and our rights. I have strong opinions.

Dina: No, no, that's true. I mean, I agree. We touched on this briefly, but what would you say are the driving forces behind your work?

Dr. Gabor: Well [,,,,], you know, the notion that the public and our young people, for example, should have the right to use public facilities without all these fears. And it's both a human rights concern because, you know, the United States was a signatory to the, you know, Universal Declaration Human Rights.

And in that declaration, among other things, you know, international agreements, is the idea that, you know, individuals have the right to security, the right to life, and so forth. And, you know, so we've signed on to many of these agreements, and we've also begun to work with groups like Amnesty International for not following through on some of those commitments. So, yeah, the right to life and safety is a prerequisite to our ability to be free. It's also essential for the economy.

If people feel terrorized, I'm worried here in Florida, for example, that we're also going to adopt open carry of firearms. And you can imagine, whether you're down there in Broward County or Miami or Delray Beach, on a Friday night. You start seeing individuals who aren't law enforcement officers who've got training, walking around with guns of different kinds, you know, I think that would have a detrimental effect on tourism and on just people going out, once again, hurting our freedoms. And if another way that it can impact us, as you know, I mean, there's been a Push by the gun lobby to have more armed staff in schools, including arming teachers. And that can also have all kinds of detrimental impacts on the environment in schools. And saying a university where you have a class on a controversial subject. I thought a lot about contentious issues, whether it was capital punishment or abortion, many, many different topics that people feel very passionate about. Now, imagine in that audience, if you have people with guns sticking out of holsters or something. Yeah. Oh, what that will do to mute the ability of people to express themselves. It defeats the whole purpose of what, you know, an educational institution, in my view, is all about. Therefore, there are some real adverse consequences associated with these types of policies. So that's what drives me.

Dina: That is a scary idea because the initial institution of education was to discuss ideas.

Dr. Gabor: Exactly. And, you know, we have, on one hand, an increasing number of people carrying guns in America in general. It's increased by five-fold over the last seven years who carry guns daily. And at the same time, we are what I would call deregulating the carrying of firearms , because we now have over half of Florida joining other states last year in removing the need for a permit to carry, right? Even before that, I went through the training. It was a sham training because it was put, you know, was done by NRA-certified individuals. I'm not saying they aren't competent, but businesses conducted it. In Canada, for example, and in other countries, training is often mandated by law enforcement. You know, companies are incentivized to pass you, so you buy their products. So, it was a sham, anyway, in my view, but now we're saying, you know, over half the states, you don't need training. You can walk around carrying lethal weapons. And so more people are carrying deadly weapons, but there's less training going on around the country. And I have to note that even among police officers who receive ongoing training, when in a combat situation, only one in six of their shots hits the mark. So, you know, there have been studies that show, you know, with the adrenaline going and somebody else out there shooting at you, so and we see from these courses how poorly civilians who do receive one training course, how poorly they perform, even in a non-combat situation, where you're firing at a paper target, not a human target who's also shooting at you. They're doing very, very poorly on those. So, imagine now, as I say, I guess it's American carnage, but it might be in the latest book that I imagine people who get no training at all. And training not just in marksmanship, but in the safe handling of guns, and in understanding the law, because it's also essential when you have this very sacred, you might call it, or sobering responsibility of carrying a lethal weapon, you ought to know when the law says it's appropriate. To use deadly force, you also need training in the law. So, imagine we're not providing people with training in the law in more than half the states, including training in marksmanship and the safe handling of guns. And we have no national storage laws, either, safe storage laws, but we're not training people in how to store a firearm safely. So, it's a recipe for a pretty bad situation, and that's what we see happening around the country when we look at the statistics relative to comparable countries.

Dina: I think primarily, like, at least for me, the graphic guide did a good job of showing through the illustrations, the comparison of the US with other countries globally. Just how, for instance, in Australia, the background check policy before obtaining a gun is about 20-28 days, something around there. And just how different that is, like, making sure the thorough background check is performed versus here. You know, it's a three-day waiting policy.

Dr. Gabor: That's why it's so important, you know, we hear all these debates back and forth, and I've been part of many on social media. But until you look at the international context, you don't see the extent to which the United States is an outlier relative to the rest of the world, in terms of the number of firearms we have per person, but also the permissive carry laws. And then we see the result. So, we should be the safest society in the world that we believe the gun lobby and its allies that guns make us safer. Not the least secure among at least comparable countries.

So that's why it's important to look at the international situation. It's why I put in the comparison with other countries on storage and carrying guns. For example, in Canada, at any given time, there's 40 million people in Canada. There's no more than 150 people who have a permit to carry a gun for self-protection. They have to prove either they're in a certain occupation that puts them at risk carrying cash or so forth or security work. Or they have to prove to the authorities that they're in imminent danger. Their life is imminent danger. So, they've received verifiable threats to their lives. You have to demonstrate that to the licensing authorities before you're able to walk around with a firearm. Here it is a different story. It's an entitlement, and we have some court decisions now that have expanded the whole view of the Second Amendment to the Constitution and now move from 2008, the court ruled that individuals have the right to have a handgun in the home for self-protection. Now that's been expanded in 2023 to outside the home. So that's become a constitutional right. That's a whole other story. I addressed it in both those books of how the Constitution. Not in my view, I'm not a constitutional expert, but most of the authorities on the Constitution and what the Second Amendment really means indicate that it's been totally mangled by the court. And deformed from its original purpose. And I love that you bring up the safe storage laws because that is such a huge something I'm very interested in and very passionate about because not even mentioning people who are using firearms with malicious intent, just the amount of accidents that happen, particularly with children getting injured is so distressing. Exactly and so preventable. And of course, suicides because I know your center is very concerned about suicide and what suicidologist believe is that the vast majority of people who attempt or commit suicide did not have an unwavering determination to kill themselves and that often they're in the midst of some crisis. They might even be drinking or using some kind of drug. And if there's a gun nearby, if that attempt is made with a firearm, it's much more likely that they will die. And I have some statistics on that as well, and that contrary to popular belief, many people do not repeat suicide attempts.

So, if you happen to have these lethal means available, at one time, they can make all the difference between life and death. And we find that when you look at school shootings, suicide and accidental shootings in 70 to 90% of the cases, depending on the study, these weapons are acquired from the home. They haven't been secured either in a friend's home or with another family member because they haven't been properly secured. And so, yes, there are some very dire consequences to not securing weapons properly. And the notion we hear from those who are opposed to safe storage, you would think that was reasonable.

You're not taking anybody's guns away. You're saying, it's okay, have a gun in your home for your defense if you want to do that, but secure it. And there are currently safes available, and so on. Well, the argument is, I don't want to have to get it out of this safe or what have you. […] You know, there are all these devices today where you could deploy your weapon in a matter of seconds. [..]

The truth is that the gun lobby and its allies they always worried about the slippery slope. They think that if they concede in one area, then it's going to be another, another, and soon we're all going to go for their guns. And all I can say to that is that there has never been a widespread confiscation of firearms in the United States. And you'll see in this last book the differences in policy between, say, the United States and Japan. In countries like Japan and Malaysia, there are fewer than one gun per every hundred people. We have over one gun. Per person in the United States. Yeah.

Dina: Yeah, no, it is pretty standard. I didn't have prior exposure really before dating my partner, and that exposed me to the frequency. I was oblivious to gun ownership growing up, as the families I was a part of didn't own any. Perspective completely shifted with exposure to different realities and more traditionally American upbringings. One of my partner's friends has a whole storage, and that's wild to me, but to my partner's friend group, it's completely normal.

Dr. Gabor: They do have, yeah. Some people have arsenals in their homes, but it would undoubtedly make a significant difference. The Durand Corporation has conducted studies examining the effectiveness of various gun laws and policies. And they consistently found that some of the most substantial evidence is in the area of safe storage and child access prevention laws, which are among the most effective measures that can be employed. Others, in my view, I might be anticipating another question of yours.

I think licensing system is something I would like to see in the United States. It's even withstood legal challenges because what's done in places like Australia and Canada and the UK and other places is we don't just rely. Here in the US, we do a quick and dirty two minute when somebody goes to a dealer to buy a gun, it's a two-minute background check looking at three databases. But the databases are missing a lot of information that's either, you know, not passed on from the states on juvenile records, mental health records, drug histories, and so on. But also, we need to do interviews, which is what's done in these other countries with an individual, do reference checks because as we saw with the Parkland shooting, that individual showed a lot of disturbing signs, but because he didn't have a felony record. He could walk in and buy his AR 15 in a store. So the only way to get around this is to do a much more thorough vetting through a licensing system. And then, as you say, various countries like Australia, Canada, and others have a waiting period because it's quite amazing how many guns after they're purchased, they're used for criminal purposes or in a suicide attempt or what have you. And so you try to give that waiting period is like a cooling off period where people who are really in a rage against somebody or against fellow workers, whatever or have this personal crisis, don't have access to lethal weapons right away.

There's a cooling off period by having that waiting period. In addition, it gives the authorities more time because we have an issue with that, too, called the Charleston loophole, but it gives them more time to do a thorough background check. Here in the United States now nationally, after 72 hours, if the FBI doesn't find there could be an alert on the file, and they'll dig into it. But after 72 hours, if they haven't completed the background check, the sale must proceed. And this is what happened in the Charleston shooting Charleston, South Carolina, church shooting that the fellow actually had drug history, but the authorities were able to track this down this criminal history. And consequently, he got ahold of a gun and shot up that church in South Carolina. So, the waiting period is very important.

Dina: Doctor Gabor, we do want to be respectful of your time. So, I know we scheduled a 30-minute interview. However, we were able to cover many of the topics in our conversation simply by asking questions. Doctor Hubbard, are there any others that you think I should try, or is it just the last one?

Dr. Hubbard: I think the last one , and I also want to know what you, as a trainer of psychologists, as I am in the school psychology department (which entails training people who are going into schools and working with kids), what can we do as psychologists as well as what we can do as members of the community to push this initiative forward and make things safer?

Dr. Gabor: Yeah, there's a lot to focus on nowadays. There was an episode on 60 Minutes or a similar show recently about the physical security of schools and efforts to harden them. I've noticed a new school that has opened near me, which resembles a prison, frankly, and I've been in many jails in my work, which is quite disheartening. But anyway, we're spending a great deal of money on that.

However, we also have to consider intervening because the worst thing we can do is, and I hear this from people and educators in other countries as well, is to ignore an individual who is exhibiting disturbing behavior and posting it to their peers, as this often happens, right? They telegraph what they're going to do. In the case of the Parkland shooter, for example, how many other students said, “This is going to be the shooter, if we have a shooter”? But the worst thing you can do, in my opinion, is expel this person from the school because now we have no idea what they're doing. We further marginalize them. And this is not a matter of being a bleeding-heart liberal; it's a matter of self-preservation that we try to intervene with these individuals.

You know, we could suspend them, do whatever you need to do, but keep track of them, work with them, and try to address their issue, because it's in our interest to do so. Otherwise, they fall through the cracks. The same thing happened with the Sandy Hook shooter, you know, that we didn't follow up. And so, I think we need community mechanisms to keep track of these individuals and the school community itself to work with them, rather than just cast them away, because we may hear from them again with this type of horrible result. So, you know, this punitive approach, let's expel people and so forth. One thing that I'm horrified about, too , is all the schools around the country that are hiring third parties to monitor students' posts. You're spending money on all this security work. You know, but how many students haven't felt frustrated from time to time? You see, I am so mad at my teacher, you know, I did poorly on this exam and so on, and adolescents, there are so many verbalizations from them that could be construed as threats, but only a tiny percentage materialize.

So, we need to do more in terms of intervention and more aggressive intervention as opposed to spending all that money just trying to expel kids, police them. You know, putting all this hardware into schools. We need to focus on the human aspect of the problem and also on, you know, issues in our communities where so many kids are unsupervised and, you know, that gets into a lot of the other problems. Still, there is a significant level of disengagement among young people today. Additionally, with all the social media and electronic devices they're involved with, we need to take action to maintain a sense of community, as what we're seeing in part is a result of that. That's why we're seeing more depression among young people, more suicidal behavior among young people. And when you get more suicidal behavior, you're also going to get more homicidal behavior because the two are connected. So that's what I would say.

Dina: Thank you. Now, that touches on also, like, the interconnection of mental health and gun violence, as well , and we have a lot to do regarding mental health and, likewise, gun violence in the country. We can finish off with one more. But why should readers care about the gun violence occurring in America, and what can they do right now to make a difference?

Dr. Gabor: Well, it's a major, it's a significant source of death. In the United States, we've reached almost 50,000 people, you know, dying from gunfire each year. It's the number one cause of death now among people up to 19 years of age. We've passed motor vehicles. Even for the whole population, we passed motor vehicle crashes as the number one cause of death. So it's a concern both in terms of mortality and morbidity, and also in terms of our freedom to move around and enjoy our lives because of the fear of gun violence.

And the second part was, what can we do about it? ….. You know, I mean, thinking is evolving, but I think we have a good handle on some of the key factors driving gun violence….I have some tables that I drew up in another book, 'Is Poverty…', which focuses on people living in communities.

Some communities have prolonged poverty, multi-intergenerational poverty, where there's a sense of hopelessness, because I looked at cities around the country and found that where you have more distressed communities, communities that have not just high poverty and unemployment, but also few businesses start, many vacant homes, and so forth.

For example, in Detroit, approximately 99% of the residents live in a distressed community. So, as I say, with all those other factors, a few businesses start, many business closings, you know, homes that are boarded up, and so forth. And, you know, it's all a recipe for a sense of hopelessness, and it's not a coincidence that places like Detroit and Baltimore and Memphis a very high rates of gun homicide and high rates of mass shooting per million population.

So, you know, poverty and some of these associated factors are very important. Sense of community as we discussed. But one more I'll just put out there a thing that we can do to address the gun violence scourge. And, of course, I believe very strongly in vetting people before they have these lethal instruments and are able to carry lethal instruments and training them properly. There's a law that was passed in 2005. Both Fred Guttenberg and I agree that this is one of the first things we would do if we could, called the protection of Commerce and Arms Act. It was passed in 2005 by the Bush Administration, it basically creates shields the gun industry from liability when you have, say, shooting or mass shootings. So, generally speaking, unless there's one or two exceptions where innovative legal strategies were used, you cannot sue the gun industry for harm, you know, in every other industry. If a product leads to harm, right, and there's death associated with it, you can take those companies, that industry to court. You can't do it with the gun industry. If the gun performs as it was meant to perform and guns are meant to kill, you know, unless the gun is defective and, you know, it discharges when it's not supposed to discharge, it cannot be sued. Now, if we could sue for every mass shooting using an AR 15, for example, if we can sue the company that manufactured that firearm, and they would very quickly have very profound financial problems. You know, a lawsuit could result in hundreds of millions of dollars in losses, if not billions, and it was done with the tobacco industry. And it might lead the gun industry to conclude that it's not in their interest, in their financial interest. To sell these weapons. That's something that could be done today literally can be passed. The repeal of it's called PLCAA The Protection of Lawful Commerce in Arms Act. And if we could repeal that, which we could do tomorrow, if you had the political will, that could make an enormous difference and could get these weapons off the streets. I guess the inventory of these weapons could be reduced a lot faster than an assault weapons ban. Though I also favor that.

Dina: Thank you. Thank you, Dr. Gabor. Thank you very much for your time and for sharing your insights and expertise.

Dr. Gabor: My pleasure. It's been a pleasure to be with you today.

Goodbyes, thank-you notes, and Arabic recipes exchanged.

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

Resources

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

Black Emotional and Mental Health Collective (BEAM): https://beam.community/

Black Mental Health Alliance:
https://blackmentalhealth.com/

Black Men Heal
https://blackmenheal.org/

Therapy for Black Girls:
https://therapyforblackgirls.com/

The Steve Fund: https://stevefund.org/

Black Mental Wellness:
https://www.blackmentalwellness.com/ Visit PsychologyToday to view a directory of Black mental health providers in Florida: https://www.psychologytoday.com/us/therapists/florida?category=african-american

The Forever Frosty Foundation
https://www.foreverfrosty.org

Lock-It Up! initiative [League of Women Voters Broward County]

https://www.lwvbroward.org/content.aspx?page_id=22&club_id=869563&module_id=453932

Free cable gun locks can be requested by email and at: gunsafety@lwvbroward.org

Speak on Suicide
https://speakonsuicide.com/