How Should the Psychiatric Profession Respond to the Recent Mass Killings?

The horrific school shooting in Newtown, Conn., which took the lives of 20 children and six adults, presents psychiatry with a difficult challenge. How do we as a profession respond to these devastating acts of public violence? What is the best way to bring our expertise—as clinicians, researchers, and educators—to bear on the controversial nexus between guns, violence, and mental illness?

We have an important responsibility to educate the public. Mass killings are, by their nature, terrifying events that are seared into the public consciousness by overwhelming media coverage. They are also very rare events that contribute little to overall violence: in 2011, mass killings accounted for only 0.13% of all homicides in the United States (1, 2). Still, they may have a disproportionate and distorting impact on the public's perception and understanding of the risk posed by the mentally ill. Indeed, McGinty and colleagues (published concurrently with this editorial) found that media exposure to reports of mass shootings increase negative attitudes about people with serious mental illness (3).

We must explain an epidemiologic fact that the public likely finds counterintuitive in the wake of a mass killing: Although mass murderers probably have more psychopathology than other killers, the mentally ill as a group pose little risk of violence. Conveying this fact is no easy task in the midst of distorted rhetoric from those who would direct public attention to the link between mass killers and mental illness and away from the politically more sensitive issue of gun control and the fact that the majority of homicides in the United States are perpetrated by people who are not psychiatrically ill and are using guns.

Why, the public wants to know, can't we prevent these tragedies?

Best estimates show that only 4% of violence can be attributed to persons with mental illness (4). We know from studies of community samples that psychiatric illness per se is a risk factor for violent behavior, but the added risk is small and associated only with certain disorders. The best study on this topic (5) showed that patients with serious mental illnesses—schizophrenia, major depression, or bipolar disorder—were two to three times as likely as people without such illnesses to be assaultive. In absolute terms, the lifetime prevalence of violence among people with serious mental illness was found to be 16%, as compared with 7% among people without mental illness.

What the public might find surprising is that alcohol and drug abuse are far more likely to result in violent behavior than other mental illnesses. People who abuse alcohol or drugs but have no other mental disorder are nearly seven times as likely as those without substance abuse to commit violent acts.

Still, these statistics are cold comfort for a public traumatized by a mass killing. Why, the public wants to know, can't we prevent these tragedies? While we welcome recent calls to improve mental health services and to invest in early screening for and treatment of psychiatric illness, we have to be frank in acknowledging that

mental health experts do little better than chance in predicting who will be violent (6). We also have to recognize that our current threshold for involuntary commitment and treatment, which requires an imminent risk of harm to self or others, seems too lax to much of the public. At present, psychiatrists can act to prevent potential violence only when the patient voluntarily seeks assistance or in very limited circumstances when patients have issued frank threats. We are legally powerless to act in myriad situations where there are warning signs of danger that fail to meet that threshold.

It would not be surprising if, in the wake of the Connecticut shooting, policy makers call for a reevaluation of the criteria for involuntary treatment. An argument could be made to loosen these criteria from imminent risk to a reasonable likelihood of violent behavior based on the presence of a combination of known risk factors for violence. For example, a person with schizophrenia with a history of impulsive rage who is paranoid, abusing alcohol, and making vague threats is at significant risk of violent behavior in the near future. In the current climate, the public might well favor a policy under which this patient can be treated, over objection if needed, before he issues—or enacts—a specific threat.

As psychiatric experts, we must also explain that lowering the threshold for involuntary treatment may discourage other psychiatric patients from being candid or seeking help voluntarily and have the undesirable effect of driving some of the sickest patients away from the mental health system.

We may decide as a society to move in this direction, but we have to make it clear that involuntary outpatient treatment is difficult to conduct, extremely expensive, and almost certain to infringe on the freedom of those persons with mental illness who are incorrectly judged to be at risk for violence. It is also unlikely to prevent mass killings, since we are poor at identifying these individuals, who have a history of avoiding psychiatric treatment.

The public also wants our expert advice about whether violent video games can induce violence in young people. It is easy to imagine such a link, in light of comments such as those of Anders Breivik, the Norwegian who shot and killed 77 children in 2011. He testified that he prepared for the massacre by playing a commando video game for several months (7). At present, though, the best available data are correlational and cannot tell us whether these violent games encourage violent impulses in individuals or whether violent individuals are simply drawn to these games in the first place (8). In short, we need more research in this important area to help clarify the causal direction.

Finally, our most difficult challenge is how to weigh in on the most controversial issue at the heart of this and other mass killings: the link between guns and violence. The statistics are sobering. More than 31,000 people die in the United States each year from gunshot wounds—17,000 from suicide and 13,000 from homicide. The homicide rate in the United States is seven times higher than the aggregated average of homicide rates of 22 other high-income countries, and the firearm homicide rate in the United States is 20 times higher than in these other countries (9). Research also has shown that having a gun at home substantially increases the risk of dying by homicide and suicide (10).

Yet, according to the 2004 report "Firearms and Violence," sponsored by the National Research Council, the empirical data are too weak for us to know which policies are likely to be effective in reducing gun-related violence (11). For example, the study found little credible evidence that the passage of right-to-carry laws decreases or increases violent crime. The report concluded that "if policy makers

are to have a solid empirical and research base for decisions about firearms and violence, the federal government needs to support a systematic program of data collection and research that specifically addresses that issue." Disturbingly, the opposite has happened. Research on the impact of firearms is now a fraction of what it was in the mid-1990s, a trend that likely reflects the success of the National Rifle Association (NRA) in blocking serious gun research. (The NRA, for example, supported legislation to block access to the highly informative data available from the Department of Justice that traces guns used in crimes.)

We should make it clear that while definitive data are lacking to determine the best gun control policy, there is substantial empirical evidence from cross-national studies to show that guns and homicide in the United States are strongly linked. At the same time, we should be forceful in speaking out in support of further empirical research on firearms. Indeed, since the Newtown shooting, President Obama has issued an executive order instructing the Centers for Disease Control and Prevention and other federal science agencies to conduct research into the causes and prevention of gun violence. He called on Congress to fund this research and to expand the federal reporting system on violent deaths to all 50 states, from the current 18 (12). New York State has been first to respond with the passage of a law to expand the state's ban on assault weapons and a new focus on the link between gun violence and mental illness, made clear by enhanced efforts to keep guns away from persons with mental illness. The new law requires mental health professionals to report when they believe patients are likely to harm themselves or others (13).

Many of us have passionate advocacy positions on socially charged issues like gun control, positions that may or may not be supported by empirical data. When we enter public discourse as psychiatric experts, we have to remember to distinguish between our professional knowledge and expertise on the one hand and our personal advocacy positions on the other. Our primary role as psychiatric experts in public discussions about the controversial links between guns, violence, and mental illness should be to educate the public and to provide public officials with the best available data and critical thinking to help inform the dialogue and the decision making that drive public policy.

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The authors report no financial relationships with commercial interests.