Acting, not Reacting, to Prevent Violence
Sandy Hook Reminds Us to Focus on One Patient, One Family at a Time

I first heard about the mass murder of little children at Sandy Hook Elementary School by a man with assault weapons when I was returning from the birth of my new grandson in a faraway place. He was born whole and contented, and in the 2 weeks I was there, he was a trusting, confident, and mellow little guy who had a big loving family around him to protect and nurture him. Yet, the night I walked off the plane I heard about the 27 other people in Connecticut, mostly children, who also had promising futures and loving families, but were now dead. These sporadic acts of violence in the United States seem to be increasing in frequency, number, and ferocity and are purposely targeted at children and strangers in public places such as malls, schools, and churches. When it happens, we as a society are then caught up in a predictable cycle of:

1. Asking “why?,” then labeling the perpetrator as mentally ill, then calling on experts to explain the “why” of the behavior. But I am reminded that Adam Lanza did not have a Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR, American Psychiatric Association, 2000), Axis II diagnosis, and that our best thinking, à la the great sociologist Emile Durkheim*, is that the majority of suicide and homicide is usually not perpetrated by those with mental illness, but by sane individuals motivated by estrangement, revenge, loneliness, power, and aggression.

2. Grieving, publicly as a nation and privately by connected family and friends. Stuffed animals are bought, shrines are placed in symbolic places, media outlets spend 1 to 2 weeks rescheduling programs to focus talk and entertainment on the latest mass murder, clergy are even shown praying or preaching, then it is back to business as usual.

3. Taking political sides; calling for more funding, programs, bills, legislation, and political posturing; involving the National Rifle Association, lobbyists, lawyers, many experts on talk programs; and much controversy and legal maneuvering that then takes us as a nation to the next shooting.

In the meantime, I think everyone can agree that we, as health care providers, need to do better with the resources we have to reduce the risk of this happening again and to buy us and our society more time until we can better figure out how to balance our constitutional freedoms with our responsibility to safeguard our families and communities.

Let’s look at what we know right now about the man who repeatedly shot little children at point-blank range: 20 years old, he had either aged out or was close to aging out of his parent’s health insurance, he was not employed, and different news sources said he had a learning disability, difficulty relating to other people, and left school at age 16 after several “episodes” and “crises” where his mother was called to talk him down. He had been seen by therapists in the past and was in a treatment program with a psychiatrist in high school (which he left at 16 to be home schooled). Yet, he lived in a house where guns were readily available, and target shooting was his hobby. Relatives and former classmates say they are shocked and cannot believe that this man—who had learning, emotional, and behavioral difficulties for all of his short life and was most comfortable with guns and shooting—would use them against his parent, then deliberately target shoot defenseless strangers at close range, then shoot himself. I am not shocked, but I am left wondering why anyone, including his family, did not consider how teaching a child who had behavioral problems to be comfortable with guns and assault weapons was increasing the likelihood that this child could and would point those guns at other targets outside of a shooting range.

Regardless of our political beliefs, can we at least agree that any child or adult with behavioral, relational, mental, and/or, emotional problems, especially ones who have difficulty with controlling impulses, delusions, compulsions, or obsessions, should not be anywhere near guns or assault weapons? Can we all do a better job at psychiatric and medical intake in determining whether the patient has guns in the house, or if he or she is connected to anyone who has access to guns? Can we also add this as a regular assessment in emergency departments for anyone arriving with behavioral or emotional issues? And can school counselors assess for this at any time they are counseling students and follow up with strong education for the student and parents about the increased risk for harm (to the child

*Emile Durkheim was a world-renowned French sociologist who wrote the classic major work, Le Suicide, in 1931. It was then translated into English and published as Suicide: A Study in Sociology in 1951. As a classic work, it systematically builds the thesis that the act of suicide is embedded in tightly interconnected social factors that motivate, induce, or aggravate any innate suicide potential.
Commentary

and to themselves) if they keep assault weapons in a house with a resident who has mental or behavioral health difficulties?

I think at this juncture we nurses, counselors, physicians, and therapists do not necessarily need to do more, we need to do better—better at assessment and better at educating the patients and family members about the increased risk of self-harm and harm to others when anyone with impulse, compulsion, relationship, behavioral, or mental health difficulties has any access to guns and assault weapons. Then we need to do better at following up, to ensure that whomever has control of those guns has heard and understood what we said and has removed them. That follow up might include a telephone call (or several), coaching, a reminder, connection to a mental health program, or more education.

In the meantime, while I am re-learning the new Current Procedural Terminology (CPT) codes and DSM-5 and paying more for professional practice insurance, I am revising my own psychiatric intake and evaluation questions to include a stronger emphasis on assessing for presence of guns or assault weapons in the house a patient lives in, whether those weapons are in a gun closet or not. And when guns are present, I will be providing follow-up education to not only the patient but whomever is the parent, significant other, partner, or involved other, about the need to remove those guns immediately for the safety of not only the patient but everyone concerned—and I hope you all will, too. Let us do what we can to remove these guns from the houses and lives of our patients and families we work with—one patient, one family at a time.

REFERENCE


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