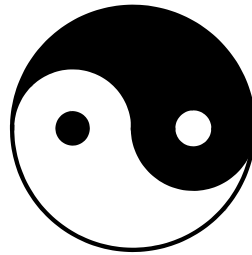


Behavioral Emergencies Update



President's Column

Providing Psychological First Aid to Survivors of Mass Disasters

James R. Rogers, PhD

The University of Akron



Applying my typical approach/avoidance behavior, I spent a great deal of time thinking (but not writing) about the various topics I could address in my presidential column. As my anxiety increased and the deadline became nearer, I found myself going to my recently discovered source of wisdom, my 12 year old son Michael. As I explained to him that I was unsure as to what to write about but needed to make a decision quickly so as to not miss the publication deadline, with all of the clarity of a fresh unbridled mind, he said “Dad, why don’t you write about your experience after 9/

11?” My immediate reaction was to generate many excuses as to why that would not be appropriate. But, as the idea continued to seep into my thoughts, I began to see its relevance in light of fairly recent events both here in the United States and across the globe. So, the purpose of this column is to talk briefly about training issues related to early psychological response to disasters and the impact that work had on me personally as a clinician.

Clearly, cyclone Nargis that struck Myanmar on May 2nd, 2008 and the 7.9 magnitude earthquake that hit Sichuan, China on May 13th, 2008 are our most recent reminders of the potential and real impact of natural disasters on human life, with many thousands killed and the lives of millions disrupted and in chaos. As we know by

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first-hand experience here in the United States, the trauma inflicted on survivors by natural events can be compounded by governmental action or inaction. For example, survivors of Hurricane Katrina, which struck the Gulf coast August 29th, 2005, suffered additional hardships and trauma created by inadequate governmental response to the disaster and many folks continue to be displaced almost three years later.

These mass disaster events as well as more localized and contained events such as the Virginia Tech and Northern Illinois massacres highlight the need to broaden training in behavioral emergencies beyond the assessment and intervention of individuals at risk for violence and self-destructive behavior to include response to survivors of terrorism and natural disasters. While we might assume that clinical training and training in behavioral emergencies in general, will prepare us to provide services in the aftermath of disaster, this may not be the case. For example, the consensus of a workshop in the fall of 2001 on mental health and mass violence was that specialized training is required for effective early intervention with survivors of mass violence (National Institute of Mental Health, 2002) and the National Child Traumatic Stress Network and the National Center for PTSD (2005) published a field operations guide for the provision of “psychological first aid” to help clinicians respond appropriately in these settings.

While efforts continue toward defining the role of behavioral emergency clinicians in the aftermath of mass disaster events and develop strategies to empirically assess intervention protocols such as that offered via the “psychological first aid” approach, much work is needed to be done in this area. As such, I believe disaster response is an important area to be embraced by the section. To highlight the importance of this topic, we have planned section programming at the annual conference related to suicide terrorism and my presidential address is focused on diversity issues related to early psychological response to mass disasters. I hope these activities will help stimulate increased interest in disaster response work.

Beyond training in interventions, another critical area to consider in disaster response work and one that goes back more directly to my son’s suggestion to write about my experience, is the issue of the personal impact of providing services in the immediate aftermath of mass disaster. Whether a natural or human induced disaster, one key component of disaster response is that no one exposed to a disaster is unaffected by the experience. This includes the clinician providing “psychological first aid” or early disaster response.

While I suspected (based on my reading and training) that my work in New York City following the terrorists’ attack of September 11, 2001 would have an impact on me personally, I was not prepared for the depth of that impact nor the difficulties that I would have in returning to my everyday life. Like folks who survive mass disasters first hand, during and following my two-weeks of work at “ground zero” (Rogers & Soyka, 2004), I experienced significant symptoms of exposure to trauma. For me, these symptoms included confusion and lack of concentration, feelings of helplessness, depression, grief, hypervigilance, intrusive thoughts and emotional reactions, and difficulty sleeping, to name a few. In addition, many of these symptoms extended for well over a year and I continue to have thoughts about my experience triggered by sights, sounds, and smells.

My point in sharing this bit of my personal experience is that I believe that we also need to improve our training related to the potential personal impact of early disaster response work. I expected that my prior training would insulate me from the negative effects of trauma. It did not. While we tend to

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discuss the issues of personal impact in disaster response training in an attempt to provide important information for clinicians to consider as they think about whether or not they are willing to work in these settings, the issues remain fairly intellectualized. What is needed to advance training in this arena are methods that connect clinicians experientially to the chaos of disaster settings. This would allow for a more thorough assessment of competency in early disaster response interventions and could provide a visceral connection to the work that could inform decision making related to ones willingness to provide services in disaster contexts.

How to do this, of course, is another matter and brings me back to thinking about my 12 year old son. Michael loves computer and console games. While debate continues related to the impact of games on kids, gaming technology and virtual reality seem to be ideally suited to enhance our current training in providing psychological first aid to survivors of mass disasters. Maybe by embracing this technology, we can find improved ways of delivering psychological first aid services to survivors of mass disasters and, at the same time, prepare clinicians for the potential personal impact of this important work.

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drbartstein@gmail.com



Dr. Donald Meichenbaum
Recipient of the 2008 Section VII Career Achievement Award

Jessica R. Richmond
The University of Akron

Donald Meichenbaum, PhD., clinical psychologist and researcher, has led an impressive life filled with notable achievements leading to his selection as the 2008 Career Achievement Award recipient. A self-proclaimed “people watcher,” he began his undergraduate career in psychology at City College of New York and obtained his doctorate in clinical psychology from the University of Illinois in Champaign. He originally started out in graduate school as an industrial psychologist and conducted group observation research at a local veteran’s psychiatric hospital. However, he soon became fascinated by the patients and decided to switch to clinical. After graduating from Illinois he accepted a teaching position at the University of Waterloo in Ontario, Canada. Today, Dr. Meichenbaum is a Distinguished Professor Emeritus at the University of Waterloo and a Distinguished Visiting Professor at the University of Miami, School of Education. His accomplishments are many and several will be highlighted in this article.

Dr. Meichenbaum is one of the founders of Cognitive Behavioral Therapy, as well as a strong proponent of the constructivist perspective. His book, *Cognitive Behavior Modification: An Integrative Approach*, is considered a classic in the field. CBM is an integration of the clinical concerns of psychodynamic and cognitive theory with the techniques of behavior therapy. During an interview with Irvin Yalom, Dr. Meichenbaum remarked that he came to realize that the cognitive behavioral therapy he had been working on his entire career was what his mother would call “New York Therapy.” You try to teach people (schizophrenics, hyperactive children, aggressive adults, traumatized individuals) to talk to themselves differently, to change the stories they tell themselves and others.

Throughout his career, Dr. Meichenbaum has been very involved with trauma patients, and has served as a consultant during several traumatic events including the Oklahoma City bombing, the Columbine school shootings, the September 11th attacks, and Hurricane Katrina. It was his involvement during these events that led him to write the manual, *Treating Individuals with Anger-Control Problems and Aggressive Behaviors*. It is within this manual that Dr. Meichenbaum describes his case conceptualization model for informing assessment procedures and treatment decision-making.

Dr. Meichenbaum has traveled all over the world by invitation to give lectures and workshops on PTSD, suicide, and violence prevention. He has authored and co-authored numerous books and handbooks in addition to those mentioned previously, including *Stress Inoculation Training*, *A Clinical Handbook for Assessing and Treating Adults with Post-traumatic Stress Disorder*, and *Pain and Behavioral Medicine: A Cognitive-Behavioral Approach*. He has authored many book chapters (e.g. Trauma and Suicide: A constructive narrative perspective; Resilience and posttraumatic growth: A constructive narrative perspective; Stress inoculation training: A preventative and treatment approach) as well as journal articles (e.g. 35 years working with suicidal patients: Lessons Learned in *Canadian Psychologist*). He was also one of the founders of the *Journal of Cognitive Therapy and Research* in 1977, and served as the Associate Editor for several years.

Over the years Dr. Meichenbaum has received numerous honors and awards. In 1988, he was the recipient of the Izaak Killiam Research Fellowship Award, which recognizes distinguished Canadian scholars who have established an outstanding reputation in their area of research. He was also appointed Honorary President of the Canadian Psychological Association for the 1998-99 year. He is currently a Fellow of the Royal Society of Canada, the Canadian Psychological Association and the American Psychological Association. Perhaps most impressive is that he holds the dual distinction of being named the most cited psychology researcher in a Canadian University (as established by a citations analyst), as well as being rated one of the top ten most influential psychotherapists of the century (reported by North American clinicians in a survey published in the *American Psychologist*).

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After teaching at the University of Waterloo for thirty-three years, Dr. Meichenbaum took early retirement in 1996; however, he did not remain idle for long. Dr. Meichenbaum is one of the founders of the Melissa Institute for Violence Prevention and Treatment and currently serves on the Board of Directors as the Research Director. The Melissa Institute was founded in 199X after the tragic death of Melissa Aptman, a Miami Native, who was murdered during a car-jacking two weeks before she was to graduate from college. The Melissa Institute is a non-profit organization dedicated to the prevention of violence through education, community service, research support, and consultation. It was designed primarily to bridge the gap between research, clinical, educational practices, and public policy. Their mission is to prevent violence and promote safer communities through education and application of research-based knowledge.

In summary, Dr. Meichenbaum is a prolific researcher, clinician, and international lecturer. His workshops receive the highest praise as he incorporates scholarship, critical-mindedness, clinical wisdom, and humor into his presentations. His dedication to “make the world safer” and “give psychology away” through the Melissa Institute and his desire to see how far he and his colleagues can affect change is admirable and demonstrates how deserving he is of this award. He is a well deserving recipient of this distinguished award.

Dr. Donald Meichenbaum (photo on right)
Recipient, Section VII 2008 Career Achievement Award



(to left, Marc Hillbrand)

**Benefits of Electronic Medical Records in
 Suicide Risk Management**

*Marc Hillbrand, PhD, Stuart Forman, MD, Jerilynn Lamb-Pagone,
 MSN, APRN, BC
 Connecticut Valley Hospital*

In spite of competent, compassionate and vigilant care, an estimated 500 to 1,000 people commit suicide in residential care settings each year in the US (Cassels, 2005). About half of these suicides occur in psychiatric hospitals, about 40% in other hospitals, and the remainder in nursing care facilities (Joint Commission on Accreditation of Healthcare Organizations [JCAH-O], 1998). Root cause analyses of a

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series of 65 hospital suicides revealed, among others, four salient problems involving the management of information. The first was failure to assess suicide risk, in particular on admission. The second was failure to reassess suicide risk, for instance after a suicidal crisis has resolved. The third was inadequate information, such as failure to obtain collateral data. The fourth was inadequate communication, especially at the time of change of shift.

The health care field is witnessing an explosion of initiatives to computerize health care records (Department of Health and Human Services, 2007). An electronic medical record is a mechanism to collect, manage, and transmit information in an efficient matter. By virtue of automation, it is intrinsically more reliable and promotes consistency of practice. The four problem areas the JCAH-O analysts identified in connection with completed hospital suicide lend themselves to such automation. We describe one hospital's experience with this process.

Connecticut Valley Hospital is a 500-bed public sector facility that houses individuals with severe psychiatric disabilities. It offers the highest level of care for such individuals in the state of Connecticut. It underwent a series of initiatives aimed at strengthening mechanisms to prevent suicide, including:

- a one-day training for all psychiatrists and psychologists designed by the American Association of Suicidology (AAS) entitled *Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians* (AAS, 2007);
- environmental changes to reduce suicide risk (e.g., elimination of support rails);
- a half-day training on assessment and management of suicide risk for all clinical staff ;
- creation of an electronic suicide risk assessment procedure.

An electronic Suicide Risk Assessment program was created to address the four aforementioned problems areas and to address previously identified problems at our hospital, such as incompletely filled out assessments and poor match between assessment and interventions. The electronic form consists of identifying information, an assessment part, an intervention part, signatures, and instructions on how to use the form. Part 1 contains a 17-item questionnaire filled out by a nurse or psychiatrist, a box to enter a narrative description of any positive item (i.e., keyed in the direction of suicide risk), and electronic signature and date boxes for the respondents. Part 2 contains a list of 14 possible interventions, such as *Change in observation status* (e.g., from frequent to constant observation), *Referral for psychotherapy*, or *Move to safer room* (one of the rooms on each unit that possess no protrusions or vents from which to hang oneself).

The 17-item questionnaire consists of questions tapping factors identified by a consensus of suicide experts as warning signs of suicide (American Association of Suicidology, 2007). These factors are summarized by the acronym IS PATH WARM [Ideation, Substance Abuse, Purposelessness, Anxiety, feeling Trapped, Hopelessness, Withdrawal, Anger, Recklessness, Mood Change). Several items were added to this list, reflecting the special population of the hospital. For instance, one item taps the presence of command hallucinations about self-harm, a symptom rare in the general population but more common

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among the individuals with schizophrenia whom we treat. Another inquires about recent anniversaries of traumatic events.

The Suicide Risk Assessment program makes specific demands on the person who completes it. For instance, items cannot be omitted. Similarly, a suicide risk assessment in which Part I (17-item questionnaire) was filled out but Part II (interventions) was not triggers a window *Assessment incomplete: Item XX was omitted* or *No interventions listed*. This mechanism insures completion of the suicide risk assessments. On a daily basis, a report is created that summarizes all the assessment completed the previous day. A senior clinician then reviews that report and addresses through consultation and supervision any suggestions for improvement of the existing plan.

This electronic Suicide Risk Assessment illustrates how automation can enhance clinical care by ensuring the completion of various tasks and facilitating the process of supervisory clinical review. We are currently investigating the impact of this novel practice and anticipate reporting on outcome next year. Initial feedback has been positive and has yielded many opportunities for improvement in the quality of the care provided to suicidal individuals.

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The Tragic Death of Dr. Kathryn Faughey and the Issue of Patient-Clinician Violence

Phillip M. Kleespies, Ph.D., ABPP

VA Boston Healthcare System

On February 12, 2008, Dr. Kathryn Faughey, a psychologist in a private practice, was horribly stabbed to death at her Upper East Side office in New York City. The assailant was a man who suffered from a severe mental disorder and who had a prior history of violence. Ironically, Dr. Faughey was apparently not the intended victim. The man later confessed that he had been in search of Dr. Kent Shinbach, a psychiatrist who shared offices with Dr. Faughey. When Dr. Shinbach heard Dr. Faughey's screams, he came to her aid and was also seriously injured and robbed at knife point. The attacker reportedly blamed the psychiatrist for having him committed to a mental hospital 17 years ago.

This event sent shock waves through the mental health community in New York and well beyond. In Massachusetts, the news from New York came on the heels of the murder of a Social Worker when she paid a home visit to a 19 year old patient in Andover, MA. Such high profile events raise questions about the frequency and seriousness of patient violence that is directed at clinicians, and about how well we prepare clinicians to evaluate and manage patient violence.

As summarized in the APA Division 12, Section VII (Clinical Emergencies and Crises) *Task Force Report on Education and Training in Behavioral Emergencies* (Kleespies, et al., 2000), there is evidence that a significant number of psychology practitioners experience a patient assault at some point in their careers. These assaults appear to be more likely to occur during graduate school years and during the first five years after completion of the doctoral degree. They are also more likely to occur to those who work with the more seriously mentally ill; and, as McNeil (1998) has pointed out, the period of greatest risk of violence in the mentally ill seems to be when the patient is having an acute exacerbation of his or her disorder. Clinicians often find these instances of patient violence, or threats of violence, quite disturbing (Cf. Rodolfa, Kraft, Reilly, 1988). Subsequently, they frequently report a heightened sense of fear and vulnerability, and, for some, a decreased sense of professional competency.

Extreme violence, however, such as that perpetrated by the patient in Dr. Faughey's unfortunate case, seems to be quite rare. In past writings (e.g., Kleespies, 2000), I have cited national surveys by Guy, Brown, and Poelstra (1990) and by Tryon (1986) indicating that between 30%-40% of psychologists sampled had been assaulted by a patient at some point in their professional career. It is important to remember, however, that most of these patient assaults resulted in minor injury or no injury at all. In their survey, Guy, et al., reported that 30% of those assaulted suffered a physical injury, but two thirds of the injuries were slight and the remainder were characterized as moderate. Usually, the emotional distress was far more disturbing than any physical injury.

While it may be reassuring that most instances of patient-clinician violence do not result in serious physical injury, one should not interpret that statement as implying that the author does not see patient-clinician violence as a problem or hazard for psychology practitioners. Twenty years ago, Rodolfa, et al., in a large survey, found that patient violence toward the clinician was rated as the most dis-

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turbing clinical event that clinicians had to confront. Further, it is concerning that Guy et al., in their national survey of psychologists, found that patient assaults on clinicians were more likely to occur during graduate school years or early in the clinician's career. Given findings such as these, I find myself once again pointing out that the profession of psychology appears to have done little to systematically educate practitioners in evaluating and managing the potentially violent patient. In their survey of patient violence, Guy, et al., (1990) reported that the psychologists in their sample had a mean of 1 hour of clinical training on the management of patient violence during their pre-doctoral training years. After graduation, the mean was 2.3 hours. I see little reason to believe that this situation has changed substantially in the years since that survey was done. Could it be that lack of adequate training is related to the findings that less experienced therapists are at greater risk from patient violence? If it is the case, as hypothesized by some, that less experienced clinicians are less likely to perceive the cues for potential violence or are less comfortable in setting limits on aggressive behavior, should they not be educated about these issues?

Of course, similar arguments can be put forth in regard to education and training with our other *occupational hazard*, patient suicidal behavior, and for training with behavioral emergencies more broadly speaking. As noted by Kleespies and Berman (2004) in an article entitled *The pre-doctoral internship: A prime site for training in behavioral emergencies*, behavioral emergencies (or situations in which the patient is at risk of life-threatening behavior) confront the clinician or intern with the need to make decisions that can have very serious, perhaps irreversible, consequences. They are decisions that can have far reaching emotional, ethical, and legal repercussions for all parties involved. It would seem to make sense to have practitioners well educated and trained in this area of practice; and the training needs to go beyond the management of legal risks. I don't hesitate to point out that our mental health colleagues in psychiatry have made training in emergency psychiatric services a required component of the psychiatric residency. Why should psychologists not be expected to observe a similar standard?

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Suicidality Fact Sheet: Cultural Implications and Ethnic Considerations

*Liliana Cordero, B.A.
Texas Tech University*

Suicide as it relates to members of ethnically diverse populations is becoming increasingly important in order to understand and better serve such populations. Empirically-supported culturally relevant therapies have not yet been developed, yet research in this area is flourishing, helping clinicians to better understand the differences and similarities between populations of varying ethnic backgrounds. Significant between-group and within-group factors have been found to be related to suicidality, yet a crucial step is finding a manner to translate these findings to clinical practice. Several approaches have been suggested, with the primary focus being on providing culturally-relevant therapy as a response to the findings that suggest ethnicity is indeed important to consider when treating clients.

The argument that suicide is a significant problem in the United States is supported with alarming statistics: suicide ranks as the 11th leading cause of death for all age groups and among the young (ages 15-24), suicide ranks as the 3rd cause of death (Kung, Hoyert, Xu & Murphy, 2008). The completed suicide rate among Black males, Black females, Hispanics, Native Americans and Asian/Pacific Islanders (8.7, 1.8, 5.1, 12.4 and 5.2, respectively) are lower when compared to Caucasians, yet still warrant attention and further empirical research to facilitate their utilization to applied settings.

In light of this information and the need to supplement it, Section VII is currently undertaking a project that will utilize previous research findings and expand upon them by suggesting manners in which the information can be applied to clinical practice and training. This project consists of two phases- the first consists of a literature review of the vital findings that have been found to date. The second phase of the project will focus on identifying the means by which to apply the empirical research findings to clinical practice and training. This final phase is vastly important since it will delineate the manner in which essential findings and their implications can be utilized by psychologists working with a high-risk client population.

By no means are these findings exhaustive given the high volume of research in this area, therefore this provides solely a glimpse into some of the vital findings that will be periodically presented. Additionally, when interpreting research findings one must be cognizant of the fact that broad labels (e.g. Asian Americans) are by no means descriptive of the diversity within specific ethnic groups (e.g. Japanese Americans).

African Americans:

The underutilization of mental health services has negative implications for any populations, yet among African Americans, has also been found to serve as a risk factor for suicide. Despite the fact mental health services are needed in this population, barriers to seeking treatment have been identified. Stigma associated with seeking treatment, financial limitations, mistrust of psychologists, and knowledge about available services were only some of the identified barriers to treatment (Thompson, Bazile & Akbar, 2004; Utsey, Hook & Stanard, 2007). As such, one cannot minimize the importance and impact that these factors have on the lives of African American individuals who are not receiving adequate mental health care in times of need.

Kaslow et al. (2004) utilized an African American sample in order to compare person risk factors among attempters and non-attempters. Of particular interest is the finding that attempters

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reported less religiosity (includes organizational religiosity, nonorganizational religiosity, and subjective religiosity) and lower levels of ethnic identity (i.e. ethnic identity achievement, ethnic affirmation and belonging, ethnic behavior, and other group orientation). In comparison to non-attempters, attempters reported lower levels of organizational and nonorganizational religiosity, less connection and affirmation by their own ethnic group and more distance from other ethnic groups. As a result of these two important issues, the authors suggest clinicians consider the value of church involvement or religious coping in addition to helping individuals feel better connected to their ethnic background as a means to better serve African American clients.

Asian/Pacific Islanders:

Following accidents and homicide, suicide emerges as the third leading cause of death for adolescents and young adults (Kung, et al., 2008), therefore, the factors that are pertinent to this age group must be considered. One of those factors is the consumption of alcohol and its subsequent impact on suicidality. Consistent with findings from previous studies, Nishimura, Goebert, Mikler, and Caetano (2005) found that after controlling for age, gender, ethnicity, and grade, alcohol use emerged as a strong predictor of suicide. In particular, the risk for suicide attempts increased over three times in adolescents who binge drink, and the risk for seriously considering a suicide attempt, making a suicide plan, and requiring treatment for suicide increased almost twice as much in this group. These findings are not ethnicity-specific, yet demonstrate that certain risk factors transcend ethnic differences and must be considered when addressing risk factors for suicide. Ethnicity-specific factors emerged when assessing the rate of alcohol consumption, with Native Hawaiian male and female students having the highest rate (bingeing and non-bingeing) when compared to other Asian American/Pacific Islander and Caucasian peers (Nishimura et al., 2005). Lau, Jernewall, Zane and Myers (2002) found that similar to non-minority peers Asian American youths demonstrated certain risk factors for suicidality such as age, depressive diagnosis, and parent-child conflict, among others. Findings specific to this group were that of a non-existent gender difference and a greater risk for suicidality among those with low acculturation and high levels of parent-child conflict. Findings may inspire clinicians to evaluate the importance of family dynamics as a function of their client's cultural background, and may choose to implement family therapy in order to better serve these particular clients. Additionally, these and other findings shed light on the importance of providing information about both suicide and alcohol use to youth who may be at heightened suicide risk as a result of these risk factors.

In accordance with overall suicide rates, elderly Chinese and Japanese Americans have been found to suffer from one of the highest completed suicide rates in these ethnic groups, partially resulting from their children's acculturation levels (Diego, Yamamoto, Nguyen & Hifumi, 1994). As a child's acculturation level increases and becomes more salient, generational conflict, family misunderstandings, psychological hardship, and stress among the elderly increase as well.

Hispanics:

Qualitative studies are invaluable when assessing risk factors for specific subgroups, and one particularly informative study was conducted by Razin et al. (1991). The authors utilized a predominantly Puerto Rican sample of hospitalized suicidal females and found several vital markers for suicide risk. When compared to their non-suicidal peers, female attempters were found to have a higher likelihood of romantic involvement, sexual activity, parental obligations, and lower financial resources and academic accomplishment. Lastly, a significant amount of suicide attempts in this cohort were preceded by interpersonal conflict (e.g. with a mother or boyfriend). The consequences of troubled interpersonal relationships can thus be seen to be extremely detrimental in this cohort, yet may become more severe when acculturation becomes a problematic factor.

The concept of *familism* (*familismo*) is a concept well-known within the Hispanic community and revolves around the belief that collective goals, family unity, cooperation and reverence to parents and family elders is of primary importance (Goldston, Molock, Whitbeck, Murakami, Zayas & Hall,

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2008). The obligations valued at home stand in contrast to the individualist values emphasized in mainstream culture, promoting a sense of confusion among Latino youths and results in significant stress that influences suicidal behavior. Similar to the generational conflict reported by Diego et al. (1994), a clashing of values and obligations creates stress among the entire family, resulting in psychological distress that in combination with other factors, may lead to heightened suicide risk. Medina and Luna (2006) examined a sample of Mexican American students enrolled in special education classes and found that, in support of previous findings, depression, substance abuse, interpersonal conflict, and school and family distress contribute to an increase in suicidality. Though some of these factors are not culture-specific, issues such as family conflict may be influenced by ethnicity and acculturation, leading clinicians to consider these factors in the context of the individual's life.

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Postdeployment Homicide

*Kyle Burchett, David Ferreira & Glenn Sullivan
Virginia Military Institute*

A relationship between criminal behavior and Posttraumatic Stress Disorder in combat veterans has been hypothesized almost since the inclusion of PTSD in DSM-III (e.g. Wilson & Zigelbaum, 1983). Some researchers (e.g. Chemtob, Novaco, Hamada, Gross, & Smith, 1997) have posited that combat veterans may be more prone to entering a cognitive, behavioral, and physiological “survival mode” when confronted with threats in civilian environments, and may be more likely to respond to perceived threats with overwhelming aggression. Multiple studies, beginning with the National Vietnam Veterans Readjustment Study (NVVRS; Kulka et al., 1990), have shown dramatically higher rates of violence among combat veterans with PTSD compared to combat veterans without PTSD. Beckham and colleagues (Beckham, Feldman, Kirby, Hertzberg, & Moore, 1997), for example, found rates of 22 violent acts in the past year for help-seeking combat veterans with PTSD, versus 0.2 violent acts for combat veterans without PTSD. One implication of the extant research is that combat exposure *per se* does not appear to increase violence risk, although the severity and quality of an individual’s combat experiences (e.g. participation in atrocities) may effect postdeployment violent behavior insofar as these factors mediate the development of PTSD.

In January 2008 the *New York Times* published a list of 121 U.S. veterans who had been charged with homicide after returning from deployments in Iraq or Afghanistan (Sontag & Alvarez, 2008). This list, and the series of articles that followed it, provoked strong reactions from some veterans’ advocates. Many expressed concern that the nation’s most recent veterans were being portrayed as “ticking time bombs” who pose a risk to civilian society. The authors of the present article examined the 121 homicide cases presented in the *Times*’ study from a clinical perspective, with the intent of clarifying the association between combat exposure and postdeployment violence in the dataset.

In addition to the information on each case available on the *Times*’ website, we gathered corroborative data from independent media outlets -- most commonly online versions of newspapers serving the localities where the crimes had occurred. In more than 80% of the cases, we gathered significantly more information about the perpetrator than was available in the original *Times* article. In fewer than 10% of the cases, we were unable to find any additional information about the case and relied solely on the account provided by the *Times*.

All but one of the 121 offenders were male (99.2%). The majority of the offenders (53.7%) were between 18 and 24 years old, and 85% were under age 30. Of the cases in which race/ethnicity was known, Caucasians represented the majority (54.4%), followed by Hispanics (23.5%) and African-Americans (22.1%). The most represented service branches were Army (62.8%) and Marine Corps (30.6%). Over 90% of the charged offenders had served in Iraq, and 10.7% had served in Afghanistan; two of the 121 has served in both countries. Eleven offenders (9.1%) had deployed overseas twice during the current hostilities and five (4.1%) had deployed three times.

The homicide victims included strangers (35.2%), friends/acquaintances (23.0%), spouses/girlfriends (18.8%), children (8.3%), and Other/Unknown (14.7%). As in the general population, handguns were the most frequently employed murder weapon. The most common criminal charge was first-degree (i.e. willful and premeditated) murder (55.7%). At the time of this study (April 2008), nearly 30% of the cases were still pending (i.e. the veterans had been charged but not convicted). Seven of the veterans on the *Times*’ list (5.8%) had been acquitted of the homicide charges against them. None of the veterans received a Not Guilty by Reason of Insanity acquittal, although considerations related to combat-exposure and self-defense appear to have influenced prosecutors in at least one case (e.g. Matthew Sepi). More than one-fifth of the cases (20.5%) involved vehicular manslaughter or homicide. All but one of these vehicular cases were primarily substance-related – the prototypical homicide victim in these cases was the passenger in a vehicle driven by an intoxicated veteran.

We reviewed the compiled case material for evidence of combat exposure. In the vast majority of cases (92%), some evidence of combat exposure was provided in media accounts of the criminal proceedings. In 40% of the cases, combat exposure appeared certain: news reports included details regarding combat decorations, injuries sustained by the accused in battle, or testimony by commanding officers or multiple fellow unit members regarding IEDs, mortar attacks, clearing buildings, etc. In an additional 52% of the cases, combat exposure appeared probable: friends or family members of the accused veteran referred to combat exposure, the veteran’s unit was known to have engaged in combat during the veteran’s deployment, the area in which the veteran operated (e.g. Fallujah) was known for intense combat, etc.

We also evaluated the case files for evidence of psychiatric symptoms. Due to the nature of our data, we could not achieve anything resembling a formal diagnosis, but we reliably detected significant psychiatric symp-

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toms related to PTSD, Antisocial Personality Disorder, Substance Abuse, or psychosis in 114 of the 121 cases (94.2%). Only four (3.5%) of the veterans demonstrated psychotic symptoms.

Significant symptoms related to PTSD were reported in 85 of the 121 cases we examined (70.2%). Family members, friends, judges, defense attorneys (and even prosecutors) referred to veterans' nightmares, insomnia, intrusive thoughts, survivor guilt, hyperarousal, hypervigilance, intense anger, depressed mood, and suicidal ideation. In general, we searched for evidence that the veteran had returned from combat somehow "changed" or disturbed. Approximately 34% of the veterans in this sample demonstrated PTSD symptoms only, an additional 19% exhibited PTSD and comorbid Substance Abuse, and almost 17% appeared to display symptoms of both PTSD and Antisocial Personality Disorder.

We identified 39 cases that appeared to involve significant symptoms associated with Antisocial Personality Disorder (ASPD; 32.2%). Evidence for ASPD included committing violence for material gain (e.g. killing a spouse for the insurance money), killing during the commission of a felony (e.g. shooting a gas station attendant during the course of a robbery), evidence of substantial criminal activity prior to the instant offense, callous disregard for others, lack of remorse, etc. In general, we searched for evidence of pre-deployment antisocial behavior or instrumental (versus expressive) aggression. Almost 17% of the veterans in this sample (n=19) demonstrated ASPD symptoms only, an equal number exhibited comorbid ASPD and PTSD, and one displayed comorbid ASPD and Substance Abuse.

Finally, each judge rated the strength of the association between the violent act reported in each case and the combat experiences of the accused veteran. We used a seven-point scale in which "1" indicated no relationship and "7" indicated the strongest possible linkage (i.e. the crime would not have been committed "but for" the combat exposure). The mean rating for the entire sample was 5.2 (standard deviation = 1.9). Over 50% of the sample was rated "6" or higher and less than 5% received ratings of "0." This approach requires further validation but a similar procedure may prove useful in assessing public attitudes toward hypothetical criminal cases in which combat-related PTSD is presented as a mitigating factor.

The prevalence of PTSD symptoms in this sample of combat veterans charged with homicide (70.2%) is much greater than has been found in other samples of returning veterans. This finding appears to be consistent with prior research that suggests that PTSD mediates the frequency and severity of violent behavior among combat veterans. However, it is also extremely important to note that a substantial minority of veterans in this sample (n=20; 16.5%) exhibited no symptoms of PTSD and appeared rather to demonstrate behaviors associated with habitual criminality. Criminal cases involving recent veterans, like those of Vietnam veterans before them, are likely to be marked by either legitimate claims of diminished culpability or cynical attempts to malingering the effects of trauma.

Social support is a strong protective factor against PTSD. To date, the over 1.4 million American soldiers that have been deployed to Iraq or Afghanistan have received generally positive reactions to their homecoming. Unfortunately, this public support is not guaranteed and might be negatively affected by misinterpretation of news reports regarding violent combat veterans. Should public support for veterans deteriorate for any reason, an already immense public health problem could become even less manageable. It would be terrible for the public to conclude erroneously that returning veterans are inherently dangerous. This is why the *Veterans of Foreign Wars* and other veterans' advocacy groups have taken pains to point out that the murders in the *Times'* dataset yield an estimated 8.6/100,000 homicide rate in the veteran population, which they contrast to the 29.3/100,000 rate among American men aged 18 to 24.

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Section VII APA Programming*Anthony Spirito, PhD, ABPP*

Section VII looks forward to excellent programs at the 2008 Convention in Boston.

Thursday, August 14th, 8am:

Peter Gutierrez will present data from a pilot study using David Jobes' Collaborative Assessment and Management of Suicidality (CAMS) with VA patients. Dr. Benner will discuss the use of telemedicine technology to monitor suicidality in high risk patients. Drs. Homaifar and Olson-Madden will present on an outpatient suicide consultation service. Israeli psychologist Ariel Merari will present on the psychology of suicide terrorism with Bruce Bongar and Brad Belsher.

Friday, August 15th, 5pm:

Dr. Gutierrez, Lisa Brenner, Beeta Homaifar, and Jennifer Olson-Madden will provide an update on research on and clinical efforts at suicide prevention targeting veterans.

Saturday, August 16th:

8am-11:50am: Section founder Phil Kleespies and colleagues will give a ½ day workshop on "Behavioral Emergencies: Adolescents at Risk." Dr. Kleespies will be giving an overview of behavioral emergencies, Dr. David Rudd will speak on suicide risk with adolescents, Dr. David Veerhagen will present on violence risk and adolescents, and Dr. Dean Kilpatrick will discuss risk for victimization with adolescents.

3:30pm: James Rogers will deliver the Presidential address entitled "Diversity perspectives on early psychological response to mass disasters."

5-6pm: Section VII Business Meeting will be held in the Division 12 hospitality suite.

Your submissions are always welcome!

**Next Section VII newsletter deadline:
NOVEMBER 1, 2008**



**If you have questions or concerns regarding the newsletter, please contact, Dr. Jennifer Hartstein
drhartstein@gmail.com**

Looking forward to receiving any articles, announcements or submissions!

SECTION VII BOARD MEMBERS

President

James R. Rogers, PhD
Department of Counseling
127 Carroll Hall
The University of Akron
Akron, OH 44325-5007
jrogers@uakron.edu

President-Elect

Anthony Spirito, PhD, ABPP
The Warren Alpert Medical School
of Brown University
Box G-S121-4
Providence, RI 02912
anthony_spirito@brown.edu

Past-President

M. David Rudd, PhD, ABPP
Texas Tech University
Department of Psychology
Box 42051
Lubbock, TX 79409-2051
david.rudd@ttu.edu

Section Representative

Marc Hillbrand, PhD
Yale School of Medicine
Director of Psychology
Connecticut Valley Hospital
PO Box 70
Middletown, CT 06457
mark.hillbrand@po.state.ct.us

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Katherine Anne Comtois, PhD
Department of Psychiatry and
Behavioral Sciences
Harborview Medical Center and
University of Washington
Box 359911
Seattle, WA 98195
comtois@u.washington.edu

Treasurer

Jennifer J. Muehlenkamp, PhD
Department of Psychology
PO Box 8380
University of North Dakota
Grand Forks, ND 58202
jennifer.muehlenkamp@und.nodak.edu

Newsletter Editor

Jennifer L. Hartstein, PsyD
138 West 25th Street
Sixth Floor, Suite 5
New York, NY 10001
drhartstein@gmail.com

Graduate Student Representative

Morgan Van Epp, MS
The University of Akron
Collaborative Program in Counseling Psychology
27 South Forge Street
Akron, OH 44325
mvc3@uakron.edu

Jennifer L. Hartstein, PsyD
138 West 25th Street
Sixth Floor, Suite 5
New York, NY 10001