Letter from the Chair

This year has gotten off to a tumultuous start for many of us clinicians. Media accounts of homicides, suicides, and interpersonal violence in the community and on college campuses have captivated our national attention and left many of us feeling helpless—yet hopeful. The unrest surrounding the killing of Michael Brown in Ferguson, Missouri, was reminiscent of the aftermath of the killing of Trayvon Martin in Miami Gardens, Florida, and so we understandably ask, Where is justice in the free world, and what does it look like? These types of assaults on African American young boys and men continue to plague our communities in unprecedented numbers.

Marginalization and the lack of equality are problems that should be addressed through applied social justice principles and professional values, ethics, and standards of practice. Everyone has a right to political, economic, and social opportunities for success and happiness. Disenfranchised groups are systematically denied such access and, thus, are left with the devastating impact of negative health and mental health outcomes. As social work practitioners, it behooves us to hold up our social justice lens and question the degree to which systemic change can be effective in addressing the dissolution that is so pervasive, both nationally and internationally. Witnessing the actions and reactions to community-based traumas is a compelling force that drives social workers in our efforts to combat insidious forms of racism, oppression, and discrimination. As we look to find peace among the people we serve, consideration should be given to the many levels at which mental health status, functioning, and outcomes are compromised. “According to social work philosophy…peace is not possible where there are gross inequalities of money and power, whether between workers and managers, nations and nations or men and women” (NASW, n.d.).

In this issue of the Mental Health Section Connection, Dr. Willa Casstevens addresses the need to pay close attention to the increase in distressed students on college campuses. She reveals myths about suicide and explains the critical nature of warning signs and awareness in the pursuit of safety and survivorship. The second article in this issue is an opinion piece that focuses on interpersonal violence. Maribel Quiala offers examples of the various ways abuse arises in families and other relationship contexts. Action and advocacy are recommended to prevent what many would deem to be a national crisis.

This issue of Mental Health Section Connection is insightful and informative. The practice wisdom and awareness are intended to expand your repertoire of knowledge and skills. I welcome your feedback and comments!

Karen Bullock, PhD, LCSW

Suicide is a leading cause of death for American college and university students. Annually, more than 150,000 youth receive medical care in emergency departments for self-inflicted injuries; for every completed youth (15 to 24 years old) suicide, there are an estimated 100 to 200 attempts (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). As a large number of college and university students fit into this age bracket, it is important to have an open conversation about suicide with social workers working with this population.

Congressional legislation and funding allocation attest that suicide is a serious public health issue for higher education. Since 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) has administered the federal Campus Suicide Prevention Program, following Congress’ initial passage of the Garrett Lee Smith Memorial Act in 2004 (Goldston et al., 2010). The act makes federal funds available to prevent youth suicide at the state, tribal, and college/university levels. Nonetheless, raising awareness about suicide risk and prevention can be a sensitive issue for colleges and universities that do not wish to alarm parents already anxious about their children leaving home. In addition, a number of myths about suicide exist that can further impede awareness-raising and prevention efforts.

Social workers need to become aware of—and challenge—these myths. College and university staff and faculty express concern, for example, about possibly “putting ideas in students’ heads” if they implement campus suicide-prevention programming. This concern is based on a common myth, that “talking about suicide may give someone the idea” (SAVE, 2013–2015). This false belief is remarkably persistent. After attending suicide prevention trainings like ASIST (Applied Suicide Intervention Skills Training; www.livingworks.net/programs/asist) or QPR Gatekeeper Training for Suicide Prevention (Question, Persuade and Refer; www.qprinstitute.com), participants may express thoughts of suicide to trainers.
However, these trainings did not “cause” these thoughts: the thoughts were already present, and attending the training offered a safe venue to express and share them so that they could be addressed. This healthy, help-seeking behavior is the sort of behavior we hope to encourage through campus prevention and awareness-raising efforts.

Six myths that the evidence-based QPR Gatekeeper Training for Suicide Prevention addresses, for example, are that (a) no one can stop suicide; (b) confronting a person about suicide will only make them angry and raise his or her risk; (c) only experts can prevent suicide; (d) suicidal people keep plans to themselves; (e) people who talk about suicide do not do it; and (f) if someone decides to commit suicide, there is nothing anyone can do to prevent it. All of these statements are false, and, as social work practitioners, we need to be able to confidently identify and challenge them as the myths that they are.

When students have thoughts of suicide, family members and friends may wonder why, with their entire lives ahead of them, they could be thinking like this. Generally, feelings of hopelessness, loneliness, or isolation, and perceiving oneself as a burden to others can put students at risk; however, each situation is unique and risk-factor constellations can be remarkably diverse (Suicide Prevention Resource Center [SPRC], 2014). In addition, risk factors can be buffered by protective factors that reduce likelihood of suicide. Protective factors can include social supports, individual characteristics/behaviors, and school/community factors (Perez-Smith, Spirito, & Boergers, 2002; SPRC, 2014). Perceived stress also appears to play a role (Mikolajczyk, Maxwell, Naydenova, Meier, & Ansari, 2008). As social work practitioners, we need to learn how to evaluate risk, make appropriate referrals, and/or provide treatment for students who may be considering or who have attempted suicide.

A collaborative team that includes social workers is helping to educate students, faculty, and staff about suicide risk and resources at North Carolina (NC) State University, which is one of the SAMHSA Garrett Lee Smith, (GLS) Campus grantees. Certified QPR trainers from the NC State University Counseling Center have trained hundreds of individuals on campus in suicide prevention. As the QPR Gatekeeper Training for Suicide Prevention makes clear, we can all take the time listen to someone in distress, and if we see warning signs, we can ask if he or she is considering suicide. When the answer is yes, we can refer that person to appropriate resources. First, of course, we need to be able to
include counseling or further including referrals that may offer additional resources, help is important, our community that they do not need to be members also need to know necessary. While professional intervention is critical, our community can offer additional resources, including counseling or further referrals that may offer additional resources. Typically, counseling or further referrals may include breaking up with a significant other, losing a family member, failing a course, or facing expulsion. Behaviors that may be warning signs include a sudden interest in or rejection of religion, giving away cherished belongings, buying a gun, or collecting pills. Verbal statements or online postings, such as “I won’t be around much longer,” or “They’d be better off without me,” or “I’ve decided to end it all” are also examples of warning signs.

Generally, the greater the number of warning signs present, the higher the risk of suicide.

If we see warning signs of suicide, “it’s OK 2 ask” (www.itsok2ask.com) and to offer resources like the National Suicide Prevention Lifeline Web site (www.suicidepreventionlifeline.org) or phone number (800-273-TALK[8255]). We can offer additional resources, including referrals that may include counseling or further evaluation. In some cases, in-patient hospitalization may be necessary. While professional help is important, our community members also need to know that they do not need to be experts to help prevent suicide.

Dr. W.J. Casstevens is an Associate Professor at the North Carolina State University Department of Social Work. Dr. Casstevens is serving as principal investigator on a United States Department of Health and Human Services, (DHHS) Garrett Lee Smith Campus Suicide Prevention Grant that intends to change campus culture around suicide and its prevention.

**REFERENCES**


**RESOURCE**


The National Association of Social Workers (NASW) offers its condolences to the families and friends of the nine people who lost their lives in the June 17 mass shooting at Emanuel African Methodist Episcopal Church in Charleston, South Carolina.
When the media exposed some of the National Football League’s (NFL) best players—as of whom were cultural icons—as batterers, it was startling. But the fact remains that domestic violence (DV) is common in America’s society—though it is typically rarely covered by media outlets. The Web site DomesticViolenceStatistics.org reports that, in the United States, every nine seconds a woman is assaulted or beaten. And this sobering figure doesn’t tell the whole story: many cases of domestic violence go unreported. So, while instances of abuse by NFL players become tabloid fodder, this scandal only scratches the surface of this enormous problem in our country and culture. Fame and fortune, in and of themselves, can do nothing to break the cycle of domestic violence. But, they can shine light on the issue and present a starting point in addressing the problem. As a society, we have important work to do to curb the acceptability of domestic violence in our culture. Shame and stigma often keep abused women from seeking help; many are harshly judged by their peers and family members. Domestic violence transcends race, ethnicity, class, and socioeconomic status.

**ACTION AND ADVOCACY**

Clearly, we can talk about this ad infinitum. What can and will we DO about it? This is a national problem that requires action and cooperation between law enforcement and private/public partnerships. Calls to the National Domestic Violence Hotline went up 84 percent in the wake of the Ray Rice NFL scandal. More hotline advocates were able to be hired with funding from the NFL, but a spike in calls illustrates the need for more action in our communities.

Domestic violence should not be sensationalized; it’s a national tragedy. It’s not funny or entertaining. We have to work toward eradicating it. It doesn’t have to be a part of our human experience. As social workers, we can help by keeping domestic violence prevention in the spotlight. We cannot and should not wait for another high-profile media incident to bring domestic violence to national attention again.

Maribel Quiala, LCSW, is a member of the Mental Health Specialty Practice Section Committee.

**REFERENCES**


NASW invites current social work practitioners to submit brief articles for our specialty practice publications. Topics must be relevant to one or more of the following specialized areas:

- Administration/Supervision
- Aging
- Alcohol, Tobacco, and Other Drugs
- Child Welfare
- Children, Adolescents, and Young Adults
- Health
- Mental Health
- Private Practice
- School Social Work
- Social and Economic Justice & Peace
- Social Work and the Courts

For submission details and author guidelines, go to SocialWorkers.org/Sections. If you need more information, email sections@nasw.org.

Did You Know?

Mental health providers, including social workers, are often positioned as “gatekeepers” in the medical process (for example, as providers of referrals for hormonal therapy and surgery), which may hamper the therapeutic alliance between them and their transgender client.