Guest Editorial

Decreasing Risk for Mass Shootings in the United States

“In the 1980s...simply putting up a barrier on the [Ellington Bridge] rails...reduced the local suicide rate 50 percent.” Captain Christopher Staeheli (2013, para. 23)

Fifty-one years ago, Kitty Genovese was repeatedly stabbed, raped, robbed, and left dying outside of her Queens, New York apartment. At least 12 neighbors heard her cries for help (reported as “Oh my God, he stabbed me! Help me!”) or heard the attack, yet only one called the police. One neighbor heard her cries and ran to help, holding Kitty in her arms until police arrived 1 hour later. Kitty died in the ambulance (DeMay, 2007; Le-Mann, 2014).

The absence of concerted community response to this protracted assault, her cries for help, and the slow death that followed gave rise to the term Genovese syndrome, or diffusion of responsibility that occurs when bystanders to an assault or murder think someone else, anyone else, will help, stop, report, or respond in some way so they do not have to or need to respond (Cherry, 2011). This diffusion of responsibility is not confined to the general public; it has also crept into our community of professional providers—nurses, therapists, advanced practice RNs (APRNs), physicians, psychologists, counselors, social workers, and other professionals who work with families, especially those families facing difficulties.

This reaction is reinforced by the extreme politicization of the issue of gun control in the United States. Providers are at risk of becoming numb, paralyzed, and hesitant, unsure of how to differentiate between guaranteeing patient safety and being seen as violating individuals’ constitutional right to bear arms. This quandary occurs as the number of mass shootings in the United States has become more frequent, more than doubling in number in the past 7 years, according to a 13-year study of 160 active shooter (i.e., mass murder) incidents between 2000 and 2013 in the United States by the Federal Bureau of Investigation (FBI; U.S. Department of Justice, 2013). Active shooter incidents are what the FBI define as “an individual actively engaged in killing or attempting to kill people in a populated area” (FBI, 2014, para. 1).

This phenomenon in providers, also called the bystander effect or
numbness to violence, is explained by Frank McAndrew, a professor at Knox College in Illinois, as a sort of fatalistic acceptance of what has now become commonplace: “One shooting is a tragedy, 20 is a statistic…you start losing your emotional response to it” (Niller, 2015, para. 4). Another example of the acceptance of these mass shootings, or active shooters, is the recent requirement by many colleges that all employees complete active shooter response training, relegating these mass murders to the status of an act of nature—something that cannot be prevented but instead prepared for and survived, such as tornados, flash floods, fire, or hurricanes.

Guns are equal opportunity weapons. They will shoot anything they are aimed at, whether they are soldiers or civilians, firefighters, teachers, children, or babies. They are also weapons of impulse, whether that impulse is momentary or lasts long enough to lift keys to the locked gun cabinet; take the gun(s) to school, church, or the movies; and use them to murder strangers. But the risk of troubled individuals accessing and using a loaded firearm and acting on impulse can be reduced, if the will to do so exists. To paraphrase U.S. Marine Captain Christopher Staeheli (2013) in his article about rethinking the assessment of suicide risk and its prevention in the military, the risk of active shooters, or more mass murders, can be reduced by restricting access to lethal means, using a multidimensional strategy that involves everyone: parents, educators, therapists, medical providers, and the criminal justice system.

I first wrote about preventing gun violence 2 years ago (Nardi, 2013), when I heard about the mass murders of 27 people, mostly young children, in Sandy Hook Elementary School. The shooter was a troubled young man who had access to guns in the home and frequented a gun range with his parent, whom he subsequently shot and killed. I advocated then that:

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 and to themselves) if they keep assault weapons in a house with a resident who has mental or behavioral health difficulties? (Nardi, 2013, p. 7)

If the assessment is positive for access to guns, then just like for every other screening or assessment, health care providers must follow up and use the therapeutic alliance created with their patients to partner with them and their family or significant others to decrease risk for injury. In this case, it should be ensured that whoever has control of those guns has removed them. Strategies for follow up may include a phone call, specific parent education tailored to their needs, coaching, or connecting them with a mental health program for needed treatment.

Since then, I have not only incorporated my own advice into my general practice, but I have learned about what all health care providers can do to restrict access to lethal means through such measures as the following:

- Learn lethal means counseling. Access the Harvard T.H. Chan School of Public Health (2015) website for their Means Matters program for families and clinicians, which provides point-to-point strategies to limit access to firearms for suicidal or troubled individuals.
- Form comprehensive partnerships with other providers and churches, schools, colleges, hospitals, gun shop owners, and the criminal justice system to problem solve prevention strategies to decrease access to lethal means by such measures as waiting periods for identification tracking, licensing, counseling, education, restraining orders, alarm systems installed on outer doors of schools, and parent education. As a professor of psychiatry at Duke University said, “We’re not go-
ing to live in a world where we do not have angry young men…but we do not have to give them easy access to guns” (Sanburn, 2015, p. 12).

- Educate parents not to foster isolation and isolative habits in their children, especially adolescents, and particularly troubled adolescents. Explain why keeping televisions, laptops, smartphones, game systems, and all other electronic communication devices out of the bedroom not only promotes good sleep hygiene, but decreases exposure to reinforcers of violent thoughts and impulses.

- Build financial incentives for gun manufacturers. Although gun makers cannot currently be held liable for crimes committed with the weapons they sell, several Sandy Hook families are suing the manufacturers of the guns that Adam Lanza used to shoot 27 people 3 years ago (Sanburn, 2015). They maintain that because the guns were manufactured for war, the manufacturers were negligent in their distribution to civilian gun shops. Suits similar to this one, coupled with strong advocacy, have the potential to build financial incentives for gun manufacturers to create and follow better safety measures related to where, how, and to whom those guns are sold.

Education and communication are the strongest tools in the goal to restrict access to lethal means and decrease risk for mass shootings. If we as health care providers have the will, if we believe we can effect change in the frequency of our nation’s active shooter incidents, then we can adapt these and other evidence-based strategies to the resources and populations served by our practice—whether in schools, private practice, hospitals, or clinics. Just counting nurses alone, there are more than 4 million RNs and APRNs in the United States (U.S. Bureau of Labor Statistics, 2012). Altogether, there are enough health and human services providers to end this epidemic of mass shootings in our country. So ask the question. Follow up on the answer. Do it now.

REFERENCES
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