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Violence has become an issue of increased concern in the United States. The “scope” of violence is broad, diverse, and affects individuals of all ages, sexual orientations, ethnicities, religions, and racial identities. Some forms of violence, such as domestic violence and gun shootings, have actually increased in recent months. The increase has been attributed to various causes ranging from the COVID 19 pandemic, to the protests following the deaths of George Floyd, Breonna Taylor, Ahmad Arbery, and others. The increase has been substantial enough to be considered a public health crisis.

The New York State Psychological Association, drawing upon the wide and diverse expertise among its members, established a Task Force to investigate the “many faces of violence,” with the goal of developing a set of suggested solutions. This publication is a direct outcome of that Task Force. Each author was asked to draw upon the best, research-based knowledge, in their respective essays. As a result, we believe that this special issue of The Journal has the potential to add significantly to the national discussion of violence. It is our hope that both scholars and policy makers in government benefit from this informed discussion.

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School Violence: Understandings, Goals, and Improvement Strategies

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K-12 School Violence: An Overview

Feeling and being safe is one of our most basic needs (Cantor, Osher, Berg, Strayer, & Rose, 2018; Maslow, 1943). But too many children in America do not feel safe in our schools today. In this essay, I will summarize current, research-based understanding about K-12 school violence and school safety. I will also outline what mental health professionals as well as policy makers and shapers can do to prevent school violence and intervene most helpfully when it does occur.

School violence is a subset of youth violence. Acts of violence and feeling unsafe undermine learning and healthy development (Center for Disease Control, 2019). Historically in the United States and around the world, K-12 educators have only recognized acts of physical violence. Over the last 40 years, there has been a growing appreciation of social-emotional violence among youth and the importance of feeling and being safe – psychosocially as well as physically (Cohen & Espelage, 2020a).

“Officially” – How Big Is the Problem?

School violence is common. The Centers for Disease Control and Prevention (CDC) has reported that nearly one in five high school students report being bullied at school in 2018, and one in seven were electronically bullied (CDC, 2019). In fact, for over a decade, the CDC has recognized that “bullying” and “bully-victim-bystander” behavior is a significant public health problem (Dynarski, Clarke, Cobb, Finn, Rumberger, & Smink, 2008). In addition to the ~20% of students who are targets of mean, cruel and/or bullying acts, the perpetrators as well as witnesses are adversely affected (American Psychological Association, 2019; Astor & Benbenishty, 2019a; Osher, Mayer, Jagers, Kendziorsa, & Wood, 2019).
Another important form of school violence is student aggression towards educators. A U.S. national task force found that students aggression impairs instruction and contributes to teacher burn-out (American Psychological Association Task Force on Classroom Violence Directed Against Teachers, 2011). A recent study found that threats against teachers were less prevalent (15.5%) than threats against peers (84.5%). Of threats against teachers, 30% were classified as serious by the school’s threat assessment team and 5.8% were attempted (Maeng, Malone, & Cornell, 2020).

Youth Violence Kills and Injures: Homicide is the third leading cause of death in young people (ages 10–24). Each day, about 14 young people are victims of homicide and 1,300 are treated in emergency rooms for nonfatal assault related injuries (CDC, 2019). Youth violence is costly: more than 21 billion dollars annually in combined medical and lost productivity costs. Weapons are a very real problem in schools (Astor & Benbenishty, 2019b). And, there is a troubling increase in U.S. adolescents dying of suicide (Miron, Yu, Wilf-Miron, & Kohane, 2019).

Exposure to violence has an adverse impact on brain development (Brea, Perry, & Morris, 2014; Shalev, Moffitt, Sugden, Williams, Houts, Danee, Mill, Arseneault, & Caspi, 2013). Recent systemic reviews and meta-analytic studies show that all forms of violence in childhood have a significant adverse impact on educational outcomes (Fry, Fang, Elliott, Casey, Zheng, Florian, & Mccluskey, 2017).

Today, in the United States there is a primary focus on the following three forms of youth and/or school violence: (1) “bullying”, (2) weapons in school, and (3) school shootings (CDC, 2019; Cohen & Espelage, 2020b). However, this narrow focus is a problem as there is a significantly wider spectrum of experiences that undermine children feeling and being safe.

The Spectrum of Experiences that Undermine Safety in School

There is a spectrum of experiences that undermine K–12 children feeling and being safe in schools. They range from normal moments of misunderstanding and/or conflict; to micro-aggressions (e.g., brief and commonplace verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative prejudicial slights and insults toward any group); to the (mis)understandings and stigma associated with mental illness that affects one
in five adolescents; to intentional verbal/cyber acts of meanness; to sexual harassment, date rape and rape, as well as additional forms of physical violence or weapons in school, murder and suicide (Cohen & Espelage, 2020c). Natural disasters, such as the 2020 coronavirus create additional sets of uncertainties and fears for children, their peers, parents, and teachers.

Misunderstandings and conflict are normative experiences that – unfortunately – too often escalate into problems. In fact, misunderstandings and conflict are ubiquitous. Unfortunately, we rarely teach children how to have controversial or difficult conversations: an essential foundation for democracy on the one hand and healthy relationships on the other hand (Hess & McAvoy, 2014).

Date rape and rape are significant problems that undermine students feeling and being safe in our schools. Although the Me-Too movement has affected virtually every sector of adult life, there continues to be a ‘deafening silence’ about these issues in K-12 school communities. In fact, there is a growing body of empirical research that shows that – roughly – one in four to one in five middle and high school girls are date raped or raped (Mumford, Lee, & Taylor, 2016; Taylor & Mumford, 2016).

Just as health is more than the absence of illness, feeling safe is more than the absence of the range of experiences noted above. Feeling safe is also grounded in feeling supported, engaged and at least some of the time, feeling joy as well as feeling safe. Over the last two decades, there has been growing appreciation that students need to feel supported and engaged. But there is more talk than actual research based educational policy or practice guidelines that support this (Cohen, & Espelage, 2020a). With terribly few exceptions, there is virtually no focus or conversations about the importance of students experiencing – at least some of the time – joy in schools.

Natural disasters and crisis are naturally a source of fear. These experiences certainly have an impact on children’s mental health (Makwana, 2019). Historically in the United States the disasters and crises we have focused on includes earthquakes and tornados as well as school shootings and suicides. The current coronavirus is a new form of disaster that we are just beginning to appreciate and address.
Weapons in Schools and School Shootings
Firearms deaths in schools, although tragic and devastating, are rare compared to deaths in other settings, such as neighborhoods and public spaces (Aston & Benbenishty, 2019; Cornell, 2018). However, 90% of California high school students reported seeing a weapon on campus during the academic year. Almost 31% of schools have at least 8% of students reported being threatened by weapons on school grounds. Weapons in schools can cause students severe short and long term psychosocial and academic harm, even if a weapon is never actually used (Rajan, Branas, Myers, & Agrawai, 2019). Today, most schools have developed plans for possible shootings in school. However, most schools have not developed plans for possible shootings at sports events and other after school activities (Smith & Lu, 2020). Over the last seven years, at least 19 people have been killed and more than 100 wounded in shootings connected to school sporting events (Center for Homeland Defense and Security, 2019).

What Can We Do? Policy and Practice Implications
There are a range of research-based policy and practice steps we can take that will dramatically enhance how safe students feel in schools. School based mental health and educational professionals and parent leaders as well as policy makers and shapers have the potential to support school safety in the following four major ways:

(1) Supporting prosocial universal K-12 improvement efforts for all students;
(2) Supporting coordinated educational, 'at risk' and targeted K-12 interventions;
(3) Addressing weapons in schools; and,
(4) Preventing school shootings.

1) Supporting prosocial universal K-12 improvement efforts for all students
Research has shown that programs that only focus on risky and/or problematic behavior (e.g., violent behavior, smoking, risky sexual behavior, substance use and abuse) tend to be ineffective (Astor & Benbenishty, 2019a; Osher, et. al., 2019). Effective and sustainable risk prevention efforts need to begin with universal or schoolwide efforts that prosocially promote systemic, instructional and relational health in the following ways:

• Fostering students as well as adults (K-12 school personnel and parents) social, emotional and academic development (SEAD). Research-based social emotional learning (SEL) and/or character education represent instructional efforts that promote SEAD. In fact,
educators and parents are always teaching social, emotional and civic lessons -- intentionally and helpfully or not! There is now an extraordinary body of empirical research that shows how helpful social, emotional and civic as well as academic learning is in supporting school and life success (American Educational Research Association, 2013; Aspen Institute, 2019; National Academies of Sciences, Engineering, and Medicine, 2016).

- **School wide efforts designed to foster even safer, more supportive and engaging climates for learning or positive school climates** (American Educational Research Association, 2013; Aspen Institute, 2019; Cohen, McCabe, Michelli, & Pickeral, 2009; Thapa, Cohen, Higgins-D’Alessandro, & Guffey, 2013).

- **Disciplinary and classroom management practices that focus on learning** rather than punishment. In spite of decades of empirical research that has affirmed how profoundly unhelpful punitive methods of discipline are, many schools and classroom leaders continue to utilize punitive methods (American Psychological Association, 2008). Punitive methods of classroom management/discipline ‘feed’ the socially unjust ‘school to prison pipeline’ (Morgan, Salomon, Plotkin, & Cohen, 2014).

- **Fostering healthy and ‘connected’ relationships** (National Academies of Sciences, Engineering, and Medicine, 2016). In fact, ensuring that every student feels connected to at least one caring and responsible adult at school is the single most important risk prevention effort that we can set in motion, as well as being something that we all need (CDC, 2009).

There are a range of school/district improvement goals that will support universal, research-based, school safety informed efforts in the following three spheres: systemically, instructionally and relationally (Berger, Berman, Garci, & Deasy, 2018; Blum & Libbey, 2004; Cohen & Espelage, 2020b; National School Climate Council, 2015).

(1) **Systemic improvement goals:**

- Policy review and reform – ensuring that policy is informed by current research. Today, there are way too many relevant policies (e.g., school safety, disciplinary, bully prevention, school improvement) that are not aligned with current research-based understandings and recommendations.

- Developing a ‘vision’ or portrait of a graduate that students, parents and school person-
nel all share and agree to. This ‘vision’ is both a collaboratively developed goal as well as one of many ways that school leaders can engage students, parents, school personnel and even community members/leaders to be co-learners and co-leaders of the improvement process.

- Utilizing prosocial measurement systems (e.g., school climate surveys) in conjunction with traditional academic and behavioral measures.
- Developing school/district wide crisis preparedness plans.
- Engaging in leadership development for students as well as educators.
- Supporting inter-generational school improvement efforts.
- Furthering meaningful school-family-community partnerships.

(2) Instructional improvement goals that support social, emotional and academic development (SEAD):

- Adults – educators’ and parents -- being a helpful living example/role model.
- Disciplinary practice/management focused on learning rather than punishment.
- Pedagogic strategies (from conflict resolution and cooperative learning to moral dilemma discussions and more) that support SEAD.
- Curriculum (involving both evidenced-based curricula like Second Steps (www.second-step.org/) and Facing History/Ourselves (www.facinghistory.org/) as well as the utilization of a backwards design model (en.wikipedia.org/wiki/Backward_design) that supports the inclusion of prosocial learning goals, strategies and measures into existing language arts, social studies/history and athletics.

(3) Relational improvement efforts:

- Fostering healthy, connected, responsible and caring relationships between educators and students, students and other students, and educators and educators.
- Fostering effective educator-mental health professional-parent partnerships.

School leaders cannot address all of these systemic, instructional and relational goals at once. What is most important is that educational leaders are intentional, strategic, data-driven, and fundamentally collaborative in their prosocial and school safety improvement efforts.
2) Supporting coordinated educational, ‘at risk’ and, targeted K-12 interventions:
Although universal prosocial efforts (e.g., intentional social, emotional and academic instruction as well as school climate improvement efforts) provide an essential foundation of effective risk prevention, some students need specific and additional targeted support (Osher, et. al. 2019). As I have depicted in Figure 1, these ‘at risk’ as well as more intensive and targeted improvement efforts need to be ‘layered’ on top of and coordinated with universal improvement efforts.

Figure 1

There are a range of research-based guidelines, “road maps,” measurement tools, and linked learning systems that are designed to honor and support a school’s systemic, instructional and/or relational improvement goals (Cohen, 2019). And there are detailed guidelines and ‘best practices’ that the U.S. Department of Education recommends (National Center on Safe Supportive Learning Environments, 2020) as well as others (e.g., National Center for Spectator Sports Safety and Security, 2019) that are important for educational leaders to learn from.

School based mental health professionals have the potential to support school leaders in their efforts to improve goals, methods, measures and learning systems. As such, they have opportunities to support all of the four major sets of recommendations noted above and below.
3) **Weapons in schools:** Paradoxically, schools are one of the physically safest places for children. However, as noted above, there is understandable and significant anxiety about weapons in schools. The following policies and related practices have the potential to anticipate and address concerns about weapons in schools (Astor & Benbenishty, 2019a; Astor & Benbenishty, 2019b; Cohen & Espelage, 2020c):

1) Policies concerning weapons and safety should have a wide scope (e.g., involve all types of weapons, go beyond fatal shootings, and pertain to all members of the school community).
2) Policies should incorporate a public health prevention approach (e.g., universal approach aimed at preventing weapons in all schools, target schools that have high levels of weapon related behaviors.)
3) Policies need to aim to promote safe, supportive and equitable climates in schools as well as for sporting and other after school activities rather than confining and punitive environments.
4) Preventing school shootings: Today, we know how to significantly reduce, if not prevent, school shootings. Overlapping with what I have summarized above, we now have empirical research that shows the value of school-based programs designed to prevent aggressive behavior (Wilson & Lipsey, 2007). And, we have many studies that show how school shootings have been averted (Langman & Straub, 2019; Madfis, 2013; National Threat Assessment Center, 2019).

The most promising means of preventing school shootings is through the use of behavioral threat assessment and intervention teams. Threat assessments are designed to help schools channel assistance to students with unresolved grievances or other mental health needs, without overreacting to threats that are not serious (Cornell, 2020; Cornell & Maeng, 2020; Cornell, et. al., 2017).

Sadly, and counterproductively, too many school districts and States are working to prevent school shootings today by “getting tough” and/or investing millions of dollars in building security systems. However, as noted above, research has underscored that punitive methods of discipline make matters worse (Morgan, Salomon, Plotkin, & Cohen, 2014). Many empirical studies have confirmed that physical security measures are not linked to increased safety; in fact, they increase student fears (National Association of School Psychologists, 2019).
States are beginning to use threat assessments more widely. However, too many school districts are being pressured to implement new programs quickly, without adequate training. And most schools have fewer than half of the recommended number of mental health professionals working in schools (American Civil Liberties Union, 2019).

Conclusion
In conclusion, this essay has summarized recent school safety related trends in the United States. Schools are one of the safest places for children and adolescents to be physically. However, this is not true psychosocially. In fact, the single most common school climate survey finding is that educators and parents report that their children/ students feel very safe on the one hand, but students too often report feeling ‘severely unsafe’ (Cohen, 2006). This essay summarizes the range of factors that undermine our children feeling and being safe in schools as well as what educators, mental health professionals and parent leaders as well as policy makers can do to support our children and our future.

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The Prevention and Mitigation of Workplace Violence: Risk, Communications & Practice

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More than two million American workers are affected by incidents of workplace violence each year. Statistics from the Occupational Safety and Health Administration (OSHA) and the Bureau of Labor Statistics demonstrate a growing number of both fatal and nonfatal workplace violence incidents in recent years. Many employers struggle to find effective solutions to this growing problem as employees express concerns about their safety. As mass shootings occur with alarming frequency and the viral nature of social media serves to amplify fears, the traditional methods organizations have used to address violence in the workplace are proving insufficient.

This section summarizes historical and current trends in organizational approaches to workplace violence. It reviews the contributing factors, both individual and organizational, that can precede incidents of employee-on-employee violence. In doing so, it demonstrates why most attempted solutions have failed at both reduction and prevention. As violence remains a leading cause of workplace injuries, employers must recognize the hazard it creates and approach the issue holistically.

Definition
OSHA defines workplace violence “as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers and visitors.” This broad definition, when applied across any number of
industries, shows how complex the issue can be for employers. In fact, the New England Journal of Medicine article entitled “Workplace Violence Against Health Care Workers in the United States” defined four categories of workplace violence by the relationship between a perpetrator and a workplace.

**Various Relationships**
The first classification of workplace violence describes a situation when no relationship exists between the perpetrator and the victim, and the violence is incidental to another crime. An example would be a delivery driver who is robbed while approaching his vehicle. The second classification is one in which the victim is a service provider for the perpetrator. An example of this would be an emergency room physician who, while providing treatment, is assaulted by her patient. The third classification of violence is one in which violence is committed by an employee or former employee. This could be a disgruntled employee threatening a co-worker, or a terminated employee returning to the workplace and shooting his former manager. The fourth classification of workplace violence is defined by a personal relationship between victim and perpetrator but the perpetrator is not otherwise connected to the victim’s workplace. This type of violence can be illustrated by a spouse or significant other who seeks out the victim in the workplace in order to commit an act of domestic violence.

**Frequency**
A 2019 Society of Human Resources Management (SHRM) survey showed that 48% of the HR professionals who responded had experienced an incident of workplace violence at their organizations, with over half occurring within the past year. According to information from the Gun Violence Archives, in the first half of 2019 there were 37 incidents reported in the United States that involved disgruntled co-workers and firearms resulting in 33 fatalities and 21 non-fatal injuries. Incidents of domestic violence have continued to rise in the United States as well. In the first quarter of 2019 the Gun Violence Archives reported 756 incidents that involved firearms, including 482 fatalities and 273 non-lethal injuries.

The definition of workplace violence is broad, and so is the spectrum of solutions. Effectively addressing the issue may involve prevention, response, or both. For organizations with a workforce comprised primarily of service providers, significant challenges exist, including the inability to control an external workplace environment, and the question of balancing client needs with
the safety of their service providers. The risks posed by employee-on-employee and workplace-re-
lated domestic violence remain a rising concern, with incident types and rates that mirror U.S.
societal violence overall.

According to statistics from the Employee Assistance Trade Association, 25 percent of working 
age adults suffer from some type of mental health disorder. Further, 20 percent struggle with al-
cohol addiction and 12 percent with other substance abuse. Both healthcare costs and fear of job 
loss have risen in recent years. Gallup reported a rise in the percentage of American workers who 
believed they would be laid off from employment, from 8 percent in 2017 to 11 percent in 2018.

In 2018, a reported one-third of U.S. employees worked 45 hours or more each week, with ap-
proximately 10 million workers reportedly working more than 60 hours per week. U.S. employ-
ees spend an average of 90,000 hours—estimated to be one third of their overall lives—at work.
Considering how many employees experience mental health issues, substance abuse, domestic 
violence, family problems, financial troubles or some combination, it is no surprise that violence 
manifests in the workplace.

**Risk Factors requiring attention**

*Organizational factors*
- Restructuring or destabilizing of the workplace
- Mass layoffs/job loss
- Disengaged employee culture/low workplace morale
- Low or decreased complaint reporting
- Lack of formal complaint reporting infrastructure
- High turnover
- Low sense of procedural justice
- Gender or other inequities (real or imagined)

*Individual employee factors*
- Performance changes
- Behavioral changes
- Attendance issues
- Domestic violence concerns
Co-worker complaints
Social isolation
Absence of mainstream social activity
Prior discipline
Family stressors
Financial stressors
Criminal history
Civil disputes, especially violent prone
History of violence/aggression
Behavioral excess or extremism
Sudden fascination with weaponry

Organizational approaches to prevent and respond to workplace violence vary widely. The risk of violence against workers differs between organizations and also among industries.

Standards
Efforts are being made to create standards to address violence in the healthcare industry. The lack of standards came under scrutiny because of high rates of violence against healthcare workers. According to 2016 Bureau of Labor Statistics data, 71 percent of reported nonfatal workplace assaults were committed against workers in the healthcare and social services industries. In response, lawmakers introduced legislation that requires OSHA to develop federal standards. With this change, healthcare employers will be mandated to establish comprehensive workplace violence prevention plans. What that means, however, remains nebulous as organizations are already struggling to find comprehensive, effective solutions. Healthcare systems, along with other organizations that employ populations of mobile workers, must find ways to address threats occurring out in communities, i.e., outside their perimeter of control. They also have to protect employees from external threats posed by persons who enter their premises.

Aside from mandates for the healthcare industry, the majority of organizations lack standardized methods of addressing workplace violence. This is particularly true for prevention. Workplace violence resources offered by OSHA, ASIS International, Homeland Security and SHRM are primarily aimed at managing emergencies. Many organizations, particularly larger ones, delegate workplace violence to various departments that include: Security, Facilities Management, Human Resources, Environmental Health & Safety, Legal, and Compliance. Security professionals
taking the lead on workplace violence issues may look to ASIS or Homeland Security for guidance, while Human Resources personnel will look to SHRM, Environmental Health & Safety to OSHA. The different classifications of workplace violence indicate that a sole department or employee may not possess expertise to manage the entire scope of this complex problem. Many companies fail to consider this issue. As a result, they miss opportunities for prevention.

Not all companies have formal workplace violence programs but the majority generally use some combination of the following:

*Most Common Preventive Elements*
- Access control and continuously monitored security technology (e.g., alarm systems)
- Policy that prohibits harassment, threats and violence
- Security awareness campaigns (i.e., “See something, say something”)
- Security guards

*Most Common Responsive Elements*
- Employee discipline
- Active shooter training
- Emergency preparedness/crisis management planning
- Security guards
- Post-incident investigations
- Unmonitored video surveillance technology

**Active Shooter Issues**
A 2018 study conducted by Everbridge found that 75.6 percent of respondents with roles in corporate security and emergency preparedness believed “active shooter” to be the top threat against their organizations. “Workplace violence,” generally, was considered to be the second highest organization threat, according to 67.4 of respondents with security and emergency preparedness responsibilities. In 2014, the United States averaged one active shooter incident a month, and since then that number has increased. The larger the business, the higher the risk. A growing number of organizations highlight active shooter training as a significant element of their workplace violence prevention planning. Similar to the use of security guards, however, the training is primarily responsive in nature, intended for use after an active shooting is already in progress in or around the workplace.
Physical Security Is Not Enough
A surprising number of workplace violence prevention programs focus heavily on the physical security of a workplace. The term “physical security” can include a building’s access controls, surveillance cameras, burglar, panic and fire alarm systems and activities performed by security guards. A reliance on physical security to address workplace violence concerns often leaves prevention and response responsibilities to security or even facilities personnel. Physical security, in the wider context of workplace violence, is certainly one element of prevention. The use of technology and security personnel, however, is insufficient to address the concept of workplace violence as a whole.

The term “security personnel” includes uniformed guards, which U.S. businesses have been hiring in record numbers in recent years. According to the U.S. Bureau of Labor Statistics 2018 Occupational Wage and Employment Data, security guard jobs rank extremely high for employment, with numbers expected to grow by 5 percent to 1.5 million workers through 2024. Security guards’ duties include monitoring entrances and exits; patrolling buildings and grounds; and observing and reporting hazards, building issues and suspicious activity. Unlike sworn law enforcement officers, security guards lack authority to make arrests. Nonetheless, with a mean U.S. annual wage of $30,730 ($14.78 per hour) and the vast majority of them unarmed, security guards are often an organization’s first line of defense against violence. While access to controlled entrances and panic alarms can be effective against external threats, they are less effective at preventing violence when the source is insider threat.

Connecting Policy and Practice
Technology, guards, and active shooter training do not address employee behavior. A historical look at known incidents of workplace violence committed by disgruntled employees demonstrates various behavioral and situational red flags that led up to certain incidents. When the precursors of violence are not recognized and addressed, the risk to an organization increases. It is unrealistic for organizations to expect security personnel to recognize and manage employee-related red flags.

Most organizations implement policy to define appropriate workplace behavior, followed by discipline when violations occur. Instead of approaching workplace behavior problems with an intervention, or prevention-focused strategy, the majority of companies segregate information held by any number of disciplines. Without information-sharing, it is challenging for organizations to move past a purely reactionary approach to violence.
An example of an all-too-common scenario: a Human Resources (HR) manager and a supervisor are planning to terminate an employee. His declining work performance has been accompanied by mood swings, including several angry outbursts. The HR manager approved leave when one of his dependents was diagnosed with a serious illness. The supervisor overheard a comment to a co-worker that indicated the employee was having financial problems. He had several unscheduled absences, in violation of policy, for which he was disciplined. He is being terminated for failing to meet the expectations the supervisor outlined in a performance improvement plan. The HR manager is concerned about how the employee will react to being fired. He asks the company’s security manager to send a guard to stand outside the room. In the event the employee becomes violent in this meeting, the guard is expected to intervene. The guard, who works for the contract security company, is new to this company’s campus. He knows nothing about the people meeting behind the door he was asked to stand outside.

This all-too-common approach to concerns about insider workplace violence illustrates the danger of silos. Approaching employee behavior as a potential red flag for violence allows organizations to measure risk, offer intervention, and tailor risk-appropriate preventive measures. The above scenario illustrates multiple “red flag” behaviors. The impact of losing a job and health benefits is not difficult to imagine. The organization approached poor attendance and performance in a strictly punitive manner. That approach could have contributed to the risk they expect a security guard to manage.

**The Cost**

Corporate spending to address workplace violence is significant. Preventive costs in the United States in 2017 include approximately 24.5 billion dollars by organizations for contract security guarding, with another $19.5 billion spent for in-house security personnel. Global figures show $6.5 billion spent on access control technology and $28 billion for video surveillance, with a high market share in the United States from manufacturing, banking and financial services, transportation, and retail industries. The market for active shooter insurance has grown considerably in recent years, which can cost companies up to $20 million per year while limiting coverage for various exclusions.

U.S. companies spend approximately $4 billion per year on employee assistance programs (EAPs) despite inadequate efficacy research and with that, many employers simply don’t attempt to address the cost-benefit proposition. The behavioral health industry is gaining visibility in the
American workplace. Such services are being embraced with convenient technology solutions complemented by licensed psychologists who coach and/or counsel using evidence-based research. Despite attempts to support the emotional health and well being of employees, in 2017 workplace remediation cost U.S. companies $36 billion. One example of a staggering remediation cost for one incident is the 2007 Virginia Tech mass shooting which ended up costing the organization $48.2 million.

Violence is expensive, with costs extending far beyond what companies are spending for prevention and response efforts. According to statistics provided by the Center for Disease Control, the cost of lifetime medical and work loss from injuries in the United States was $671 billion. Medical and work loss costs associated with fatalities was $214 billion. The cost of domestic violence, which can clearly impact a workplace, has risen to $2.1 trillion in medical costs and $1.3 trillion in lost productivity, and includes both victims and perpetrators.

Where Current Strategies Need Improvement

Workplace violence, as defined earlier, is not a simple issue for organizations to address. Silos prevent sharing of information and there are typically many missed opportunities to assess risk meaningfully, especially using multi-disciplinary approaches.

Human Resources personnel and managers generally maintain information that spans the employee lifecycle: pre-hire screening, interview notes, health benefits, leave and performance management information, as well as information about employee conduct and reasons for issuing employee discipline, including termination. Efforts to manage, rather than understand, an employee’s behavior are often made after a problem occurs. Despite the rising number of U.S. workers whose attendance and performance might be affected by mental and physical illness, substance abuse, and family and financial anxieties, organizations have continued to spend more on security guards than on employee-focused, proactive management solutions.

Physical security may be a necessity, but more often than not it exists in a silo, disconnected and disengaged. Monitoring doors and parking lots is often substituted for managing employee behavior. Many organizations roll out “security awareness programs” purportedly to address workplace violence. When devoid of multi-disciplinary strategy and process, employees may perceive these programs as purely superficial.
The Importance of Employee Perceptions

There may be a significant impact on organizations when employees feel unsafe in the workplace. This may arise from perceptions that reported concerns have gone unaddressed, or from employees who go through stressful situations with the sense that their employer doesn't care. Whether employees are actually at risk of violence or simply feel someone poses a threat, it comes at a cost to the organization.

Many companies work hard to recruit and retain top talent. High levels of employee turnover can be expensive in any industry. Stress in the workplace and absenteeism both have an impact on productivity, which can translate into lost revenue for an organization or department. Harder to define, but certainly quantifiable, is the cost of an actual incident of violence. It can impact business continuity as well as the entire workforce and can lead to lost customers and brand damage. According to a 2007 Harvard Business Review article entitled Reputation and Its Risks “... in an economy where 70%-80% of market value comes from hard-to-assess intangible assets ... organizations are especially vulnerable to anything that damages their reputations.”

Wellness is an area that U.S. companies recognize has a positive impact on productivity. Employer-sponsored wellness programs encourage employees to eat well, exercise, and meditate, seemingly understanding that healthy employees are assets. More significantly, managerial practices themselves have attracted attention as key to the establishment of a culture of organizational wellness where the definition of wellness includes both financial and non-financial factors (Diamante, 2006). Organizations are advised to focus on the human resource programs, practices, and policies that can enable healthy cultures to thrive.

What should be done now?

Organizations should consider a multi-disciplinary approach to workplace violence. This is especially true for companies with concerns about insider threats or, based on internal data, are concerned about their cultures (i.e., level of trust, lack of business codes of conduct, patterns of incivility, lack of fairness and respect, high levels of job dissatisfaction or disengagement), turnover, and absenteeism and litigation frequency on employment-related matters and managerial conduct. A multi-disciplinary approach translates into human resources, information security, technology and operations, and safety and security professionals working together to create the policies, programs, preventive and response mechanisms necessary to build and secure a healthy workplace.
Recommendations

- Create policy focused on anti-bullying and civility in the workplace
- (in addition to Equal Employment Opportunity policy and practice compliance)
- Conduct managerial training focused on awareness that is backed by policy and practices to act on a concern
- Communicate based on knowledge of the target audience
- If there is a call to action then ask for it; if you see something, say something – and offer multiple avenues for reporting – be specific with contact information
- Ensure that your messages resonate; translate data into words that will move the recipient
- Ensure fairness in how all employees are treated, and communicate your policies and practices
- Ensure organizational mechanisms are in place to respond to threat
- Run scenarios, practice handling threats, and incorporate debriefing feedback

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Violence Against Women: Sexual Assault, Sexual Harassment and Intimate Partner Violence

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Gender based violence (GBV) has been defined as “violence that is directed at an individual based on his or her biological sex or perceived adherence to socially defined norms of masculinity and femininity” (2012, United States strategy to prevent and respond to GBV globally). Although both women and men have been victims of GBV, women are most often targeted. This section will focus on violence against women. Despite the desperate situation occurring during the 2020 pandemic, GBV (e.g., domestic violence, child abuse) has increased. Compared to last year, New York State has witnessed a 30% increase in domestic violence calls and a 15% increase in the report of domestic violence incidents calls made to police (Governor’s Press Office, 2020). Local news reports child abuse claims are down, probably due to underreporting. Another factor is that it is often teachers who observe and report child abuse, but teachers have had reduced contact with children during the pandemic.

In 2017, a few high-profile Hollywood actresses alleged that Harvey Weinstein, a powerful Hollywood producer, had sexually assaulted them when they were younger. Harvey Weinstein’s described pattern of serial sexual assaults was so egregious that the movement MeToo, established by Tarana Burke in 2006, gained momentum globally (#MeToo). Despite some backlash against the #MeToo movement, similar allegations were made against several high-profile men, including Charlie Rose, Matt Lauer, Louis C.K., James Levine and Bill Cosby. Each of them has been fired or lost his reputation.
Harvey Weinstein became a defendant in a criminal trial in New York City in 2020. On February 24, 2020, Weinstein was convicted of a criminal sex act and 3rd degree rape. He was sentenced to 23 years in prison, and now is considered to be a sex offender. Several brave women suffered through brutal cross-examination during the trial but have now achieved some sense of justice. The verdicts also serve as a victory for the #MeToo movement.

Violence against women and girls takes many forms including sexual assault, sexual harassment, intimate partner violence (IPV), sex trafficking, and child sexual abuse. In this section we will focus on sexual assault, sexual harassment and IPV.

**Sexual Assault**

**Definitions and Statistics**
Zounlome and Wong (2019; citing Strang, Peterson, Hill, & Heiman, 2013) described the overall term of “sexual aggression” as consisting of sexual assault: “obtaining nonconsensual sexual acts through intoxication, physical threats or physical force” and “sexual coercion as: obtaining sexual acts through verbal pressure or manipulation (e.g., lies)” (p. 528). The Center for Disease Control (CDC) definition was more explicit. Rape was defined as “any completed or attempted unwanted vaginal . . . or anal penetration” (NISVS, 2018).

The 2018 NISVS CDC report estimated that “1 in 5 women experienced an attempted rape in her lifetime. In the United States, 43.6% of women (nearly 52.2 million) experienced some form of contact sexual violence in their lifetime.” The CDC also reported that close to 25% of Black women, nearly 20% of White women, about 15% of Hispanic women, over 25% of American Indian or Alaska native women, and more than 30% of multiracial women were rape survivors. The World Health Organization (WHO, 2017) identified violence against women as a “major public health problem, and a violation of women’s human rights.” Statistics related to GBV against women are only estimates since sexual violence is among the most underreported crimes.

**Risk Factors for Victimization and Types of Perpetrators**

Sexual assault has been investigated extensively in university settings where women students are particularly at risk. Mellins et al. (2017) created an online survey for undergraduates consisting of standardized measures to identify victimization risk factors. Women experienced higher rates
of sexual assault (28%) than men (12.5%), risk increased over the four college years, and “sexualized touching” was more common than rape or attempted rape. The risk increased if students were members of a sorority and/or if the students had participated in a “hook-up” at any time. Drinking to excess was another marker for potential sexual assault.

For many years, research on sexual aggression focused primarily on women victims. Recently, however, researchers have investigated motives and types of perpetrators in order to facilitate development of targeted interventions to prevent sexual aggression. In a qualitative exploratory study, Hipp et al. (2017) analyzed the justifications and motivations of self-described sexual assaulters who responded to an online post. The most common self-justifications included “sexual scripts” (e.g., “no means yes”; p. 85), “victim blame” (e.g., if the victim did not fight back; p. 85), and “hostile sexism” (e.g., anger and hostility towards women”; p. 86). Although the Hipp et al. study (2017) was interesting in that anonymous reports avoid the problem of social desirability in response to sexual aggression questions, the inability to describe the sample and participants who might have lied, limits generalization from the study. A more rigorous study was conducted by Zinzow and Thompson (2015). A standardized scale including “behaviorally specific questions” related to sexual assault was administered to a large group of male undergraduates. The majority of respondents were classified as non-perpetrators, but the following categories of perpetrators were identified: The most common grouping for 16% of the sample was in the “incapacitated group attempted/completed rape . . . where the victim was too drunk . . . to stop what was happening” (p. 36); “13% in the verbal coercion group” where “threats, verbal pressure were used” (p. 36); and 5% in the forcible group, “using force or threats” (p. 37). Other findings suggested that rape-supportive beliefs/norms, and risk behavior characterized different categories of perpetrators, suggesting the importance of tailoring various prevention programs to specific perpetrator types.

Consequences of Sexual Assault

Prior research has identified post-traumatic stress (PTSD) as a major psychological consequence of sexual assault. Recently some investigations have broadened the types of psychological symptoms exhibited by survivors. Walsh, Keyes, Koenen, and Hasin (2015) found that in a large sample of women who had experienced GBV, signs of PTSD, depression and phobias, as well as a “substance use disorder,” especially alcohol, were observed. Dworkin, Menon, Brystrynski, and Allen (2017), in an extensive meta-analysis, also found that sexual assault produced psycho-
logical effects beyond PTSD. For example, suicidality was identified as of particular concern for survivors of sexual assault. Finally, the CDC listed other possible consequences of sexual assault: “Physical: bruising, injuries; Psychological: depression, anxiety; Chronic: gynecological, gastrointestinal, cardiovascular and sexual health problems; and negative health behaviors including alcohol abuse, drugs and risky sexual behavior.”

Prevention Approaches

A number of approaches have been suggested to reduce the incidence of sexual assault, including risk reduction, a “social norm” approach, and bystander intervention. In 2015, Menning and Holtzman described a comprehensive program called “Elemental” which has shown promise in changing adverse sexual attitudes (e.g., rape myth acceptance) of men, and sexual assault risks for women, among other effects. Elemental consists of 1. Primary prevention, a component which focuses on improving communication, “healthy relationships,” and creating “respectful sexual environments” (p. 513). The program includes trained leaders, lectures, videos and role-playing. 2. Risk reduction trains participants (primarily women) to accurately identify high risk potential sexual assault situations and provides “response options and physical techniques” (p. 514) to defuse threatening situations.

Zounlome and Wong (2019) used the social norm approach to influence male participants’ attitudes toward sexual assault. Undergraduate men were provided with social norms indicating that other male students at their university disapproved of sexual assaults. Compared with a control group, men in the social norm condition showed a decrease in rape myths and decreased reported intentions to engage in future sexual assaults. Of course, behavioral intentions do not necessarily predict behavior but clarifying social norms is one possible effective approach to prevention.

A related study by Armstrong and Mahone (2017) examined the possibility that bystander intervention in potential sexual assault situations may prevent the assault from being carried out. In a survey, the researchers found that women were more likely to indicate that they would intervene in a possible sexual assault situation than men. Anti-sexual assault information and prevention programs might be based on this bystander intervention concept. However, these programs have not been uniformly effective. Prevention programs should include an emphasis both on protecting women from sexual assaults (e.g., risk reduction) and preventing men from perpetrating sexual assaults.
Recommendations

Sexual Assault Survivors
Risk Reduction: Self-defense training can be useful to women by enabling them to recognize risky situations and to either escape, defuse the situation, or defend themselves physically against a potential predator.

Once a woman has experienced sexual assault, Greeson, Soibatian, and Houston-Kolnik, (2018) describe how Sexual Assault Response Teams can coordinate responses to the victim. First, women should be encouraged to report the assault to the police, and medical personnel. The next step would be prosecutors in the criminal justice system bringing the case to trial, aided by advocates for survivors. All individuals who will interact with the survivor should be trained to react nonjudgmentally and to believe credible victims.

In the Harvey Weinstein trial, prosecutors asked an expert witness to testify about false rape myths, discuss power differentials, and explain complex relationships between the alleged perpetrator and the survivors. Despite the complex trial, jurors were engaged, deliberated for five days, and split their decisions, which is an indication that prosecutors can try cases related to sexual assault and be effective. Judges’ instructions also are crucial in jury trials.

At sentencing hearings (e.g., in the Harvey Weinstein trial), survivors alleging sexual assault, and other survivors not plaintiffs in the case, often testify to their continued anguish and symptoms following the assault, which may provide some closure. Clearly appropriate sentences within the guidelines -- in the case of Harvey Weinstein, 23 years -- may give survivors some closure. Victims of sexual assault may be more willing to come forward with sexual assault allegations following the Weinstein trial and sentencing.

The statute of limitations for rape allegations is 20 years. Some consideration may be given to extending the time frame.

Perpetrators
Targeted programs designed to prevent sexual assault related to the type of perpetrator, e.g., whether incapacitated, verbal coercion, or forcible attempted/completed rape, need to be developed. More intensive programs for perpetrators using force or weapons will be necessary.
Community Culture
The culture on college campuses should be changed to encourage communication about sexual issues, consent issues, debunking the rape myths, creating social norms which are anti-sexual attacks, and decreasing drinking and drugs on campus. Derogatory remarks about women and objectifying women should be discouraged. Social media should ban posts which represent hostile sexism, or encourage violence against women.

The culture in the United States appears to be changing towards believing women’s allegations of sexual assault. Prosecutors may be more willing to try these types of cases, and victims more willing to move forward with allegations of sexual assault.

Sexual Harassment

Definitions and Statistics
Sexual harassment is a type of sex discrimination which involves “unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature” (EEOC Website). This conduct can be overt or implied; affect the victim’s employment, work performance; or create an “intimidating, hostile, or offensive work environment” (EEOC website).

In educational settings, sexual harassment constitutes sexual behaviors that “interfere with academic or professional performance,” “limit the person’s ability to participate in an academic program,” or that “create an intimidating, hostile or offensive social, academic or work environment” (Association of American Universities, 2019).

In the United States, sexual harassment constitutes a violation of Title VII of the Civil Rights Act of 1964 and it does not have to be specifically about sexual behavior or sexual in nature, i.e., motivated by sexual desire, urge or activity, nor directed towards an individual target (National Academies of Sciences, Engineering, and Medicine, 2018; RAINN website). Making derogatory or negative blanket statements about a specific gender as a whole also constitutes harassment (RAINN website).

To illustrate this, both of the following examples constitute sexual harassment: (1) An employer is attracted to an employee and consistently asks her out on dates despite the fact that she persistently rejects these overtures; and (2) An employee suggests that her colleague should not hold
a position that is traditionally or conventionally held by men. In educational settings, Title IX of the Education Amendments of 1972 applies: “sexual harassment is defined as unwanted sexual behavior that interferes with a student’s right to receive an equal education” (Hill & Kearl, 2011). State and local laws may also prohibit harassment, and if race and sex are involved, Title VI of the Civil Rights Act of 1964 may apply.

Sexual harassment was first recognized as a coercive behavior by the U.S. courts in the late 1970s during cases in which women lost their employment after rejecting sexual overtures from their employers (National Academies of Sciences, Engineering, and Medicine, 2018). Over time, sexual harassment became understood as targeted at an individual (through coercion, quid pro quo sexual harassment), at a group, or within a space at large (hostile work environment sexual harassment).

With quid pro quo (a Latin phrase meaning something for something) sexual harassment, an individual’s submission or rejection of sexual advances and behavior is tied to employment decisions or is made a condition of employment. Behaviors such as requests for sexual favors, sexual questions or vulgarities, degrading verbal or physical contact, offensive language, sexist print or visual material, or offensive or vulgar graffiti which are unwelcome, can create a hostile work environment and interfere with an individual’s job performance.

Retaliation which is prohibited by law occurs when individuals who have reported harassment, have witnessed the event, or oppose harassment, are subjected to behaviors designed to punish. Examples include being given poor performance evaluations or low grades, difficult or less desirable work, or unfair schedules. Making threats, subjecting the person to physical or verbal abuse, spreading false rumors, or treating them harshly or unfairly are other examples.

Three primary related terms have emerged as refinements of the definition of sexual harassment -- sexual coercion, unwanted sexual attention, and gender harassment (Fitzgerald et al, 1988; Fitzgerald, Gelfand, & Drasgow, 1995; Gelfand, Fitzgerald, & Drasgow, 1995). Sexual coercion includes sexual advances that make conditions of employment, education, promotion, etc. . . in the workplace and educational settings contingent upon sexual cooperation (National Academies of Sciences, Engineering, and Medicine, 2018).
Unwanted sexual attention consists of unwanted sexual advances that does not include threats to employment, education, promotion, etc. Rather it includes such behaviors as unwelcome or offensive expressions of romantic interest, unwanted touching, hugging, and other unwelcome gestures of a physical nature, including assault (Cortina, Koss, & Cook 2018; Fitzgerald, Gelfand, & Drasgow, 1995; Fitzgerald, Swan, & Magley, 1997).

Gender harassment is defined as a “broad range of verbal and nonverbal behaviors not aimed at sexual cooperation but that convey insulting, hostile, and degrading attitudes” based and directed at gender (Fitzgerald, Gelfand, & Drasgow, 1995). Fitzgerald, Gelfand, and Drasgow (1995) further deconstructed gender harassment into two types: sexist hostility (e.g., implying that a woman is not suitable for a leadership position or other position traditionally held by men) and crude harassment (e.g., name-calling rooted in derogatory gender-based discrimination such as using “slut,” “pussy,” or “sissy” to describe someone in the work place).

**Prevalence**

The Center for Women and Work (2020) notes that estimates of sexual harassment at work range from 25% (no specific definition given) to 85% (behaviors are specified). Disparities exist with women, racial and ethnic minorities, and sexual and gender minorities experiencing sexual harassment at higher rates (Center for Women and Work, National Academies of Sciences, Engineering, and Medicine, 2018). Lesbian and bisexual women (Cortina et al., 1998; Konik & Cortina, 2008), and women who are stereotypically masculine in behavior, appearance, or personality (Berdahl, 2007b; Leskinen, Rabelo, & Cortina, 2015) all experience sexual harassment at greater rates than other women. Women with more progressive or gender-egalitarian beliefs also tend to experience sexual harassment at higher rates (Dall’Ara & Maass, 1999; Siebler, Sabelus, & Bohner, 2008).

According to the National Center for Educational Statistics (Dilberti et al., 2019), principals and other school administrators from 2,762 primary, middle, high, and combined schools report that about 3.3% of middle school students and 2.8% of high school students experience “conduct that is unwelcome, sexual in nature, and denies or limits a student’s ability to participate in or benefit from a school’s education program.” Among 33 institutions of higher learning, sexual harassment ranged from 11 to 25 % (Cantor et. al, 2020). About four in ten students (41.8%) stated that since enrolling in their institution they had experienced at least one incident of sexual harass-
ment, and about one in five (18.9%) reported that this behavior interfered with their education or work, limited their participation, or created a hostile environment. Undergraduates who were women (31.3%) or sexual minorities (46.3%) reported the highest levels of harassment. About one in five (19.9%) women graduate/professional students reported harassment.

One online national survey on sexual harassment prevalence conducted by a nonprofit called Stop Street Harassment and analyzed by the Center on Gender Equity and Health at the University of California, San Diego, found that 81 percent of women experienced at least one instance of sexual harassment during their lifetimes (Chatterjee, 2018; Kearl, Jones, & Raj, 2019). Lifetime experiences of harassment were higher for Lesbian and Bisexual women (95%) than cisgender women (80%). Within the past six months, the highest rates of harassment were reported by Lesbian or Bisexual women (39%), Black women (35%) and women aged 18–24 years (32%). For women the most frequent types of harassment experienced were verbal (77%), unwelcome touching (51%), cyber-sexual harassment (41%), being followed (34%), unwanted genital flashing (30%), and sexual assault (27%).

Findings from this survey also indicated a high prevalence of sexual harassment or assault experienced by children and teenagers: 57 percent of women reported experiencing sexual harassment as a child or teenager; 27% reported that they first experienced sexual harassment or assault between the ages of 14 and 17 years (Chatterjee, 2018; Stop Street Harassment, 2018).

**Risk Factors**

**Individual Risk Factors**

Recent research shows that being a perpetrator of harassment or discrimination can cut across race/ethnicity, sex, age, and religion. Harassers can be individuals in leadership positions, supervisors, co-workers or clients/customers, and victims can be those who are indirectly affected as well as the direct target.

Harassment varies by individual characteristics and settings. For example, in university settings, women graduate/professional students are more likely to be sexually harassed by faculty members or instructors (24% of incidents vs 5.5% for undergraduates.) Undergraduates are more likely to be harassed by fellow students.
General patterns mentioned demonstrate that targets of sexual harassment are most often women of lower status and that perpetrators are men of higher status (Durana et. al., 2018). Being a women-of-color, LGBTQ, gender nonconforming, men who do not fit traditional masculine norms, and individuals perceived as outsiders, heightens the possibility of being a target. Recent research has focused on women harassers.

**Structural Risk Factors**
Feldblum and Lipnic (2016) note that prior research indicates that organizational factors are the best predictors of sexual harassment. Sexual harassment at work varies by type of occupation. The highest rates of harassment occur within the hotel and food industry, retail, manufacturing, and health care and social services. Women in the construction industry also experience disproportionately high rates of harassment (Center for Women and Work, 2020).

Harassment is higher in male dominated industries or professions. It is greater in organizations that are less diverse (for example, in terms of gender, race, culture, language or ability status), or where some workers are perceived to be valued over others (e.g., management is reluctant to challenge their status and they may not see rules as applying to them). It also is greater where significant power differentials exist which can lead to exploitation and fear of reprisal (e.g., working in hierarchical organizations, universities, and government agencies, or working while undocumented).

Organizations with young employees who may be exploited or unaware of norms and laws, and where compensation is based on client or consumer satisfaction (e.g., working for tips), also experience higher rates of harassment. It is higher in organizations with monotonous jobs or low intensity work that engender “too much free time,” and those that tolerate or encourage alcohol consumption.

Workplaces characterized by isolated settings where it is difficult to monitor or control employer behavior (e.g., night shifts, working alone, domestic workers, farm workers in a field) or where senior management is located off-site (Center for Women and Work, 2020; Feldman & Lipnic, 2016; Shaw et. al, 2018) also have greater levels of harassment. Harassment is higher as well when macro level events external to the organization (e.g., terrorist acts, government stances on immigration) impact the views of individuals and shift the organizational climate.
Consequences

Harassment has adverse outcomes for individual health and well-being with more negative effects incurred when the perpetrator has greater power over the target and the harassment is more frequent, intense, and of longer duration. Individuals can experience a range of negative emotions including anxiety, depression, shock, denial, confusion, powerlessness, anger, fear, frustration, irritability, shame, self-consciousness, low self-esteem, insecurity, embarrassment, betrayal, guilt, self-blame, and isolation (Center for Victim Advocacy and Violence Prevention, 2010).

Physiological reactions include disturbed or inadequate sleep, headaches, changes in weight, gastrointestinal problems, dermatological reactions, sexual problems, fatigue and exhaustion, panic reactions, elevated blood pressure, and chronic pain (Center for Victim Advocacy and Violence Prevention, 2010). Increased use of tobacco, alcohol or prescriptions drugs can occur and individuals also report lowered life satisfaction (National Academies of Medicine, 2018).

In Kearl, Jones, and Raj’s 2019 survey study, 31 percent of women experienced anxiety and depression stemming from experiences of sexual harassment. Some female targets of sexual harassment made behavioral changes after their experiences, including changing their routines (23%), changing jobs (9%), changing their home dwelling (5%), changed schools, or dropped out altogether (2%). Sexual harassment also affected people’s interpersonal relationships: some ended friendships or a romantic relationship (15%), while others ended a hobby or stopped participating in a community activity (5%). Reactions varied by group with reports of depression and anxiety higher for younger women, gender and sexual minorities, and individuals with disabilities. The latter two groups also reported making changes in their lives.

In school settings, harassment can lead to lack of interest in learning; less motivation; changes in classes, advisors, majors, career goals or educational programs; poor performance; leaving school; and loss of academic networks (Center for Women & Work, 2020; National Academies of Sciences, 2018).

Work related effects for individuals include absenteeism, lateness, decreased job satisfaction, withdrawal, poor work performance due to stress, unfavorable performance evaluations, interference with career advancement, altered relationships with colleagues, burnout, less commitment to job (angry and disillusioned), intention to leave, and change or loss of job (Center for Women
Organizations experience absenteeism, lower morale, employee turnover, having to replace employees, reduced productivity at work, use of managerial time, loss of customers due to poor employee attitudes, health system usage, and legal costs incurred from investigations, legal assistance, compensation for workers, and potential court cases (Center for Women & Work, 2020; Deloitte, 2019; National Academies of Sciences, 2018; Shaw et. al 2018).

**Prevention**

The Equal Employment Opportunity Commissioner (EEOC) (Feldblum & Lipnic, 2016) has noted that leaders need to establish an organizational culture where harassment is not accepted, where comprehensive and strong policies and systems are in place to ensure that harassers are held accountable, and where action is taken when harassment occurs. In addition, there needs to be “regular, interactive, comprehensive training of all employees” to “help ensure that the workforce understands organizational rules, policies, procedures, and expectations, as well as the consequences of misconduct.”

To help prevent retaliation, the EEOC notes that it should be clear that retaliation is prohibited and protected by law; that managers should be aware that they are responsible for halting, addressing and preventing retaliation; that employees will be held accountable for complying with and enforcing policies and the organization should “respond to discrimination questions, concerns, and complaints promptly and effectively.”

Establishing policies such as pay equity, paid family leave, and sick time not only promote economic justice and gender equity but also can prevent sexual harassment by increasing women’s economic opportunities and self-sufficiency (Center for Women and Work, 2020).

In school settings, preventive actions would include providing comprehensive sexual education with a curriculum that includes discussions on healthy relationships; promotes school cultures where caring and respect is emphasized and sexual harassment is not tolerated; developing poli-
cies that clearly define acceptable and non-acceptable behaviors with consequences and penalties for violations.

Other actions should include increasing awareness of federal and state laws and school policies; developing systems for identifying and reporting incidents; creating a climate where students feel comfortable in reporting incidents; establishing safe ways of reporting complaints or grievances; communicating to students, school staff, faculty and administrators school policies, and taking action when incidents occur.

**Recommendations**

Research indicates that sexual harassment training can increase knowledge of policies and behaviors that constitute sexual harassment, but it has not been as effective in preventing sexual harassment or changing behaviors or attitudes (National Academies of Sciences, 2018).

Environments where sexual harassment is less prevalent generally have explicitly condemned sexual harassment and produce transparent guidelines for related behaviors.

In academic settings, school administrators should address gender harassment; create diverse, inclusive, and respectful environments, and ensure that policies and procedures align with these values; try to flatten hierarchical structures by using committees to mentor students rather than one individual only; develop transparent and accountable mechanisms for addressing harassment and providing support to targets of harassment through systems that allow for safe ways of reporting incidents; and preventing retaliation and access to support services (e.g., health care, legal).

The EEOC (2017) views the five core principles useful in preventing harassment and applicable to addressing it as well:

- Committed and engaged leadership,
- Consistent and demonstrated accountability,
- Strong and comprehensive harassment policies,
- Trusted and accessible complaint procedures, and
- Regular, interactive training tailored to the audience and the organization
Durana et al. (2018) argue for legal reforms that include expanding worker rights and making reporting harassment a more streamlined process; encourage leaders of organizations to work to change cultures by not tolerating harassment, offsetting power imbalances, and taking steps to address male dominated workplaces; having workers and their allies advocate for change both individually and in groups; and revamping training.

**Intimate Partner Violence**

Aggressive or abusive actions that occur in close relationships are known as Intimate Partner Violence (IPV). IPV can include both current and former personal relationships involving dating partners, spouses, boyfriends/girlfriends, and sexual partners, and can include a range of behaviors including stalking, psychological aggression, physical violence, economic controlling behavior, and sexual violence (Breiding et al. 2015).

Stalking is defined as “a pattern of repeated, unwanted, attention and contact that causes fear or concern for one’s own safety or the safety of someone else” (Breiding et al. 2015). Stalking behaviors include unwanted communication; watching, following or spying; unexpected visits or leaving objects; damaging possessions or property; and threats of harm. Psychological aggression “includes expressive aggression (such as name calling, insulting or humiliating an intimate partner) and coercive control, which includes behaviors that are intended to monitor and control or threaten an intimate partner” (Smith, 2018).

Physical Violence involves “the intentional use of physical force with the potential for causing death, disability, injury, or harm,” and can involve using one’s body size or strength, weapons, or restraints against another individual (Breiding et al. 2015). Sexual violence involves sexual acts “committed or attempted by another person without” the free consent of the other person or if the person is incapacitated and is unable to refuse or consent (Breiding et al. 2015). Both physical and sexual violence also include being coerced to commit acts against others or involving others.

Findings from a 2015 survey (Smith, 2018), show that during their lifetime over a third of women (36.4%, 43.5 million) living in the United States experience psychological aggression, 30.6% experience physical violence, 18.3% experience sexual violence with contact, and 10.4% experience stalking.
Although many types of individuals experience IPV, rates of IPV differ by race/ethnicity. Lifetime prevalence of rape, physical violence, and stalking are higher for Native American Women (37.5%), Black Women (29.1%), and Latinas (23.4%) compared to their White (24.8%) and Asian/Pacific Islander (15.0%) counterparts (American Psychiatric Association, 2020). Other at-risk groups include those who have low income or low educational attainment or who are unemployed, individuals who had adverse childhood experiences (ACEs), are younger, or are a member of a sexual minority.

IPV adversely impacts physical and mental health. About two out of every five (41%) of female IPV survivors had a physical injury, and over 40% of female homicides are the committed by their partners (Niolon, 2017). Physical effects can include gastrointestinal symptoms, chronic pain, headaches, cardiovascular issues, traumatic brain injuries, choking, musculoskeletal injuries, nervous system damage, unplanned pregnancies and pregnancy complications, and exposure to STDS (American Psychiatric Association, 2020, Niolon, 2017).

Mental health effects can include depression, anxiety, PTSD, and substance use (American Psychiatric Association, 2020; Niolon, 2017). About 52% of women who complete surveys report PTSD symptoms as a result of physical violence, sexual violence, or stalking (Smith et al., 2017). Other impacts included feeling fearful (62%), being concerned for one’s safety (57%), missing at least one day of school or work (25%), and needing medical care (19%).

According to the CDC (Niolon 2017, CDC 2019) prevention involves
- “Promoting healthy, respectful and nonviolent relationships,
- Educating youth and couples on healthy relationships,
- Educating community members on how to help,
- Disrupting trajectories that lead to IPV through parenting and family support programs, promoting early intervention in abusive environments,
- Creating protective environments in schools and communities,
- Strengthening economic supports for families,
- Supporting survivors to increase safety and lessen harassment.”
Conclusions and Overall Recommendations

The World Health Organization (WHO) stated that violence against women is a public health issue and a “violation of women's human rights.” Whatever form this violence takes, including the issues of sexual assault, sexual harassment, and IPV covered in this section, the physical, psychological, and chronic repercussions are similar and devastating.

Final recommendations for eliminating and reducing the effects of violence against women (GBV) include the following:

1. Laws must be passed clearly defining the prohibited behavior, and the laws must be enforced. Perpetrators of the three types of violence must be prosecuted effectively. A consideration of extending the statute of limitations for these prohibited acts should be examined.

2. Victims or survivors should be interviewed by police officers (or in the case of sexual harassment, by HR personnel) in a nonjudgmental manner, and support service personnel as well as police should be trained to listen to victims. Procedures for reporting sexual harassment should be made accessible and easier with no retaliation for reports.

3. Cultures must be changed. If a “rape culture” exists, or one dismissive of sexual harassment and IPV is prevalent, these cultures should be changed. Rape myths and other false ideas should be debunked by psychologists. Social media platforms should be encouraged to identify and ban posts encouraging violence against women. Films and streaming programs sometimes portray brutalizing, degrading, and disrespectful comments and actions against women, creating a culture of legitimizing violence against women.

4. Programs targeting identified perpetrators should be established and evaluated for effectiveness. For those serial perpetrators who use violent means in their attacks, more intensive prevention programs would be necessary.

5. Early intervention at young ages should be developed to teach boys and girls how to interact in relationships free of violence.

6. Gender needs to be considered in responding to health crises like COVID19 as strategies used to stem the spread of disease can also increase the likelihood of violence.
Expanding the number of and access to safe residences and increasing awareness of available resources such as hotlines or other ways to safely report violence and potential interventions are critical.

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Religious Based Hate Crimes and Violence

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This section reviews the historical and legal framework for religious protections, groups affected by religious hate crimes, common characteristics of offenders and victims, media’s role, and the relative cost to society of such hate crimes. Recommendations are provided for policy makers in the concluding statements.

Legal and Historical Perspectives

The U.S. Constitution emphasizes the importance of freedom of religious expression (First Amendment, U.S. Constitution, 1791) and includes the provision that “No religious Test shall ever be required as a Qualification to any Office or public Trust under the United States” (Article VI, U.S. Constitution, 17910). This provision provides a clear separation between Church and State. Although these laws offer some religious protection, they do not address the consequences when religious expression is infringed upon through the violence and persecution.

Title I of the Civil Rights Act (1968) was crafted for federal prosecution of individuals “who willingly injures, intimidates or interferes with another person, or attempts to do so, by force because of the other person’s . . . religion.” Subsequent laws were introduced to increase the penalties for hate crimes (Violent Crime Control and Law Enforcement Act, 1994) and/or damaging religious property (Church Arson Prevention Act, 1996) to further clarify the original Civil Rights Act of 1968. Nevertheless, hate crimes laws related to prosecution of individuals who perpetrate religious hate crimes vary from state to state. For example, Arkansas, Georgia, Indiana, South Carolina, and Wyoming don’t have state laws protecting religious groups from hate crimes (Anti-Defamation League [ADL], 2019). However, even with the laws designed to protect religious communities, violence has become a frequent occurrence. Examples include the massacres that occurred at the Emanuel African Methodist Episcopal Church (2015 in South Carolina), the Tree of Life Synagogue (2018 in Pennsylvania), and the Chapel Hill murders (2015 in North Carolina).
In New York State, Penal Codes 485.00, 485.05 and 485.10 provide a mechanism for criminal prosecution of hate crimes and Penal Code 240.31 allows prosecution for aggravated harassment against people or damage to houses of worship. Civil actions are pursuant of Civil Rights Law 79-N. Section 837 of NY Executive Case Law, which empowers agencies to collect data on religious hate crimes.

In New York State, religious communities experience murder, assault, and defacement of property based on religious biases at alarming rates. For example, in a recent attack, a knife-wielding man entered a Rabbi’s house in Monsey, New York, yelled anti-Semitic epithets, and injured five participants at a Chanukah party (December 28, 2018). A second example: a Muslim MTA worker was pushed down the stairs, called “a terrorist,” and told she shouldn’t be working for the city” (December 5, 2016). Religious hate crimes have steadily increased since a low point in 2014.

Groups Affected

The Federal Bureau of Investigations’ (FBI) reporting classification system was relatively limited, but its statistics have become more nuanced over time. As can be seen in Figure 1, anti-Jewish, anti-Muslim, anti-Christian, anti-Other Religion, and Total Hate crimes have been on the rise since 2014. For the purpose of consistency with earlier reports, anti-Mormon, anti-Jehovah’s Witness, and anti-Other Christian were re-aggregated into anti-Christian Hate Crimes; anti-Buddhist; anti-Hindu, and anti-Sikh hate crimes were re-aggregated into anti-Other Religion hate crimes in this figure. However, more detailed analyses of these groups are provided in the next section, when discussing specific victims of religious hate crimes. No notable trends were found when examining hate crimes towards members of multiple faiths or secular individuals. Thus they will be excluded from further analysis.
Several governmental and non-governmental organizations track hate crimes in the United States. In addition to the FBI’s reporting statistics, the Anti-Defamation League (ADL) has also collected data on anti-Semitic incidents since 1979. Finally, the Southern Poverty Law Center (SLPC) has tracked the number of hate groups across the United States. The SPLC (2019) estimated that there were over 1000 hate groups identified throughout the United States.
Perpetrators

Demographics Variables
According to Cheng (2013), the relevant factors linked to perpetrators of hate crimes include the perpetrator’s age, gender, and ethnicity. More specifically, perpetrators tend to be young, White males. Cheng (2013) notes that those who were members of a hate group had a higher probability of being perpetrators of a hate crime. Using a special distributed lag model, Jendryke and McClure (2019) found that roughly 40% of hate crimes were directly linked with the geographic location of hate groups. Moreover, they found that urban areas tended to account for the greater than predicted frequency of hate crimes. Similar data revealed that religiously motivated hate crimes on college campuses occurred more often in larger cities as opposed to suburban and rural communities (U.S. Department of Education, 2019).

Hate Group Membership
It is important to be aware of the number of hate groups in America. In a 2019 report, the SPLC identified 1020 active hate groups and divided them by type. In this intelligence report, they identified the following hate groups: 51 Ku Klux Klan, 112 Neo-Nazi, 148 White Nationalist, 63 Racist Skinhead, 17 Christian Identity, 36 Neo-Confederate, 264 Black Nationalist, 17 Anti-Immigrant, 49 Anti-LGBT, 100 Anti-Muslim, and 163 General (SPLC, 2019). Per the SPLC, 2018 was the year with the largest number of hate groups in the past two decades.

Personality Factors
Cheng (2013) also noted several personality characteristics of religiously motivated hate crimes. These individuals scored high in outgroup prejudice, aggressiveness, social dominance, and right-wing authoritarianism (RWA), and were more likely to be perpetrators of hate crimes. Johnson et al. (2012) found RWA mediated the relationship between religious fundamentalism and hateful beliefs.

Victims

Anti-Jewish Attitudes
The Anti-Defamation League’s Global 100 international survey described 11 commonly held negative stereotypes towards Jewish individuals (e.g., Jews have too much power in international financial markets, Jews have too much control over the global media). For individuals to be con-
sidered as harboring anti-Semitic attitudes, they must strongly agree with a majority (6 or more) of the items. Worldwide, the ADL estimates that over one fourth of the world’s adult population (greater than 1 billion adults) harbor anti-Semitic attitudes. Regionally, the Americas are the second lowest area, trailing only the Oceanic countries. The United States, relative to other countries and regions of the world, scores fairly low on anti-Semitic attitudes with an estimated 10% of its adult population. Nevertheless, this equates to over 22 million Americans.

**Anti-Jewish Violence and Hate**

A careful inspection of the FBI statistics reveals several noteworthy findings. The first result was that anti-Jewish hate crimes are consistently experienced at disproportionately high rates relative to all other religious groups. The FBI data indicate a high point in 1999 (with 1289 victims, a general downward trend until 2014 (with 648 victims), and a reversal of this trend from 2015-2018, as can be seen in Figure 1. Similar results were found using the ADL data (Cohen et al., 2016; Kaplin, 2017). According to the ADL, the number of anti-Semitic hate crimes in 2017 and 2018 were the second and third highest in reporting history relative to the high-water mark of 2066 in 1994.

**Anti-Muslim Violence and Hate**

Religiously motivated hate crimes are linked to the experiences of the nation. For example, if one were to look at anti-Muslim incidents before and after the September 11, 2001, a marked shift in anti-Muslim hate crimes emerges. Between 1995-2000, anti-Muslim hate crimes never reached 50. However, in the years that followed, anti-Muslim hate crimes spiked to several hundred. In general, anti-Muslim hate crimes remain only second to anti-Jewish hate crimes. Moreover, it is reasonable to believe that anti-Muslim hate crimes are underreported due to the level of surveillance of the community. The number of anti-Muslim hate crimes was at historic highs in 2015-2018, with only 2001 having higher rates of anti-Muslim incidents.

**Anti-Christian Hate Crimes**

While identifying as Christian makes one a religious majority in the Unites States, it does not make a person immune to religious hate crimes. Anti-Christian hate crimes have also been on the rise in 2015-2018. This finding could be a result of the FBI including hate crimes among non-Catholic and Protestant denominational groups. Interestingly, in 2001, anti-Christian hate crimes were at an all-time low with only 76 hate crimes. This is noteworthy because, as discussed above, that year was marked with all-time highs in anti-Muslim hate crimes. This should be con-
trasted with the all-time highs depicted in 2017 (203 victims) and 2018 (198 victims).
It is important to note that prior to 2015, Christian hate crimes were either categorized as either anti-Catholic or anti-Protestant hate crimes. Interestingly, anti-Catholic hate crimes appear to be increasing slightly, whereas anti-Protestant hate crimes appear to be declining. Afterwards, several additional Christian groups were added to the FBI reporting. Because these data were only collected in the current political climate and there are relatively few data points, it is difficult to interpret these data with confidence. Nevertheless, preliminary trends suggest that anti-Mormon, anti-Jehovah’s Witness, and anti-Other Christian group hate crimes have had a slight increase, whereas anti-Orthodox Christian hate crimes appear to be on the decline.

**Anti-Other Religious Groups**

From 1995-2014, many groups were clustered into a “other religions” category. This included Mormons, Jehovah’s Witness, Orthodox Christians, and other miscellaneous Christians, as indicated above. Moreover, this category included members of the Sikh, Hindu, and Buddhist communities. Using the framework that the FBI used from 1995-2014 and extrapolating it to 2015-2018, we once again see a rise in hate crimes from 112 in 2016 to 203 in 2018.

**Anti-Sikh, Hindu, and Buddhist Violence and Hate**

One critical challenge with the FBI reporting statistics, as noted above, is that Sikh, Hindu, and Buddhist religions were not represented. Unfortunately, South Asian religious minorities became more vulnerable to racial discrimination and racial profiling as a function of the September 11, 2001, terror attacks (Abdelkader, 2014; Ahluwalia, 2011; Prashad, 2005; Puar & Rai, 2004). Sikhs were targeted on their streets and attacked, which led to injuries and deaths (Ahluwalia, 2011; Ahluwalia & Pelletiere, 2010; Mishra, 2013; Puar & Rai, 2004). A famous example was Balbir Singh Sodhi, a Sikh-American gas station owner who was brutally murdered days after September 11th. The perpetrator of this crime reportedly stated, “going to go out and shoot some towel-heads” the day before the incident (Kaur, 2016). In addition, many children were physically and verbally abused by their schoolmates (Bajaj, Ghaffar-Kucher, & Desai, 2016). Yet, by collapsing these data into the “anti-Other” religious group, this did little to address the needs of Sikh, Hindu, and Buddhists, as religious minorities.

Anti-Sikh sentiment was on the rise from 6 victims in 2015 to 69 victims in 2018. This reflects
the sharpest increase of the three groups. Anti-Hindu (from 5 victims in 2015 to 14 victims in 2018) and Buddhist (from 1 victim in 2015 to 11 victims in 2018) had negligible gains across the four years data have been collected. Similar to the Other Christian groups added in 2015, it is difficult to interpret these data with confidence.

The Role of the Media

The media play an instrumental role in disseminating information to the general public. However, if the media allow sensationalized language to exaggerate the homogeneity, militancy, and violence of Muslims, it could distort how a community is portrayed (Bahfen, 2018). In one study, Samaie and Malmir (2017) examined the media’s portrayal of Muslims and Islam between 2001-2015. The authors reported that the media consistently used terms like “violent,” “religious radicalism,” and “Islamic extremist” when describing the Muslim community. The use of these words, specifically when discussing Muslims, reinforces tropes against the Muslim community. They do not reflect the fullness of tradition and rich values of the Muslim community. Moreover, this pattern could result in increased hate crimes against the community. For example, Mahmood (2012) found direct connections between the national rhetoric and anti-Sikh hate crimes following the September 11, 2001, attacks.

Another mechanism for promoting religious hate speech is social media. Cyber hate speech is a commonly used mechanism of the Alt Right movement (Jakubowicz, 2017). The mischaracterization of religious groups creates polarization and inter-group conflict, and predisposes society towards violence (Grambo, 2019; Portilla, 2018). This violence has resulted in discussions about the limits to free speech laws (Beausoleil, 2019; Citron, 2014; Grambo, 2019). While the United States protects all speech (including hate speech), international law does not do the same (Sangsuvan, 2014). As a result, technology companies are challenged to monitor and remove objectionable and malicious content from their sites (Wright, 2017). Ozalp et al. (2019) tracked anti-Semitic hate speech and potential organization-based interventions via Twitter. These authors stress the need for anti-hate organizations to counteract hate rhetoric through tweeting positive information. More specifically, Ozalp et al. (2019) found that tweeting positive information resulted in more frequent retweeting and longer persistence on social media. This points to another potential way to counteract hate speech.
Health Outcomes Related to Religious Hatred

The American College of Physicians (2017) stated that hate crimes are a growing public health problem. Discrimination results in a wide variety of physical outcomes such as coronary artery calcification, high levels of C-reactive protein, high blood pressure, low-birth-weight infants, cognitive impairment, poor sleep, visceral fat, and mortality (Paradies et al. 2013, 2015; Samari et al., 2018). In addition, advocacy for religious minorities could result in a person being the victim of physical violence (Hoefer, 2019).

Religious minorities report higher levels of sadness, fear, isolation, depression, worry, loss of safety, and anxiety as a result of harassment, verbal abuse, and physical assault (Abu-Ras, Suarez & Abu-Bader, 2018; Hodge, Zidan, & Husain, 2016; Kunst, Tajamal, Sam, Ulleberg, 2012; Sway, 2005). Discrimination results in depression, psychological distress, anxiety, and substance abuse (Paradies et al. 2013, 2015; Sameri et al., 2018). At the same time, religious minorities are less likely to seek mental health treatment (Amri & Bemak, 2012; Padela & Zaidi, 2018).

Summary of Recommendations

Based on the aforementioned information, we make the following recommendations to legislators and policy makers:

1. Government officials should condemn all forms of religious hate crimes and discrimination.
2. Government officials should further coordinate with anti-discrimination groups such as the Anti-Defamation League, Southern Poverty Law Center, and the Institute for Social Policy and Understanding.
3. Initiate or increase school-based funding to reduce the various forms or religious hate that occurs in schools and universities.
4. Undertake outreach to affected religious communities which experience various forms of hate.
5. Increase interfaith dialogue to aid in awareness and tolerance of religious minorities.
6. Study the role that media plays in the propagation of religious hate crimes.
7. Provide additional funding to support free or low-cost physical and mental healthcare for those adversely affected by religious hate crimes.
8. Coordinate further with psychologists to better understand the motives of perpetrators of hate and to improve treatment outcomes.
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Racialized Violence and Hate Crimes

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The American Psychological Association (APA) has maintained a commitment to racial and ethnic equality (APA Taskforce on Race and Ethnicity Guidelines in Psychology, 2019), resolving to support the promotion of “organizational equity and well-being within organizations and communities inside the discipline, as well as outside of the discipline through organizational consultation and advocacy” (p.15). Their commitment extends to psychologists on matters relating to victims of violence and supports efforts to eliminate violent crime, along with “the policies that perpetuate them” (Paige, 2005). Furthermore, the APA drafted a resolution regarding its position on firearms violence and prevention (APA, 2014). The resolution included three guiding principles: (1) implementing a ‘science-based public health strategy; (2) acknowledging that firearms violence affects different populations differently, and; (3) implementing use of comprehensive mental health services to address the mental health needs of perpetrators.

For a significant portion of violent acts, diagnostic criteria for mental disorder illness do not apply. Rather, moments of acute personal distress or crisis can lead to an act of violence (APA, 2014). Psychologists who understand race and ethnicity can apply that knowledge to community-based gun violence. But they must also consider the “pandemic” of racism specifically related to anti-Black violence that leads not only to increased rates of mortality, but also to direct and vicarious traumas (APA, 2020). According to 2018 FBI hate crimes reports, approximately 60% of single-bias hate crimes targeted victims because of their race or ethnicity; of those, 47% of the victims were African Americans. Thus, relative to their portion of the U.S. population, African Americans, more than any other group, are victimized by hate crimes (U.S. Department of Justice, 2018a). Racism and racism-related stress, combined with direct and vicarious exposure to violence, increases levels of violence perpetration, violence victimization, and violence-related trauma among African Americans.
Race, Racism, and Violence: Definitions

Racism can be defined as a system of oppression by a dominant group over a non-dominant or marginalized group. The dominant group utilizes its power to provide resources to its own racial group while denying those resources to marginalized racial groups. Individually and culturally, White people engage in both microaggressions and racially-traumatic acts as a means to enforce White superiority and cultural dominance (Liu, Liu, Garrison, Kim, Chan, Ho, & Yeung, 2019). Anti-Black racism has been strongly and clearly implicated as the cause of violent civil disorder in African American communities in the 1960s. The Kerner Commission Report (National Advisory Commission on Civil Disorders [NACCD], 1967), ordered by then-president Lyndon B. Johnson, concluded that structural racism, including discriminatory policing, as well as residential and economic discrimination, led to the formation and maintenance of ghettos characterized by relatively low levels of homeownership, employment, and education. Combined, those forces negatively impacted police/community relations. The institutional and systemic racism that contributed to civil unrest in the 1960’s persist to the present day (Kinder & Drake, 2009).

Unlike stereotyping, prejudice, and discrimination, racism refers specifically to unfair and unequal dynamics between dominant and non-dominant groups (Harrell, 2000). Racism can take individual, cultural, and institutional forms (Jones, 1997). Individual racism (carried out by single individuals) serves as the foundation of cultural and systemic racism, as individuals enact culturally-consistent values and systems which require participants and workers to implement racist policies and practices. Individual racist acts reflect internalized racist beliefs and result in the target’s experiencing lower mental and physical health outcomes. Well-being and personal capital decrease insofar as access to dominant-group power decreases. Social and economic marginalization, combined with persistent experiences of racial discrimination, helps explain how racism-related stress (Harrell, 2000; Utsey, Chad, Brown, & Kelly, 2002) may contribute to the very behaviors law enforcement agencies seek to suppress.

Individual Racism: An example of individual racism would be a loan officer who, bombarded with exposure to racially-denigrating media representations of African Americans, internalizes racist beliefs about African Americans being lazy, and denies an African American applicant a loan based on the applicant’s racial group membership. Consciously or not, that loan officer’s racist attitudes, coupled with their institutional power, can result in institutional policies that negatively impact African Americans. Psychologists argue that often individual racist attitudes underscore implicit biases, attitudes and beliefs toward or against a group that is outside the con-
conscious awareness of the individual perpetrator (Greenwald, McGhee, Joy-Gaba, & Nosek, 2010; Kurdi, Seitchick, Axt, Carroll, Karapetyan, Kaushik, Tomezsko, Greenwald, & Banaji, 2019). Thus, racial residential and school segregation is a consequence of individual, cultural, and institutional racism. Furthermore, as indicated in the Kerner Commission Report (NACCD, 1967), the maintenance of low-income Black ghettos is directly related to racial violence.

**Cultural Racism:** Cultural racism is enacted as a result of having internalized attitudes and practices considered superior to, and having more value than, that of non-dominant racial groups. A timely example of cultural racism includes the widely-reported events experienced by DeAndre Arnold, a Trinidadian high school student, threatened with being unable to participate in his graduation ceremony unless he cut his hair (USA Today, January, 2020). His hair was worn in dreadlocks, consistent with his Caribbean cultural background. School officials, nonetheless, maintained that the high school rule policy was applied as usual, rather than as an act of racial discrimination. Even if unintentional in its creation and maintenance, the school’s hair length rule policy exemplifies cultural racism. The combined racial and power imbalance not only involved cultural bias, it is also related to institutional racism insofar as the administrators referred to a specific institutional (school) policy. Institutional racism, therefore, can serve as both a cause and an effect of cultural racism, as individuals carry their personal and cultural values into the workplace at all levels. Cultural biases, prejudices, and discriminatory practices influence the policies and practices of institutions such as schools, hospitals, law enforcement agencies, and legislative bodies.

**Institutional Racism:** Once adopted, interrelated institutional objectives that result in persistent, discriminatory, and harmful outcomes is referred to as systemic racism. While institutional racism refers to the operation of a specific organizational entity (e.g., a corporation, industry trade group, or legislative body), systemic racism refers to interlocking processes and mechanisms of power driven by individuals and institutions alike that by their mere existence can oppress, denigrate, and destroy aspects of the non-dominant culture. Structural inequities are both the cause and consequence of a broad number of racial disparities in educational attainment, employment status, annual income, net worth, health status, and incarceration rates. The school-to-prison pipeline (Mallett, 2016) reflects systemic racism insofar as various institutions (e.g., education, law enforcement, and government) operate, often without an awareness of their impact, to deny opportunities and resources to members of the non-dominant group.
Hardeman and colleagues (2016) urge their fellow medical professionals to confront the realities of systemic racism. They make five main points as guidance: (1) understand racism in America from a historical perspective; (2) understand how health disparities are shaped by racism; (3) become familiar with the basic meanings of race and racism; (4) move beyond considerations of racial categorization into explorations of racism as processes and systems; and (5) “center at the margins,” i.e., strive to position non-dominant group voices at the center of discourse.

The co-occurrence of high levels of violence along with a limited level of access to mental health care often manifests as unmet mental health care need. It is important to consider the combination of individual, cultural, institutional, and systemic racism and sociodemographic, health status, and health insurance status variables as reasons for having unmet mental health needs (Alang, 2019). African Americans are twice as likely than members of other racial or ethnic groups to report they did not get the mental health treatment they needed (referred to as “unmet need”). In terms of frequency, the cost of treatment or lack of insurance were the most cited reasons for having unmet needs. This was followed by minimizing the need for treatment, experiencing barriers to accessing treatment, seeking to avoid being stigmatized for having a mental health need, and perceiving that treatment would not be effective. Double-discrimination (i.e., facing discrimination based on race and carrying mental disorder diagnoses), “institutional mistrust,” and racial microaggressions were also noted as concerns among African American mental health care seekers (Alang, 2019).

Individual, cultural, institutional, and systemic racism underlies and fuels ethnoviolence, that is, violence enacted to manipulate, exploit, and destroy individuals, cultural resources, and institutions of a non-dominant and despised racial group (Helms, Nicolas, & Green, 2010). Ethnoviolence is “violence and intimidation directed at members of ethnic groups that have been marginalized and stigmatized by the dominant or host culture because their inability or unwillingness to assimilate threatens the dominant group’s entitlement to society or community resources (Helms, Nicolas, & Green, 2010; p. 54).”

Mass incarceration is a form of racialized violence that affects not only the convicted perpetrator, but also the communities faced with lowered levels of social and economic capital. Lengthy sentences, often for non-violent crimes, are associated with measures of social disorganization predictive of increased potential for violence. Instability in families and child behavior problems
increase under such conditions (Meuntner, et al., 2019), despite the fact that longer sentences (< 2 years) tend not to result in further decreases in recidivism. In fact, lengthy prison sentences may increase likelihood of more criminal behavior (Mears, Cochran, Bales, & Bhatt, 2016).

In the United States, over 600,000 prison inmates are released each year (U.S. DOJ, 2020). Most of these individuals lack the social and psychological resources to re-integrate into society. Joblessness and homelessness, instead, lead them to commit additional crimes concentrated in their respective local communities. Given the relatively high rates of incarceration of African American males, Black communities are tasked with managing social and economic strains while mitigating the associated potential for violence (U.S. DOJ, 2020). Reentry challenges also can lead to anxiety and desperation. In a qualitative study examining men’s post-incarceration reentry strategies, a recently-released 30-year-old African American man stated:

“I know I want to change. I just didn’t know how. And everybody kept throwing my past in my face. Never give me no opportunity, never helped me. No, nothing. So, yea, I went back to the streets. Went back to the streets, got caught up (Palmer & Christian, 2019; p. 590).”

Racism and ethnoviolence can result in race-based trauma syndromes that due to their invisibility, subjective nature, or subtlety are difficult to observe and measure using traditional psychometric approaches (Helms, Nicolas, & Green, 2010). Nicolas (2019) describes a similar construct, racialized violence, a “phenomenon that not only results in harming and ending Black lives but also obstructs liberation and psychological well-being of Black people around the world (p. 587).” Racialized violence can be physical, emotional, or structural. Physical violence is the most serious race-related stressor (Carter, 2007) and racially-motivated hate crimes are the most salient, impactful, and traumatic of violent crimes (APA, 2020). The pernicious nature of hate crimes is related to their ability to destabilize the “core aspects of identity” of their targets. Racially-motivated violence is uniquely traumatic for African Americans (Carter, 2007; Helms et al., 2010). Moreover, exposure to viral video recordings of police killings of unarmed African Americans results in widely-distributed racialized violence exposure reverberating psychologically and geographically in a “spillover effect” (Bor, et al, 2018), further contributing to mental health disparities and negative physical health outcomes in marginalized, largely urban, Black communities.
Concentrated violence, especially gun violence in African American communities, should not be seen as a phenomenon caused by an inherently dysfunctional African American culture. Rather, the scourge of gun violence can be seen as part of a large multinational trend. Specifically, out of the 50 most violent cities in the world, 47 are located in the Western Hemisphere and require regional and global cooperation (Carbonari, 2018). It is projected that homicide rates in the Americas will reach 39.6 per 100,000 inhabitants by the year 2030, a rate over 10 times as large as the rate among continental Africans, 16 times as large as found in Asia, 23 times as large as Europe’s rate, and 5 times as large as the global rate of 7.9 per 100,000 individuals. Despite the cultural and geographic differences within the Americas, certain similarities in victim and perpetrator variables may be found, including the overrepresentation of male victims, and the presence of poverty, poor educational attainment, and social inequality. Among these victims, individuals of African descent are overrepresented. For example, Chicago’s 2016 statistics report a 14.1 per 100,000 homicide rate for Whites, compared to a rate of over 388 per 100,000 for African Americans, a homicide victimization rate 27.5 times higher (Carbonari, 2018).

Youth and Young Adult Violence

Statistics, Risk Factors, and Consequences
Exposure to violence (ETV) “includes both direct victimization and indirect exposure through witnessing a violent act and can occur across multiple settings, including family, school, and community environments (Dusing, DiClemente, Miller, Onyeka, Murphy, Richards, & Moore, 2019; p. 653).” Wallace et al. (2018) concluded that risk factors for African American youth and young adult violence can be explained by a combination of individual, family, peer/social, and community risk factors. Black children’s experiences with violence is shockingly widespread and associated with internalizing symptoms such as anxiety and depression (Cooley, et. al, 2019) as well as externalizing symptoms such as aggression (Dusing et al., 2019). In a study by Cooley, Ritzel, Fraser, & Blossom (2019), 95% of African American children reported witnessing at least one act of community violence (approximately 2.5 times the national average). These youth also reported witnessing serious acts of violence at alarmingly high rates: physical assault (84%), robbery (50%), seeing a dead body (42%), and murder (31%).

Using data from the National Vital Statistics System and the National Crime Victimization Survey, Sheats, and colleagues (2018) uncovered elevated rates of violence exposure as well as disparities in reported victimization by violence attributed to both race and sex. Homicide was
the leading cause of death for Black males aged 10-34 years old, accounting for 41.2% of all deaths; it was the second leading cause of death for Black females, accounting for 11.7% of their deaths. By contrast, homicide was the fifth leading cause of deaths for both White males and White females. Black-White violence disparities increase as a function of crime severity level, with the disparity in victimization by violence greatest for homicide. Rates of aggravated assault were significantly higher for Blacks than Whites, regardless of sex. Black females were victims of aggravated assault at a rate nearly twice that of White females. Interestingly, there were no statistical disparities in aggravated assault between Black and White males, nor were there any disparities at all between African Americans and Whites in simple assault victimization.

Repeated and pervasive exposures to violence (especially when the perpetrator is a family member) is associated with children's beliefs that violence is acceptable and normal, increasing the likelihood of them committing aggressive acts. Violence exposure is an example of an Adverse Childhood Experience (ACE): “potentially traumatic events that occur in childhood (0-17 years) such as experiencing violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die by suicide (National Center for Injury Prevention and Control, 2019; p. 7).” Presence of reported ACEs is associated with reduced levels of well-being and physical health; incremental increases in ACEs are correlated with lasting negative effects on health, maladaptive behaviors, and life potential (National Center for Injury Prevention and Control, 2019). Experiences of adverse childhood circumstances, especially violence, are at the center of African American youth's likelihood of being violently victimized, being a perpetrator of violence, or both.

For African American youth and young adults discrimination and economic stress are implicated in violence exposure and racial disparities in violence experiences (Sanchez, Lambert, & Coolsey-Strickland, 2013; Sheats, Irving, Mercy, Simon, & Crosby, 2018). Sanchez and colleagues (2013) concluded that African American boys and girls report equal frequencies in experiencing violence. Yet, consistent with broad research findings, boys experience more externalizing symptoms than girls, who experience more internalizing symptoms relative to their male peers. Economic stress, discrimination, and experiences with violence were correlated with each other and each type of life event was correlated with both internalizing and externalizing behaviors. There is evidence that experiencing violence is predictive of engaging in future violent behavior. Markers of systemic racism, discrimination, and economic pressures are most strongly associated with internalizing symptoms while violence exposure is associated with externalizing behaviors (Sanchez, et al., 2013; p. 430).
Violence victimization disparities may best be understood as a function of socioeconomic disparities attributable to the clustering of poverty combined with violence associated with systematic racial segregation (Sheats et al., 2018). Structural inequalities including spatially-concentrated poverty and violence are typically found in areas with the highest concentrations of African American residents, “plac[ing] Black residents at greater risk for trauma from violence exposure and lowered resiliency relating to stress (Garo, 2019; p. 261).” Not only do African American boys suffer from a higher risk of community-based trauma, they also are overrepresented among those facing harsh disciplinary consequences at school. Social frustrations resulting from structural inequalities are often acted out as aggressive behaviors that contribute to cycles of hostility between school-based law enforcement and African American children (Garo, Allen-Handy, & Lewis, 2019). Trauma and strain theory, as applied to African American youth violence, suggests that psychological trauma is a cause of violent externalizing behaviors at home and school.

**Law Enforcement in the Schools**

Systemic racism contributes to exposure of African American youth to disproportionately high levels of violence exposure, trauma, and law enforcement contact. Educational institutions represent a critical social context in which Black children's mental health outcomes are either positively or negatively impacted. Therefore, an examination of violence resulting from the trauma and strain experienced by African American children in schools is essential for understanding the causes and consequences of violence.

An estimated fourteen million United States students are in schools with a police presence but without the presence of either medical (school nurses) or mental health (counselors, social workers, school psychologists) staff (ACLU, 2019). Owing to implicit dehumanizing biases, African American children may not be afforded the empathy and nurturance afforded to their White peers, leading to increased police violence used against them (Goff, Jackson, Di Leone, Culotta, & DiTomasso, 2014). These authors also found that relative to their age mates, Black children are seen as several years older than White children, exposing Black youth to criminal justice system perceptions that they are less innocent and more culpable for their crimes than are White youth of the same age. Racial disparities in adult arrest rates can be reduced if racial disparities in school-based punishments are reduced (Barnes & Motz, 2018), hence supporting the concept of a “school-to-prison pipeline.”
African American students report subjective experiences of dehumanization in contact with law enforcement (Norbert, Crawford, Praetorius, & Hatcher, 2016). At the same time the bulk of students at public schools are becoming a majority ethnic minority (NCES, 2019), schools have increased the presence of law enforcement officers (ACLU, 2019). Law enforcement officers increasingly have replaced school counselors, social workers, and school psychologists as staff tasked with managing problematic student behavior. Moreover, the increased placement of law enforcement in schools is disproportionate to the seriousness of real and perceived school-based crime. Thus, criminalization and dehumanization of normal African American youth behaviors are disproportionately associated with “cascading effects that impact future involvement with the criminal justice system (Barnes & Motz, 2018; p.2329).”

Black youth have been identified as both victims and perpetrators of violence, as exposure to violence and a relative lack of interventions leave these children vulnerable to trauma (Jagers, Sydnor, Mouttapa, & Flay, 2007). In New York State, between the 2013 and 2015 school years, school arrests increased 23%. Overwhelmingly, offenses in the “serious” category did not involve weapons: 94 percent involve physical attack or assault without a weapon and threats of physical attack without a weapon (ACLU, 2019). Sexual assaults accounted for 1 percent, physical attacks or fights with a weapon amounted to 1 percent, robbery without a weapon comprised 2 percent, and possession of a firearm or explosive device was 2 percent. The disproportionate presence of armed law enforcement, relative to number of mental health support staff, and in the context of relatively limited serious offenses, suggests a pattern of over-policing in schools, especially the over-policing of African American children in urban public schools. It seems, therefore, there has been a depiction of African American schoolchildren as perpetrators of violent crime, not vulnerable victims who witnessed and experienced violence. As stated previously, this problem is compounded by a lack of access to trauma-focused mental health care in the schools.

Using 2015-2016 U.S. Department of Education’s Civil Rights Data Collection (CRDC) data, the ACLU compiled state-by-state statistics on student-to-school counselor ratios, student-to-school social worker-ratios, and student-to-school psychologist ratios. New York State did not meet recommended ratios for counselors or social workers, but was among a handful of states that met student-to-school psychologist recommended ratios. Compared to the recommended 250 students per school counselor recommendation, the national average was 444:1; New York State had 357:1. Compared to the recommended student-to-social worker ratio of 250:1, the national average was 2,106:1; New York State’s ratio was 773:1. Compared to the recommended 700:1 student-to-school psychologist ratio, the national average was 1,526:1; New York State had 648:1.
Overall, African American children have been overrepresented among those in contact with law enforcement in schools, facing school suspensions and expulsions for relatively minor infractions. Disparities in punishment also represent intersectional processes where multiple demographic vulnerabilities increase risk for unfair treatment (Crenshaw, 1991). For example, disability interacts with gender to increase this risk, as African American male children with disabilities and African American girls, relative to their non-disabled and male peers, respectively, face harsher punishments for similar infractions. In New York State, arrest rates were twice as numerous for Black girls than White girls (ACLU, 2019). Surprisingly, according to Bureau of Justice Statistics data (BJS, 2012), over 450,000 violent crimes in schools were not reported. It is unclear if these unreported crimes represent positive outcomes obtained without law enforcement intervention, or unreported and untreated violence victimization.

Combined, elevated levels of poverty, racism, and violence exposure are associated with self-harming and other-harming behaviors, disproportionately affecting Black boys, who are more likely than Black girls to harm others as expressions of their psychological distress (Sanchez, Lambert, & Cooley-Strickland, 2013). African American male schoolchildren are disproportionately identified as threats, disproportionately subject to disciplinary sanctions, and subject to punishments reflecting racial disparities compared to their White male peers. Across contexts, there exists a devastating impact of violence on Black youth and young adults aged 10-34, as violent victimization contributes to adverse childhood experiences particularly for members of the youngest half of that group. Communal (cultural) values and the capacity for empathy contribute to greater violence self-efficacy, which in turn leads to lower levels of violence reported by African American youth (Jagers et al., 2007). As a corrective, “trauma-sensitive practices blended with balanced cultural responsiveness” is recommended (Garo, et. al, 2019).

Additional interventions should include: (1) improving the economic conditions for African Americans living in poverty; (2) improving community infrastructure, services, and anti-violence norms in African American communities; (3) providing African American youth with connections to caring adults; (4) implementing culturally-sensitive school-based social skills programs; and (5) funding and maintaining hospital-based therapy programs capable of addressing the deleterious effects of violence-induced trauma (CDC, 2019).
Schools can play a vital and beneficial role in reducing the criminalization of childhood behaviors among African Americans and advocating for a justice and care model. To that end, the American Federation of Teachers (AFT, 2020) resolved to hold police in schools accountable for misconduct, separate school safety from policing, and support trained school staff to address the needs of children affected by violence and violence-related trauma.

**Community-based Police Violence**

The lawfulness of police-involved violence occurring in African American communities has been viewed with suspicion among community members. There is a belief that individual law enforcement officers (and the criminal justice system within which they work) are inherently unjust, racist, and discriminatory. Research used to understand these perceptions points to implicit dehumanizing biases White Americans hold against African Americans. Subtle racial biases, however, are difficult to detect (Nier & Gaertner, 2012) and, where present, they are difficult to modify (Joy-Gaba & Nosek, 2010). Nonetheless, the prevailing body of research leaves no doubt that humans are subject not only to controlled cognitive process, but also to automatic cognitive processes (Dovidio, Kawakami, Johnson, Johnson, & Howard, 1997). Implicit biases have been specifically linked to prejudicial behavior (McConnell & Liebold, 2001). In order to reduce implicit biases, “implicit bias training” is used to retrain or re-sensitize law enforcement officers who may be at risk for disproportionately applying their discretionary police power in a way that adversely impacts racial and ethnic minority groups.

Implicit biases (Greenwald, McGhee, & Schwartz, 1998) have been implicated in self-report and experimental studies demonstrating that anti-Black biases negatively and disproportionately impact African Americans in “decision to shoot” armed or unarmed Black targets. White law enforcement officers and White civilians are more likely to set a high standard of threat (exercise more restraint) when confronted with a decision to shoot a White suspect and set a low standard of threat (are more trigger happy) when faced with a Black suspect (Correll, Park, Judd, & Wittenbrink, 2007; Correll, Park, Judd, Wittenbrink, & Sadler, 2007).

Sadler, Correll, Park, and Judd (2012) found that a combination of variables, including amount of direct contact with African Americans, having anti-Black attitudes, and holding anti-Black stereotypes about aggressiveness and threat, leads to a biased “decision to shoot.” Specifically, the overestimation of violence, as opposed to objective levels of violence, are associated with anti-Black decisions to shoot. These tendencies are linked not only to implicit factors, but also
explicit awareness of racial identity, particularly in the presence of activated anti-Black stereotypes. Under conditions where racist stereotypes are evident, Whites who report “a high level of connection, belonging, and social value from being White (Johnson & Lecci, 2019; p. 39)” are less empathetic to Black targets. Whites who have lower levels of identification with “whiteness” were less affected by negative stereotypes of Blacks and were more empathetic to Black targets of police-involved shootings. In other words, implicit biases associated with shooting unarmed Black Americans reflect personally-held attitudes and beliefs enacted in specific contexts and scenarios wherein culturally-constructed stereotypes are present.

For centuries, African Americans historically have faced dehumanization (Gates, Jr., 2019) and have been the targets of “simianization” (making an equivalence between Blacks and apes), and “infrahumanization” (ascribing ‘primitive’ levels of emotional and cognitive abilities to Blacks). Goff and colleagues (2008) demonstrated that implicitly associating African Americans and apes results in increased agreement with law enforcement violence when the target is Black and increased the likelihood of agreeing with death penalty verdicts for African Americans. When the essential humanness of an individual is denied, that individual faces an increased likelihood for victimization. Dehumanization is a critical step in enabling amoral acts, allowing perpetrators of violence to rationalize their acts by minimizing the inherent human value of the target of the violence. Perpetrators or enablers of violence morally disengage, that is, they “decouple” their violent impulses from the normal violence-inhibiting cognitive processes of guilt and self-censure (Bandura, 2002). There also are racial disparities in dehumanization. Dehumanized Blacks are more likely than dehumanized Whites to be adversely impacted by law enforcement-related shooter bias (Mekawi, Breslin, & Hunter, 2019).

**Hate Crimes**

In 2018, racially-motivated victimizations were found to be the most common type of single-bias hate crime in the United States -- they constitute 59.6% of all hate crimes, more than three times the rate of the next highest category of hate crime, religious hate crimes. African Americans comprised 47.1% of all 5,155 victims of race/ethnicity/ancestry hate crimes, more than all other race/ethnicity/ancestry single-bias hate crime victim categories combined (U.S. Department of Justice, 2018a). African Americans were found to make up 24.0% of all hate crime offenders compared to Whites who comprised 53.6% of all hate crime offenders (U.S. Department of Justice, 2018b). A major category of growing terroristic threats to the United States, and to African Americans in particular, is from White Nationalist racists and far-right extremists (Bergen &
Salyk-Virk, 2019). The preferred weapons of choice appear to be firearms, rather than explosives. Whereas a combined 213 people were killed by terrorist groups described as ‘Far Right Wing (109)’ and ‘Jihadist (104)’, ‘Black Separatist/ Nationalist/ Supremacist’ groups were responsible for a total of eight deaths in the United States in 2018. White Nationalists and Jihadists, therefore, are responsible for a combined 26.6 times the number of terror-related deaths than Black Nationalists (Bergen & Salyk-Vick, 2019).

Notwithstanding the horrific nature of chattel slavery, post-Reconstruction (Redemption-era) racial violence evolved from “leaderless resistance” to more organized White supremacist vigilantism, historically exemplified by the Ku Klux Klan (KKK). The KKK, undoubtedly, was formed to violently reinforce a racially-hierarchical caste system with the intention of leaving African Americans without economic or political power (Du Bois, 1935/1998; Foner, 2005; Gates, Jr., 2019; Johnson, 2020). As violent as they were, the KKK nonetheless maintained a “ritualized and carnivalesque” quality that spoke to the dehumanizing objectification of the victims (Wilson, 2020). Such was the devaluing of Black lives and the need to demonstrate White superiority that, in 1916 in Waco, Texas, the dismemberment and burning of an African American teenager was attended by more than 15,000 bystanders (Wilson, 2020). Between January 1956 and June 1963, there were 138 bombings in the southern United States carried out by the KKK (Wilson, 2020).

**Conclusion: Violence Prevention and Intervention**

In its Gun Violence Prevention Resolution (APA, 2020), the American Psychological Association described three categories of gun violence prevention: primary, secondary, and tertiary. Primary prevention (universal prevention) refers to efforts to develop healthy environments and experiences for the general population. It reflects the existence of resources that facilitate the development of skills necessary for non-violent conflict resolution. Secondary prevention (selective prevention) requires identifying at-risk individuals and may include the provision of one-on-one support and community-based services. Culture-based models of violence prevention are effective in reducing violence. Wallace, McGee, Malone-Colon, and Boykin (2018) concluded that the combination of a strong racial identity, having community connections, and espousing a healthy spirituality, are associated with lower levels of violence. Translated into faith- and community-based social services, this culturally-responsive approach can serve as a tertiary prevention effort insofar as it reduces the harmful effects of violence.
Psychologists presently are unable to strongly predict the likelihood that an individual will commit a violent act. Some perpetrators act violently due to a pre-existing plan to inflict harm, while others act out violently because of an emergent emotional crisis. Accurate assessment of how dangerous a person is depends on “a range of personal, social, and situational factors that can lead to different forms of violent behavior in different circumstances (APA, 2020; p. 5).” Furthermore, APA (2014) advocates for policy makers to focus on encouraging and facilitating mental health service utilization and helping to reduce the stigma attached to mental illness and mental health care. Such efforts can be applied to primary, secondary, and tertiary prevention efforts.

Bast and DeSimone (2019) recommend a three-part strategy to counter youth involvement with violent gangs and terroristic organizations. The overarching principle is to make prevention and intervention efforts local and community-based. Violence prevention among youth involves:

1. early education to make children and educators more aware of “pathways to violence” and to instill in youth values for non-violent trajectories,
2. early intervention to redirect youth from pathways to violence,

Carbonari (2018) asserts that although violence prevention and intervention should be culture-specific and community-based, it also requires adopting a global perspective. This may especially be the case in the Western hemisphere where 47 of the world’s 50 most violent cities are located. Such initiatives typically involve a combination of “advocacy, technical assistance, capacity building, peer-to-peer exchanges, and funding of specific interventions” (Carbonari, 2018; p. 6). Doing so generally involves developing robust and sustainable regional and national networks of stakeholders. An expansive regional anti-violence agenda linking spatially-concentrated violence to underlying factors and solutions includes:

- implementing coordinated public-safety measures
- valuing community-based partnerships
- committing to political support across administrations and election cycles
- using data effectively
- interacting with municipal and regional peers with “transparency, candor, and humility”
- maintaining a focus on fairness, justice, and equity
- organizing all efforts to reduce lethal gun violence
Primary Prevention

Violence in African American communities is highly correlated with spatially-concentrated poverty. Therefore, identifying specific geographical locations (i.e., communities) with high levels of reported and unreported violence is a necessary step toward targeting social services to members of those communities. Schools also are important settings for primary prevention efforts. Providing high quality, universal, taxpayer-funded, primary, secondary, and post-secondary education to all students is essential for the healthy development of children, adolescents, and adults equipped to address local, regional, and global challenges impacting their families and communities. This may include outreach and enrichment for students to promote emotion regulation and anti-violence attitudes. It may also include training for community members deployed in interdisciplinary anti-violence teams in African American communities. To prevent African American youth violent assaults, the imbalance of law enforcement and school-based counseling must be reversed. Students need access to mental health care services, professional staff trained to meet the emotional needs of children, and psychologists who identify and assess mental disorders and emergent psychological crises in developing children. Armed law enforcement should be removed from schools, with budgets reallocated to staffing counselors, social workers, and psychologists at professionally-recommended provider-to-student ratios.

Secondary Prevention

Teachers, staff, and students should be required to demonstrate age-appropriate competencies in cultural diversity and anti-Black racism. Revisions to core public education curricula should include teaching emotion regulation, empathic understanding, and conflict resolution, as well as social and restorative justice. Funding initiatives that educate families about trauma and how it may be transmitted through violence exposure in their communities is an important, although neglected part of community-based mental health care. Doing so requires a commitment to funding community-based organizations staffed by culturally-competent psychologists and advocates that collect and use locally-relevant data to help members of local communities better understand their challenges and generate solutions. Community- and church-based laypersons may be trained in mental health screening and mental health first aid.

Tertiary Prevention

This form of prevention refers to efforts to “contain the damage” resulting from acts of violence that already had taken place. Tertiary prevention can include reducing the number of non-violent and first-time violent offenders facing incarceration. It is recommended that, where effective,
a combination of restorative justice programs, increased educational and employment resources, and community-based parenting skills programs should be fiscally supported. Educational, job-readiness, housing, and substance abuse avoidance and treatment programs should be offered at religious and other community-based organizations. Relationships among mental health care workers, medical practitioners, and social scientists should be strengthened and supported. By doing so, critical violence-related data can identify unmet need and tailor treatments deployed specifically with individuals and families in their respective communities. Psychologists, educators, policy-makers, and legislators, along with other elected and appointed officials, must demonstrate the will to reduce the occurrence of violence while simultaneously reducing suspensions and expulsions in public school settings and providing alternatives to the destructive revolving doors of incarceration.

Recommendations for Legislators and Policy Makers

1. Increase the reliability and transparency of New York State crime statistics, particularly those related to hate crimes.
2. Support funding for research to further explore the determinant and consequences of crime underreporting.
3. Require reporting of statistical data related to violence in institutional settings including, but not limited to correctional facilities, nursing homes, health care facilities, and foster care placements.
4. Replace school disciplinary officers with professionally-recommended levels of social service, medical, and mental health care providers.
5. Remove all armed law enforcement from schools.
7. Empower and fund community stakeholders in violence prevention and intervention efforts.
8. Take an interdisciplinary, regional, and global approach to anti-violence solutions.
10. Support legislation and policy aimed at reversing mass incarceration.
11. Use the best social science research to inform recidivism reduction and prisoner reentry programs.
12. Support legislation seeking to reduce violence perpetrated against the most vulnerable African American victim groups, including children, women, and the elderly.
13. Improve access to mental health services for victims of violence targeting African American sexual minorities.

References


Additional Resources

American Psychological Association ACT: Raising Safe Kids Program
https://www.apa.org/act

APA Public Interest Directorate Violence Prevention Office
https://www.apa.org/pi/prevent-violence

APA Office of Ethnic Minority Affairs
https://www.apa.org/pi/oema/index

The National Child Traumatic Stress Network
https://www.nctsn.org

National Center on Safe Supportive Learning Environments
https://safesupportivelearning.ed.gov/

Centers for Disease Control and Prevention Violence Prevention Technical Packages
https://www.cdc.gov/violenceprevention/pub/technical-packages.html

https://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_
Impact of Violence on LGBTQIA+ Communities

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LGBTQIA+ communities consist of people who identify as sexual minorities (e.g., bisexual, questioning, asexual), gender minorities (e.g., transgender, gender nonbinary), and as intersex (I). Societal discrimination and government protections, inconsistent and often inadequate, create varied needs and concerns among LGBTQIA+ communities. In this paper, we outline multiple ways violence impacts the psychological/physical well-being of LGBTQIA+ communities and identify recommendations to protect this marginalized population. We define violence as “immediate or chronic situations that result in injury to the psychological, social, or physical well-being of individuals or groups” (American Psychological Association, 1993).

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1 “LGBTQIA” stands for lesbian, gay, bisexual, transgender, questioning, intersex, and asexual. Often times LGBTQIA is frequently displayed as “LGBT.”
2 Gender and sexuality identities not captured through “LGBTQ” is often represented with a “+” (e.g., two-spirit, genderqueer; demisexual, pansexual).
3 “Queer” as a gender and/or a sexuality identity is sometimes included (e.g., LGBTQQIA+).
4 “[A]n umbrella term for persons whose gender identity, gender expression, or behavior does not conform to that typically associated with the sex to which they were assigned at birth.” (“Transgender People, Gender Identity and Gender Expression,” 2020)
5 “An adjective describing a person who does not identify exclusively as a man or a woman. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all non-binary people do.” (“Glossary of Terms,” 2020)
6 “An umbrella term that refers to a range of traits and conditions that cause individuals to be born with chromosomes, gonads, and/or genitals that vary from what is considered typical for female or male bodies. A former medical term, ‘intersex’ has been reclaimed by some as a personal and political identity.” (Human Rights Watch (HRW), 2017, p. 19)
Statistics

Housing and Shelter
Access to safe housing can be difficult for LGBTQIA+ communities. At present, 26 states and 5 territories have no explicit prohibitions of housing discrimination based on gender identity or sexual orientation (“Nondiscrimination Laws,” 2020). LGBTQIA+ youth report a 120% increased risk of homelessness compared to heterosexual and cisgender7 youth (N=26,161; Morton et al., 2017). Durso and Gates (2012) reported that of 354 U.S. agencies that support homeless youth, approximately 40% of their clients identified as LGBTQIA+ and were often kicked out by caregivers due to their sexuality or gender identity. Homelessness impacts LGBTQIA+ youth at similar rates in both rural and nonrural communities (Morton et al., 2017); however, Black and Native LGBTQIA+ youth disproportionately experience homelessness (Centrone et al., 2009). Older LGB adults can also have difficulty locating assisted living spaces that allow same sex relationships and value non-biological social networks (Boggs et al., 2017).

Transgender adults experience unique barriers to accessing safe housing options. The 2015 U.S. Transgender Survey (USTS; N=27,715; James et al., 2016) reports that 30% of transgender respondents were homeless at some point in their lives. Seventy percent of transgender respondents who used shelters in the last year experienced verbal harassment, physical attacks, and sexual assault (52%); were kicked out after being “found out” (9%); were forced to dress/present in the wrong gender (14%); and felt safer dressing/presenting as the wrong gender (25%). Transgender respondents also reported avoiding shelters for fear of mistreatment (26%) and some were denied access to shelters because of their gender identity (4%).

Interactions with Healthcare and the Criminal Justice System
Institutions expected to offer safety and care have historically been used to delegitimize and harm LGBTQIA+ communities. For example, homosexuality was pathologized and listed in the DSM as a mental health disorder until 1973. While some laws and standards of practice have changed, issues of concern continue to exist within healthcare and the criminal justice system. For instance, the U.S. Department of Health and Human Services suggest at least 775 surgeries and procedures were performed on intersex babies/youth in 2014. Such surgeries and procedures

7 “Cisgender” references individuals who identify as the gender that they were assigned at birth.
are often medically unnecessary, experienced as nonconsensual, and can result in sterilization, pain, infection, additional surgeries/procedures, and reduced physical sensation and sexual pleasure (HRW, 2017; Minto et al., 2003).

Access to healthcare and safety is particularly complex and inequitable for transgender individuals who are incarcerated; further inequities exist based on race and ethnicity. For instance, the 2015 USTS (James et al., 2016) reported that 58% of transgender respondents who were incarcerated experienced misgendering, verbal harassment, physical violence, and sexual assaults; and 30% reported physical and sexual violence by employees/staff. Rates of sexual violence experienced by transgender people in prison and jails (20%) were higher than for incarcerated cisgender people (prison 4%; jail 3.2%). Almost half (45%) of transgender people forcibly detained on the basis of their immigration status reported mistreatment such as being denied gender-affirming hormone therapies, physical violence, and sexual assault.

HIV and AIDS disproportionately impact LGBTQIA+ communities, communities of color (specifically Black and Latinx people and gay and bisexual men8), and those who are incarcerated (The Centers for Disease Control and Prevention (CDC) 2018; CDC, 2019; Robinson & Moodie-Mills, 2012). In a 2012 national survey of LGBTQIA+ people and people living with HIV (Lambda Legal, 2015), respondents living with HIV were more likely to report verbal and physical abuse by prison employees/staff. While the rate of incarcerated people living with HIV is substantially higher than those not incarcerated, barrier methods (e.g., condoms) are only made accessible in approximately 1% of U.S. prisons (Robinson & Moodie-Mills, 2012).

Physical and Sexual Violence
The Federal Bureau of Investigation’s Hate Crime Statistics Report (Chibbaro, 2019) recorded a 5.8% increase in hate crimes targeting LGB persons from 2017 (1,130 incidents) to 2018 (1,196 incidents). Hate crimes targeting transgender people also increased from 2017 to 2018, often are fatal, and exhibit inequities based on race and gender. The Human Rights Campaign (2019) reported that of the (likely underestimated) 26 transgender individuals murdered in the U.S. in 2019, 91% were black transgender women.

8 Reflects individuals who also identify as transgender, and may not identify as gay and/or bisexual.
The CDC (Breiding et al., 2013) found that LGB respondents experience similar or higher rates of intimate partner violence (IPV) and sexual violence than straight respondents. Bisexual cisgender women are disproportionately impacted when compared to lesbian and straight cisgender women (Breiding et al.). The CDC reports that gay (40%) and bisexual (47%) cisgender men have experienced sexual violence in their lifetime, and the USTS (James et al., 2016) report 54% of transgender respondents experienced IPV while 47% have been sexually assaulted. IPV among LGBTQIA+ communities is likely underreported, and many LGBTQIA+ individuals experience law enforcement hostility (7%) or indifference (12%) while making a report (National Coalition of Anti-Violence Programs, 2017).

School and workplace overt violence/discrimination. School and the workplace are important societal experiences and contribute to the economic safety of the individual and the larger society. In a national online survey (N=23,001; Kosciw et al., 2018) more than half of LGBTQIA+ students reported that they experienced verbal harassment based on sexual orientation, gender expression, and gender. Students reported being punched, kicked, or injured with a weapon because of sexual orientation, gender expression, and gender; and 57.3% of LGBTQIA+ students reported sexual harassment. Protections against workplace discrimination are also inconsistent or lacking. For example, 36 states lack leave laws that would protect an LGBT person's ability to get leave to care for a same-sex partner, and 11 states allow state-licensed child welfare agencies to refuse services to children and families if the sexual orientation of the children or families conflicts with the agencies' religious beliefs (“Foster & Adoption Laws,” 2020).

Risk Factors
As evidenced by the research identified above, specific risk factors that contributed to experiences of violence include a) normalization of discrimination and violence against LGBTQIA+ individuals from family-of-origin, community, and institutions, b) inadequate legal protections or policies, and c) cisgendered, heteronormative standards of care and practices as related to healthcare, education, criminal justice, and housing.

Protective Factors
Affirming policies and institutional support impact LGBTQIA+ communities and create opportunities for authentic relationship formations and communal care as well access to safer shelter, housing, educational, medical, and working environments.
Many LGBTQIA+ individuals rely on partners and friends as their social network (Boggs et al., 2017) since many may not be able to rely on traditional forms of support such as biological family, families of origin, or religion (Durso & Gates, 2012). Policies that increase access to and support these networks can be protective. For example, Rostosky et al. (2009) found that LGBTQIA+ respondents from states where straight-marriage amendments were not passed reported significantly lower minority stress (e.g., negative messaging, negative/biased conversation) and reduced psychological distress (e.g., stress, depressive symptoms) than participants from states where such amendments passed.

Supportive policies at work and school can have a significant positive impact on LGBTQIA+ individuals’ safety and well-being. For example, Kosciw et al. (2018) found that transgender and gender nonconforming (trans/GNC) students in schools with trans/GNC-specific policies/guidelines and school-supported gay-straight alliances reported reduced absences due to safety concerns. LGBTQ students with more supportive staff reported higher levels of self-esteem and lower levels of depression. Likewise, access to gender-affirming bathrooms and housing on college campuses is related to reduced suicidality (Seelman, 2016), improved academic performance, and improved social engagement (Woodford et al., 2017).

Badgett et al. (2013) conducted a review of 36 studies to examine the impact of LGBTQIA+ supportive policies and workplace climate on LGBTQIA+ employees. Supportive policies were linked to greater job commitment, increased job satisfaction, improved workplace relationships, improved health outcome, less experiences of discrimination, and more openness about being LGBTQIA+. In addition, less reported discrimination and more openness were linked to greater job commitment, increased productivity, and improved health outcomes.

**Negative Health and Other Consequences to LGBTQIA+ Communities**

Health disparities exist among LGBTQIA+ communities across the lifespan, when compared to straight and cisgender populations. Cited differences included increased rates of depression, anxiety, disordered eating, body dissatisfaction, internalized stigma, low self-esteem, social disengagement, suicidality, substance misuse, asthma, HIV, and AIDS (Bockting et al., 2020; Frost & Meyer, 2009; Kosciw et al., 2018; McClain & Peebles, 2016; Pflum et al., 2015; Seeleman, 2016; Sullivan et al., 2019; Valdiserri et al. 2019; Woodford et al. 2017).
These findings, in relation to LGBTQIA+ communities’ experiences of violence, are best explained through a model of minority stress (Myer, 2003) where “stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental [and physical] health problems” (p. 674). A systemic review by Cornell University (2018) supported the model of minority stress, as 82% of studies evidenced gender and sexuality-based discrimination, and such discrimination was associated with negative health disparities among LGBTQIA+ people.

Contextualizing health disparities among LGBTQIA+ communities with intersecting identities (e.g., race, socioeconomic status, age, ability) and historically supported violence/neglect in larger societal practices, highlights the role of structural inequalities as opposed to oversimplified assumptions of “risky” behavior, individual pathology, or arrested development (Cyrus, 2017; Robinson & Moodie-Mills, 2012).

**Recommendations**

1. Our recommendations aim to reduce violence impacting LGBTQIA+ communities, with a focus on improving institutional protections and increasing affirming services and resources:

2. Specificity in policies: Policies and interventions should be tailored according to the population and reflect the different needs within LGBTQIA+ communities.

3. Support ethical research: Due to the evolving and differing needs among LGBTQIA+ communities, it is essential that ethical research is conducted, particularly among those most marginalized and at risk of violence (e.g., Black transwomen).

4. Legal protections: Policies that protect the needs of LGBTQIA+ communities should be prioritized.

5. Financial support: It is essential to increase funding to services that already offer protections and communal support (e.g., funding for existing LGBTQIA+ community spaces and programming; funding for affirming shelters for homeless and housing-insecure LGBTQIA+ youth and adults).
6. Anti-bias training & intervention programs: Education, criminal justice, healthcare, housing, and workplace institutions should be incentivized to create long-term programs that: identify ineffective and harmful institutional standards and practices (e.g., binary practices within organizations such as workplaces or state-funded shelters; harassment and abuse in schools or prisons), and create affirming practices aimed at reducing bias, discrimination, and violence against LGBTQIA+ communities (e.g., reduce barriers to reporting bias/discrimination).

7. Mental health resources: Mental health practices and policies that help LGBTQIA+ communities navigate minority stress and systemic bias should be encouraged and supported.

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New York State’s rate of death by suicide (the number of deaths per 100,000 total population) for 2018 was 8.3. This metric is the most current available data from the Centers for Disease Control and Prevention (CDC), and this rate is low compared to other states. When noting rate of death by suicide, New York is ranked 49th out of 50. However, when examining overall number of deaths, New York State is ranked among the top five states for sheer number of deaths by suicide, culminating with 1,723 deaths in 2018. This is the highest recorded number of deaths by suicide per annum in the history of the State (CDC, National Center for Health Statistics, 2020).

Each death represents a human being with an average of 115 close friends, family members, neighbors, co-workers, treating clinicians, doctors, nurses or first responders whose lives have been forever affected by the pain of suicide. Put another way, sixty percent of the population report they know at least one person who has attempted or died by suicide (Cerel, Maple, Aldrich, & van de Venne, 2013). Each tragedy of death by suicide is also estimated to cost New York State $1,167,918 dollars in productivity and medical costs. That is a total cost of $1,806,769,000 – almost two billion dollars – for the year 2018 alone (American Foundation for Suicide Prevention (AFSP), 2020).

Regarding suicide attempts (attempts that do not result in death), it is estimated that for every individual who dies by suicide, 30 individuals attempt suicide and survive (CDC Rural Health Policy Brief, 2018). It is understood that the number of reported suicides in any state and, indeed, nationally, is 10 to 25 percent lower than the actual number of deaths by suicide. This is likely due to discrepancies in the way coroners record reason for death (terming it an “accident” for instance, instead of a suicide; Rockett, 2018).
All of the aforementioned signifies that in New York State, there are as few as 43,075 individual suicide attempts per year and as many as 53,850. The New York State Department of Health (NYSDOH) reported that over 10,000 individuals were hospitalized on an inpatient unit in 2017 for a survived suicide attempt and over 10,000 were seen in emergency rooms for a suicide attempt (not all were hospitalized). Those are the highest recorded metrics in the history of the State (New York State Office of Mental Health, April 2019). Regarding individuals seeking help for suicidal ideation, the number of calls to the National Suicide Prevention Lifeline in 2018 that were exclusively from New York State reached a five-year all time high at approximately 95,000 calls for that year (Suicide Prevention Resource Center, 2019).

**Cultural Aspects of Suicide in New York State**

When death by suicide is examined from a racial and gender group standpoint, the New Yorkers most vulnerable as of 2017 are men at a staggering rate of 13.3 per 100,000 New York State residents. White men followed by Asian men are the most common male racial groups to have died by suicide in 2017, the age group of 45 to 64 being most affected. The United Health Foundation, which draws its data from the CDC WONDER database, reported that in the period 2015-2019, the only racial group to see a reduction in suicide deaths in New York State were Asians. All other racial groups measured (Caucasian, Latino/Latina, and African American) increased, with African Americans seeing the sharpest ascent in rate of suicide across those four years measured. The rate of suicide for Caucasian men remained high but unchanged (United Health Foundation, 2019). This overall increase or maintenance in suicide death rate across racial groups measured suggests that those groups are not responding, or have not received adequate evidence-based interventions that emphasize suicide prevention (Joe, Canetto, & Romer, 2008).

It is crucial to examine the research on access to mental health services and access to culturally appropriate mental health research for minority groups. New York State is home to the largest Puerto Rican population in the country, is fourth among states with the highest Hispanic population (25% ethnic minorities, non-white), has over 20% foreign-born citizens, houses the largest number of African Americans within its borders, and is a leading recipient of migrants from around the globe (Migration Policy Institute, 2018). In addition, there is a strong correlation between Lesbian, Gay, Bisexual, or Transgendered populations and suicide risk (Russell & Joyner, 2001). Given these realities, it is crucial that New York State’s suicide prevention plan includes culturally appropriate suicide prevention access, assessment, and interventions. Culturally specific symptom expression as well as culturally specific risk (e.g., minority stress, social disenfranchise-
ment and lack of support group, concerns about seeking help, access to culturally appropriate mental health) are an aspect of life in the State for minorities. Therefore, culturally appropriate outreach is warranted (Joe et al., 2008).

Additionally, veterans have been profoundly affected in New York State by suicide. In 2019, the Department of Veteran’s Affairs (VA) completed a comprehensive report on veteran suicides in the nation. This examination included collecting data about veteran suicide on a state level. Their findings noted that of the nine states in the Northeast USA (Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont), New York accounted for 20% of those veteran suicides with 136 veteran suicides in 2017 (VA, Veterans Health Administration, Office of Mental Health and Suicide Prevention, 2019).

The tabulation of how many people have attempted suicide or died by suicide is not easily measured, and existing data likely underestimate the true number. Lack of reporting of attempts (e.g., the attempter does not get medical or psychiatric care) or incorrect classification of death (e.g., terming a suicide an accident) confound the true count, except to say that the number reported is almost certainly lower than the number of people who die by or attempt suicide (Rockett et al., 2018). This pattern is likely why the January 2020 Report on Suicide Prevention Activities (New York State Office of Mental Health) called for “accurate and complete data collection by medical examiners’ offices during investigations of suicide deaths.”

Understanding what accounts for this high number of deaths by suicide, suicide attempts, and suicidal ideation (e.g., Lifeline calls) requires further study of the unique risk factors and disparities among counties, socio-economic groups, races and ethnicities, age groups, genders, and professions that comprise the New York State population.

**Resource Allocation and Interventions**

It is a convenient but incorrect myth that one factor – such as an undiagnosed mental health disorder or gun ownership – is solely responsible for suicide, a suicide attempt, or suicidal ideation. There is empirical evidence that suicide is the result of a confluence of factors (Pompili, 2018). Since the sources of suicide, suicide attempts, or suicidal ideation are complex and multi-facetted, the solutions required to address and reduce suicide are also complex and multi-facetted. It is realistic to compare tackling the issue of suicide to other safety measures the State has put in place to keep its citizens safe (e.g., seatbelt wearing). The solutions should include a range of
measures: technological advances (e.g., the implementation of suicide prevention interventions such as Applied Suicide Intervention Skills Training (ASIST) and Local Outreach to Suicide Survivors (LOSS) Teams); legislation (e.g., funding for inpatient units; passing laws aimed at means restrictions; improving standards used by coroners and medical examiners for classification of death by suicide, and requiring technology on suicide intervention and assessment to be periodically updated); and a shift in public opinion (e.g., discussing the problem of suicide openly and more public awareness campaigns designed to reduce stigma). However, in order to be effective, multi-systemic suicide reduction interventions must be implemented with sensitivity and awareness of various aspects of social and economic disparities that create more risk among various populations (Joe et al., 2008).

Means Restriction Interventions
New York State has implemented some life-saving means restriction legislation such as the landmark passage of The New York Secure Ammunition and Firearms Enforcement Act of 2013 (The SAFE Act), which allows mental health providers and first responders to report concerns about the mental health of current and potential gun owners to a state background check system. There is clear evidence that firearm safety laws such as The SAFE Act in New York State reduce suicide deaths by restricting access to the most lethal means: firearms (New Yorkers Against Gun Violence, 2015; Anestis, Houtsma, Daruwala, & Butterworth, 2019). Accordingly, the number of deaths by suicide in the State could be higher were it not for means restriction policies. However, there are other means of death by suicide that have come to the fore, notably death by suffocation which is now New York State's number one cause of death by suicide (New York State Health Connector, 2020). It is not realistic to eliminate access to plastic bags, plastic wrap, and other means of suffocation unless an individual is placed on an inpatient unit (Barber & Miller, 2014). This is not to say that all individuals who have suicidal ideation or have a plan to die by suicide using suffocation as a means must immediately be placed on an inpatient unit. However, if a given individual has means, plan, and intent to die by suicide, an inpatient unit is an appropriate option to keep them safe until the suicidal crisis has passed.

While the number of deaths by suicide in New York State rises, the number of psychiatric inpatient units is declining. As of December 2018, New York State tabulated 7,468 inpatient hospital beds total across all counties and public and private inpatient facilities (New York State Office of Mental Health, 2019). This represents a 600- bed decline from 2014 (New York State Office of Mental Health, 2015). Onondaga County exemplifies a county that has seen a reduction in the
number of hospitals that would normally be a place where suicidal individuals can get round-
the-clock care, including inpatient hospitalization to keep individuals safe from death by suicide
(Mulder, 2019; LeBlanc, 2019). A reduction in physical locations, such as inpatient hospitals, is
problematic for New York State given that in 2018, the year with the most recent publically avail-
able data, the number of calls to the National Suicide Prevention Lifeline that were exclusively
from New York State reached a five-year all time high at approximately 95,000 calls (Suicide
Prevention Resource Center, 2019). Nationally, the suicide rate has increased by 40% since 2000
to an apogee of 38,000 among adults aged 16 to 64 in 2017 (Peterson et al., 2020). Since approxi-
mately 90% of people who die by suicide have an underlying and potentially treatable mental
health condition (American Foundation for Suicide Prevention, 2020), it is concerning that ac-
cess to treatment on an inpatient unit, where they would likely be safe from engaging in suicide,
is declining. Indeed, 20 counties – one third of New York State – have no psychiatric inpatient
capacity. Of those 20 counties, seven are among the top ten in rate of death by suicide (New York
State Department of Health, CHIRS, 2019). Closing inpatient units, especially in rural parts of
the State, is not preferable to ensuring that the existing inpatient units and providers are utilizing
the most effective and up-to-date technologies and interventions to stem suicidal crises.

Regarding outpatient facilities, in 2018 the New York State Office of Mental Health (OMH)
reported a capacity for 17,533 treatment slots across partial hospitalization (PH), intensive psy-
chiatric rehabilitative treatment (IPRT), continuing day treatment (CDT), personalized recov-
ery-oriented services (PROS), and assertive community treatment (ACT) combined (New York
State Office of Mental Health, 2019). Compared to 2014, this is an increase of 1,150 slots (New
York State Office of Mental Health, 2015). While this increase in outpatient slots across all types
of programs (PH, IPRT, CDT, PROS, and ACT) is encouraging, comparing the needs of inpa-
tient and outpatient psychiatric patients is like comparing apples to oranges. Deinstitutionaliza-
tion and The Community Mental Health Act of 1963 were and are important strides towards
autonomy and freedom of choice for people with suicidal ideation and other mental health issues.
However, some people still need the stabilization of an inpatient psychiatric unit -- sometimes
in combination with outpatient programs or before entering such programs (American Medical
Association (AMA), 2003).
Clinical Interventions
When an individual is having suicidal ideation or performing behaviors associated with suicide (e.g., giving away possessions, acquiring means such as weapons, or telling others they are considering suicide), it is a crucial time to implement evidence-based interventions (Rudd et al., 2006). Psychological interventions are deemed evidence-based when they have shown, in rigorous and replicated studies, to reduce suicidal ideation, attempts, or gestures. It is encouraging that there are several evidence-based interventions that reduce suicidal ideation, attempts, and gestures, and they broadly fall into the category of means restriction, clinical intervention, or postvention.

Although the standard of care for a suicidal individual remains an evaluation for inpatient hospitalization, these interventions should begin prior to as well as during hospitalization if they have not already taken place on an outpatient basis. The reasons for this approach are supported by research: suicidal crises usually peak quickly and are accompanied by extremely high levels of emotion and motivation, requiring fast and all-encompassing means restriction and empirically supported suicide reduction interventions concurrently (Barber & Miller, 2014). Therefore, while the suicidal crisis is at its peak and accompanied by intent to die, inpatient hospitalization is the safest place for a suicidal individual. However, life-saving evidence-based clinical interventions that can be administered both on an inpatient and outpatient setting (Brodsky, Spruch-Feiner & Stanley, 2018) include Cognitive Behavioral Therapy (CBT; Brown et al., 2005), Dialectical Behavioral Therapy (DBT; Linehan et al., 2006) and Collaborative Assessment and Management of Suicidality (CAMS; Pistorello et al., 2020). These interventions are designed to be provided by psychologists, social workers, and psychiatrists. Another intervention that shows promise is ASIST (Gould, Cross, Pisani, Munfakh, & Kleinman, 2013), which can be applied by any person whether they are in a skilled medical or psychological role or not. ASIST was directly cited in the January 2020 Report on Suicide Prevention Activities (New York State Office of Mental Health), as an intervention that is being implemented by community gatekeepers.

Postvention
Postvention is defined as, “an organized response in the aftermath of a suicide to accomplish any one or more of the following: to facilitate the healing of individuals from the grief and distress of suicide loss; to mitigate other negative effects of exposure to suicide; to prevent suicide among people who are at high risk after exposure to suicide” (Suicide Prevention Resource Center, 2019). Since one in five of the 115 individuals impacted by suicide report feelings of devastation
and a major life disruption (Suicide Prevention Resource Center, 2019), coupled with the fact
that exposure to the suicide of a close associate puts one at a greatly increased risk of suicide,
appropriate postvention is a necessary means to stem further suicide (Jordan & McIntosh, 2011).

There are two methods of postvention: passive and active. In passive postvention, an individual
affected by someone else’s suicide must locate their own psychological aid if they do so at all. In
active postvention, a team or at least one individual is deployed as a support person to an individ-
ual affected by suicide. LOSS Teams (http://www.lossteam.com) are comprised of first respond-
ers, other suicide survivors, and mental health professionals. All members of a LOSS Team are
instructed in crime scene etiquette (so as not to disrupt the police and medical examiner’s work)
as they are deployed to the crime scene to support the survivor(s) – defined as family, friends,
and others who have been affected by a suicide death. LOSS Teams have strong results including
decreasing the amount of time that an individual reaches out for mental health support from
4.5 years to 48 days. Given that rapid contact with mental health experts increases positive out-
comes and decreases death by suicide for suicide survivors, it is understood in the field of suicide
prevention that ‘postvention is prevention.’ There are currently LOSS Teams in 17 U. S. states.
Unfortunately, in New York State, no LOSS Teams exist. This lack is a significant deficiency in
New York State’s ability to assist survivors of suicide, who, because of their survivor status, are at
increased risk of death by suicide (Pitman, Osborn, Rantell, & King, 2016). Implementation of
a LOSS Team requires the ‘buy in’ or explicit requirement of local coroners, medical examiners,
and detectives. These professionals must be convinced that this approach is positive for the com-
munity and will lead to a decrease in suicides in their jurisdiction (Campbell, 2011)

Conclusion
In sum, suicide prevention in New York State is an addressable but complex problem. It is cru-
cial to remember that each person who dies by suicide is a family member – someone’s son or
daughter, sibling, spouse, neighbor, co-worker, or friend. We must not be daunted by the myriad
factors that go into suicide prevention, but instead view these as opportunities and places where
we can intervene and save lives. However, it is important to ensure that our interventions are
evidence-based, that clinicians and gatekeepers have the proper training, and that we provide
adequate environments for people to recover from suicidal crises. Just as important are culturally
sensitive interventions and means restriction. It is a large task, but with partnerships and with
clinicians, gatekeepers, and legislators working together, it is possible to reduce suicide in New
York State.
References


Gun Violence and Gun Safety

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Gun violence has been called an epidemic in the United States. According to the National Vital Statistics Reports, in 2017 alone, 39,773 people died from firearms-related injuries in the U.S. (NVSR, 2019). Gun-related deaths occur in three distinct contexts: 1) mass shootings, 2) homicides, and 3) suicides. Mass shootings receive intense media coverage, generate understandable public alarm, and appear to fuel increases in purchases of firearms. However, mass shootings are far from the primary source of gun deaths. Suicide accounts for roughly 60% (23,854) of firearms-related deaths. Homicide accounts for 37% (14,542) of firearms-related deaths.

Gun Violence Statistics

Each year, roughly 600 American women are shot to death by an intimate partner (Federal Bureau of Investigation, 2012-2016). Additional firearms-related deaths include: 553 deaths involving law enforcement; 486 categorized as “unintentional”; and 338 categorized as “undetermined.” The recent trends in military and law enforcement deaths by suicide are concerning. For example, in 2019, the New York Police Department saw 10 members die by suicide, twice as many as the previous year. In a group of 8 – 16-year-olds, 93% reported witnessing serious interpersonal violence such as hearing or seeing gun shots (Corigliano, Javier, Kupferman, & Rapaport, 2012).

There has been a recent spotlight on police-related killings and gang-related homicides in urban black communities. In 2020, 35 of the 50 largest cities including New York City have seen a rise in shootings (Hilsenrath, 2020). These shootings are primarily gang related. Gun activity has spiked in cities such as New York City.
These increases are occurring in the context of multiple lockdowns related to the COVID-19 global pandemic. A movement of protests followed the recent killing by police of George Floyd, an African American, leading to an increased focus on social justice including the Black Lives Matter movement. These two dynamics – the pandemic and the brutal slaying of Mr. Floyd – have contributed to the destabilization of communities of color, the erosion of protective factors such as social, educational, and law-enforcement supports, and have amplified and exacerbated ongoing inequities in low-income Black and Latinx communities.

**Mass Shootings**

Public mass shootings accounted for 547 deaths between 1983 - 2013 according to the Congressional Research Service (Bjelopera, Bagalman, Caldwell, Finklea, & McCallion, 2013). Media coverage and public interest often focus on these dramatic events despite the relatively small number of deaths involved. The authors stated that: “While tragic and shocking, public mass shootings account for few of the murders or non-negligent homicides related to firearms that occur annually in the United States” (Bjelopera et al., 2013). In a more recent year (2018), the FBI identified 27 “active shooter incidents.” Mass shootings, including school shootings, evoke a strong public response in the United States and generate an immense amount of media attention. This attention is to be contrasted with the much larger number of suicide and homicide deaths that command relatively less attention from the media, legislators, and communities. The conversation around mass-shooting/gun safety could and should be expanded to bring attention to the tens of thousands of lives that are lost every year from suicide and homicide. Perhaps more of them can be saved.

**Risk and Protective Factors**

**Firearms Culture and Values**

Although sparking controversy, gun ownership and firearms-related activities are highly valued across many American communities. In fact, the United States has the highest rate of civilian firearm ownership in the world (Small Arms Survey, 2007). It has been noted that with more than 300 million guns (Hepburn, Miller, Azrael, & Hemenway, 2007) there are “about as many guns as people.” A recent 2017 Pew Research Center finds that even if they did not personally own a gun, seven-in-ten respondents have experience firing a gun at some point. Three-in-ten U.S. adults say they own a gun and an additional 36% report being open to owning a gun in the
future. Only 1/3 of adults reported no current firearms ownership or openness to owning one in the future. Another survey found that 37% of U.S. households included gun owners, with 24% of respondents reporting that they owned a gun and 13% reporting that another member of their household owned a gun (DeSilver, 2013). Similar findings (35%) were recently reported by the 2018 General Social Survey and the Gallup Organization (Smith, Davern, Freese, & Morgan). Firearms are often sought for hunting, sport, and self-defense (Pew Research Center, 2013.) Although gun ownership is very popular in the United States, it increases the risk of death by suicide. Therefore, it is critical to find ways to identify and encourage voluntary safety measures. Public health and social media campaigns can encourage integration of these practices and be used to warn against operating a firearm after consuming alcohol, due to impaired judgment.

**Legal Firearms Ownership**
People are motivated to own legal firearms for personal protection and for many social reasons including hunting (1/3 often/sometimes), skills-building (shooting/gun range 43% often/sometimes), family activities, competitive sports, marksmanship, law-enforcement, military, and local and state competitions, as well as personal safety and community events (such as gun shows 25%). Gun enthusiasts include a diverse set of individuals such as athletes training for Olympics or Paralympics and LGBTQ social clubs such as the Pink Pistols. There are significant gender differences in gun ownership: 12% of women and 37% of men identified as being personal gun owners (Pew Research Center, 2013.) For both men and women shooters, social and skill building activities are often a motivator; 43% of women who own guns report they go shooting or to a range “at least sometimes.”

**Homicides and Firearms Demographics and Risk Factors**
Firearms were involved in 75% (14,542) of 19,510 homicides in 2017 (NVSR, 2019). Homicides disproportionately affect African American males among whom homicides represented the 4th (8,643) leading cause of death in 2017. These deaths often involve handguns used in inner city and gang-related violence.

A second source of gun homicides is intimate partner violence, a crisis that is escalating concomitant with increased stressors related to the 2020 COVID-19 Global Pandemic. Everytown for Gun Safety (2019) reports, “Every month, an average of 52 women are shot and killed by an intimate partner.” Additionally, since 2015 there were over 5,489 fatal shootings by an on-duty police officer (Tate, Jenkins, & Rich, updated July 2020). Males represent 95% of people fatally
shot by police, and over half are between 20 and 40 years old. Half of the deaths are White Hispanics who are killed at almost twice the rate while Black Americans are killed at closer to three times the rate of White Americans relative to their representation in the population.

**Gender, Race, and Age Firearms-related Risk Factors**
Fowler et al., 2015 cites the National Vital Statics System (NVSS) research that indicated that males account for 86% of all victims of firearm deaths; the firearms death rate for males was 6.5 times higher, and the male to female firearm homicide rate was about 5:1. Young adults (25-34) have the highest rate of fatal firearm injury followed by those in the 15-24 age group. Overall rates conceal important patterns; demographic profiles differ for death by homicide versus death by suicide. For example, rates of firearm suicide increase with age. The highest rates are found among persons aged 65 and older, followed by the 55-64-year old age group, and then by the 45-54-year-old age group. Conversely, rates of firearm homicide are highest among adolescents and young adults, and decrease with age. The annual rate of firearm homicide was 8.9 per 100,000 among youths 15-24, and 8.0 among those 25-34 years of age. Both younger age groups had rates of firearm homicide that were 1.8 to 10 times higher than those over 34 years of age. Black adults (57%) say they know someone who has been shot, compared to 43% for Whites, and 42% for Hispanics. Blacks and low-income Americans were more likely to have been threatened by someone with a gun (32% of Blacks, 20% of Whites, 24% of Hispanics; NVSR, 2019).

**Suicide and Firearms Risk factors**
The Centers for Disease Control and Prevention, National Center for Health Statistics highlighted the fact that suicides represented the 10th (47,173) leading cause of death in the United States in 2017. Suicides represent the 8th (36,782) leading cause of death for males, the 9th (42,019) leading cause of death for Whites, the 9th leading cause of death for Hispanics, and the 9th (38,106) leading cause of death for White-non-Hispanics. For male White-non-Hispanics, suicides rise to the 8th leading cause of death accounting for 29,708 deaths in 2017.

The largest number of firearms-related deaths are death by suicide, i.e., 51% (23,854) of suicides involved a firearm (NVSR, 2019) in 2017. The Department of Defense issued its Annual Suicide Report (DOD, 2019) indicating that “the suicide rate in civilian populations have increased over time; the military is showing similar trends,” and in 2018, “the suicide rate for active-duty U.S. military members was the highest on record.”
Financial Costs of Gun Violence

One analysis estimated that gun violence imposed total costs of $174 billion to the United States in 2010 at an average of $645 per gun, $5.1 million for each fatality, $433,000 for each gun injury requiring hospital admission, and $116,372 for each firearm injury requiring only emergency department admission (Miller, 2012). These estimates do not include the impact on those who endure consequences from witnessing or fearing firearm violence in their homes or communities when firearms are used as a source of intimidation and coercion (Sorenson & Wiebe, 2004; Truman, 2011). Given the vast expense of gun violence, significant investment in gun safety would reduce not only the emotional cost, but also the direct and indirect financial costs on society. Forty-four percent of U.S. adults know someone who has been shot.

Evolving Prevention and Risk Reduction Knowledge

Background checks for gun owners have been questioned in terms of their effectiveness. The Bureau of Justice Statistics (2013) reported that: “In 2004, among state prison inmates who possessed a gun at the time of offense, less than 2% bought their firearm at a flea market or gun show and 40% obtained their firearm from an illegal source.”

Additionally, proposals legislating screening and background checks find limited support in psychological research as we currently have “...no reliable methods to accurately predict which individuals will or will not engage in firearms violence at a particular time or under specific circumstances” (APA, 2014). The APA Panel of Experts Report on Gun Violence reveals that many policies seeking to restrict access to firearms by persons with mental disorders use “broad criteria that bear little relationship to actual risk” and fail “to identify persons who may pose significant or imminent threat of violence” (Fisher & Lieberman, 2013). The panel, however, also stated that some policies can significantly reduce violent offending among persons with histories of involuntary psychiatric commitment (Swanson, McGinty, Fazel, & Mays, 2013).

Researchers are unable to predict who will engage in a mass shooting incident. However, on an individual basis, psychologists are experts in applying “methods for behavioral threat assessment and person-specific violence risk management planning once an individual has been identified as making or posing a threat of violence, including firearm violence.” This individual-focused assessment and intervention can be used to drive down the number of deaths from both homicides and suicide.
Prevention Recommendations

Legislative and Educational Actions to Address Mass Shootings

The American Psychological Association (2014) called for a response that must be “comprehensive” in addressing issues including risks, access strategies, educational interventions, research limitations, and diversity issues. A comprehensive approach will be more effective than overly simplistic “gun bans” that may be ineffective and over-reliant on questionable “background check legislation” that serves to stigmatize people in crisis.

Public health messaging is needed to educate communities to understand that mass shootings are rare, public spaces are generally safe, and that currently there are no reliable predictors to identify individuals who will commit a mass shooting. Legislators must recognize that many policies, programs, and practices intended to reduce the harms associated with firearms currently lack evidence of efficacy and may contribute to unintended consequences (National Research Council, 2005; Institute of Medicine and National Research Council, 2013). Poorly researched policies may increase gun deaths by escalating gun purchases, stigmatizing gun ownership, and eroding the trust between gun owners and mental health or government entities.

The strong reactions and resulting media coverage of low-frequency events such as mass shootings or police shootings can be used to drive a larger conversation about reducing the high frequency of suicides and homicides. Policymakers and advocates must go beyond the isolated focus on stigmatizing and restricting firearms, and focus on the contribution of identifiable and modifiable factors such as depression, substance use, and community resources to the higher rates of suicide, and the contribution of emotional crises to incidents of gun violence (APA Resolution, 2014).

The American Psychological Association has determined that gun restriction legislation, although often popular, has a limited research base and may have unintended consequences. The American Psychiatric Association notes that registries like NICS can be helpful in some situations, but they are minimally effective in identifying people at acute risk of harm to self or others. In addition, they can unfairly stigmatize individuals with mental illness.

Mass shootings and police shootings are serious and need to be addressed. Additionally, public and legislative leaders have an opportunity to capitalize on the attention and passion that is evoked in response to mass shootings and police-shooting deaths, i.e., to expand the conversation
to raise awareness about firearms-related homicides and suicides. Swanson, McGinty, Fazel, and Mays, (2015) warn that “media accounts of mass shootings by disturbed individuals galvanized public attention and reinforce popular belief that mental illness often results in violence.” Their review of epidemiological studies shows that “most people with serious mental illness are never violent.” However, they note, “mental illness is strongly associated with increased risk of suicide, which accounts for over half U.S. firearms-related fatalities.” This research team argues that “Policy making at the interface of gun violence prevention and mental illness should be based on epidemiological data concerning risk to improve the effectiveness, feasibility, and fairness of policy” which again points to an increased need for resources to reduce risk of firearms-related death by suicide that number in the tens of thousands each year.

**Legislative Actions to Reduce Firearms-related Suicides**

Psychological practices such as cultural competence, harm-reduction, behavior change, and crisis-intervention strategies should be integrated into legislative policies. There is a particular risk of death by suicide for some individuals who have access to firearms. Therefore, working with, not against, gun owning and social and professional shooting communities such as military, law enforcement, and others, is critical to encourage stronger safety practices. These practices include safe storage when firearms are not in use or during seasonal hunting, and periodic trips to gun ranges. Additional safety interventions such as establishing easy access to anonymous off-site firearms storage during times of high risk or during a crisis, and strengthening connections with mental health professionals, as well as individual, family, and community supports for people who are at risk or in crisis are essential.

People who value firearms are sensitive to negative comments by politicians and mental health professionals. Rozel and Mulvey (2017) stated that “mental health professionals play a critical role in assessing their patients for violence risk, counseling about firearm safety, and guiding the creation of rational and evidence-based public policy that can be effective in mitigating violence risk without unnecessarily stigmatizing people with mental illness.” Gun owners should not be demonized by those who do not understand their values, or worse, denigrate gun ownership. Specific training and messaging are required to build trust and signal that legislators, health care providers, and communities understand and value people who choose to own and operate firearms safety. Saving lives and reducing deaths from suicide must include public health strategies and engage community organizations. More training on safety practices must be supported and encouraged. In addition to education and training, many gun owners seek social and recreational
experiences involving guns. These activities might provide avenues to engage gun owners with pro-safety messaging. A Pew Research Center report helps to identify popular gun activities. The respondents reported firearms-related activities in which they participate, such as TV programs or videos about guns (39%); visiting websites about guns, hunting, or other shooting sports (35%); listening to gun-oriented podcasts or radio shows (11%); and participating in online discussion forums about guns (10%) (Pew Research Center, 2017).

Encouraging help-seeking behavior by persons in crisis and avoiding reinforcing stigma are critical to addressing gun safety. Policies and practices that further stigmatize individuals with serious mental illness may deter them from engaging in needed psychological or other services (Appelbaum, 2013). One important messaging intervention to reduce death by firearms-facilitated suicide is to reframe the issue as increasing safe firearms use and ownership.

Support is needed to develop multiple options to provide safe, anonymous, off-site storage, or a support system that temporarily and voluntarily reduces access to firearms during a crisis, regardless of mental health diagnosis.

There should be increased dissemination and implementation of research-supported psychological interventions to reduce risk of death by suicide with specific focus on higher risk populations such as older White males, rural communities, LGBTQ-identified individuals, as well as military and law enforcement communities.

Another way to reduce suicide is to increase research and investment in issues that limit access to mental health care. Many people who are at risk of gun-related suicide or homicide do not have access to mental health care due to cost, geography, culture, or stigma. Guaranteed universal telehealth and mental health coverage, and increased funding for psychology internships and postdoctoral residencies, could help close the gaps in coverage.

**Legislative Actions to Reduce Firearms-related Homicides**

Homicides occur in the context of relationships and communities. There should be more funding for comprehensive psychological research on effective interventions to reduce firearm homicides. This funding should provide support for comprehensive individual and community assessment to identify and address systematic economic and racial disparities in access to economic, educational, social, and health services. Legislators and stakeholders should:
• Increase access to safe housing, mental health, and financial resources for individuals who are involved in relationships with threats of intimate partner violence.
• Increase tracking and reporting of police shootings, identify underlying causes such as racial bias, and increase training in non-lethal and de-escalation approaches to crisis intervention for law enforcement.
• Identify and review policies in which community safety and policing can be improved by reducing reliance on armed police officers and increasing integration of psychologists and medical professionals trained in assessment and de-escalation, rather than employing armed police when responding to a person or community in crisis.
• Increase programming to develop a more thorough understanding of the community and individual precursors to involvement in affiliations that engage in gun carrying and gun use such as gangs.

Underlying Forces Contributing to Gun Violence in Black Communities
Gun violence in black communities is a deadly problem. The homicide rate for Black Americans in all 50 states is, on average, eight times higher than that of White Americans (Center for Disease Control and Prevention, 2017). U.S. residents are 128 times more likely to be killed by everyday gun violence than by international terrorism; Black people are 500 times more likely to die this way (Xu, Murphy, Kochanek, & Bastian, 2016). Importantly, most urban areas, especially those that experience the most gun violence, are characterized by poverty, inequality, and racial segregation (Sampson, 2013). Media coverage nationally of gun violence such as the school shooting in Parkland, Florida, in February, 2018, and the mass shooting that occurred in Las Vegas at an outdoor concert, is immediate and detailed. Yet this same type of coverage is absent when gun violence is committed in low-income, mostly racial/ethnic minority communities. Although occurrences in such communities are not often massive, they occur often. Despite their frequency, they are not covered in the media as a social problem in need of help, but rather as “just a way of life for black and brown people” (Mitchell & Bromfield, 2019). Additionally, nearly 3,000 children are shot and killed each year in the United States, with guns taking the lives of 10 times more black children than white children (Fowler, Dahlberg, Haileyesus, Gutierrez, & Bacon, 2017).
Community Connections and Workforce Development to Reduce Gun Violence

Legislators and other stakeholders are encouraged to partner with state leadership organizations such as the New York State Psychological Association, the New York Association of Black Psychologists, and Black Psychiatrists of Greater New York, as well as Latinx mental health associations, to craft and develop comprehensive community and individual interventions that reflect the roles of individual, family, community, and systemic institutional structures that serve to prevent firearms deaths.

Reducing gun violence by increasing firearm safety is a workforce development issue. Many more psychologists with specific training are needed “to conduct basic and applied research and evaluate programs and practices for prevention and intervention in firearm violence” (Aiken, West, & Millsap, 2008). Significant relationships between exposure to community violence and emotional and behavioral functioning speak to the effects of trauma related to gun violence. (Corigliano, Javier, Kupferman, & Rapaport, 2012).

The American Psychological Association encourages graduate psychology programs to rigorously train students in evidence-based program development, implementation, and evaluation methods to support the ability of psychologists to help reduce firearms violence across multiple levels and populations, and to enhance their ability to effectively interpret and communicate the results of such efforts to the public and to policy makers. Specifically, the American Psychological Association indicates that the need for psychologists in “increasing and applying knowledge about the disparate occurrence and types of firearm violence across different populations and at different levels (e.g., individual, family, community, societal) is fundamental to firearms violence research, prevention, risk identification and management, treatment, and evaluation.”

Firearms and Cultural Competence, and Counseling on Access to Lethal Means: Considerations for Mental Health Professionals, Legislators, and Community Stakeholders

Many legislators, policy developers, and health care providers lack both an understanding of firearm culture and exposure to it. As a result, they are at increased risk for biased decision-making or poorly informed attitudes toward patients who own firearms, live in households with firearms, or work with clients for whom firearms have relevance, e.g., military, law enforcement, sports, or hunting.
Psychologists such as Pirelli and Witt (2017) have called for greater cultural competency among psychologists. Pirelli, Wechsler, and Cramer (2019) advocated a need to detail the prevalence of firearm-related issues in the United States, contextualize firearm-related issues in forensic treatment and evaluation scenarios, delineate a number of firearm subgroups, and recommend considerations for mental health professionals to develop cultural competence as it relates to firearms and associated subcultures.

**Counseling on Access to Lethal Means: CALM**

Examples of interventions to increase safety and reduce risk include Counseling on Access to Lethal Means: CALM. Themes and learning goals include reducing access to lethal means. The program is an evidence-based strategy for suicide prevention. Tasks include advising clients on specific off-site and in-home secure storage options for firearms, discussing strategies to limit access to dangerous medications, and working with clients and their families “to develop a specific plan to reduce access to lethal means.” The Suicide Prevention Resource Center, Education Development Center is supported by HHS, SAMHSA, CMHS to offer this course.

**Firearm Anticipatory Guidance Training in Psychiatric Residency Programs**

In addition to psychologists, psychiatrists are also focusing on the need for cultural competence and content competency related to firearms safety and culture. One study called for increased training in psychiatric residency programs. The researchers stated that most individuals who attempt suicide (80%) meet diagnostic criteria for mental illness. An overwhelming number of residency programs (79%) reported they had not seriously thought about providing firearm injury prevention training. Support is needed to help reduce firearm violence in the United States (Price, Thompson, Khubchandani, Mrdjenovich, & Price, 2010). Similar leadership support is needed by the American Psychological Association and the New York State Psychological Association.

**References**


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