GVP41 Terri DeRoon

D: Please state your name.

T: Sure, Terri DeRoon Cassinii.

D: And Terri is it okay if I ask how old are you?

T: Yes, I am forty-one.

D: You look good for forty-one, girl.

T: Well, thank you. (laughter)

D: And can you share with me your experience with gun violence?

T: Absolutely. So, I am the medical director for the trauma psychology program here, at Froedtert Hospital in the Medical College of Wisconsin. And so, I'm a faculty member in the department of surgery in the division of trauma and acute care surgery. And initially my job was to design a psychology program that was responsive to our trauma survivors that came through our trauma center, which includes our gunshot wound survivors. And so, the majority of gunshot wound survivors that happen in the city of Milwaukee get transported to Froedtert Hospital. We see about 450 gunshot wound survivors a year. And so, a number of those individuals get admitted to the hospital and are treated inpatient for their injuries and our psychology service works with those patients inpatient and also outpatient, as about half of gunshot wound survivors develop PTSD, or Post-Traumatic Stress Disorder, and/or depression after a traumatic event. And part of our job is to try to prevent that from happening, or in those individuals who are diagnosed with PTSD or depression, trying to treat them so that the severity of, of those illnesses dissipate.

D: Wow. I didn't know you hooked me up this well. (laughter) So, explain to us what happens when a gunshot victim comes to Froedtert.

24 T: Mhmm. They're trans-they could be transported in many different ways, sometimes by
25 ambulance, sometimes they're brought here by friends or family. They're brought into the
26 trauma bay of the emergency department and our trauma surgery team is along with the
27 emergency department physicians and nurses and advanced practice providers will treat those
28 trauma patients. And they'll make a determination of what injuries were incurred because of the
29 gunshot wound and then what intervention is needed in an emergent fashion. And sometimes that
30 might mean emergent surgery, sometimes that might mean, you know, some of our gunshot
31 wound survivors get discharged from the emergency department because maybe the bullet went
32 through the body in a way that it didn't cause a lot of damage. And then if they do get admitted
33 to the hospital and maybe they have surgery, then they're cared for on the inpatient side with our
34 nurses on the floor, we have a wonderful group of nurses both in the surgical ICU and on the
35 trauma unit floor to handle the medical care of these trauma patients. At that point, they may be
36 exhibiting distress. Sometimes gunshot wound survivors will report hearing flashbacks of the, of
37 the shooting. They may report seeing the shooting as if it were happening over and over again in
38 their mind and they can't get it out of their mind. Some gunshot wound survivors will have
39 nightmares when they're sleeping or have trouble falling asleep 'cause they're scared because of
40 what happened to them. And those are early symptoms of Post-Traumatic Stress Disorder. So, if
41 somebody on our team sees that or hears that they might be having these symptoms or if one of
42 our social workers screens patients and determine that they're at risk for developing long-term
43 distress related to the shooting, then our trauma psychology service is consulted. And then we
44 start and initiate a consultation and treatment if needed with those patients. And if needed after
45 discharge, we'll also continue treatment outpatient.

46 D: So, I'm in the hospital, I've been shot and I can't go asleep because I'm afraid. Well, what
47 would a nurse do or?
48 T: Yeah so, the nurse, the nurse would page us, the tr-the psychologists as a part of the trauma
49 team. And then we would do an evaluation to determine what symptoms people are having and if
50 the symptoms are like, fear of being, not being able to sleep, or fear that the person that shot
51 them is gonna retaliate again. We would work with them to make the changes necessary to help
52 them feel safe, remind them that the unit is a locked unit, remind them that they can't you know,
53 not, not anyone can get into the unit, we can also make patients what we call "nondisclosure"
54 where their name isn't anywhere listed publicly or if someone were to call to try to find what
55 room they're in, the operators wouldn't be able to acknowledge that those patients existed at the
56 hospital. If some, and then we also know that people who are exhibiting these re-experiencing
57 symptoms, these nightmares or flashbacks or hearing as if the gun-the gunshots are happening
58 again, we know that when individuals don't talk about what happened, we know that that can
59 make those symptoms worse. So, we do a lot of education around what we call "nonavoidance",
60 of making sure that patients understand that it was ru-we can imagine it was very scary, but also,
61 they're, they're alive and yet, holding in everything that happened won't allow them to
62 emotionally recover. And so, we encourage them to tell us the story of what happened, in a, and
63 kind of over and over and over again in a way that allows them to kind of look at the story from
64 all sides emotionally, so that they can come to some sort of resolution with it. And we continue
65 that on an outpatient basis if necessary.
66 D: Wow. So, in telling your story, you're saying it actually helps—
67 T: Mhmm.
68 D: —Post-Traumatic Stress.

69 T: Mhmm.

70 D: Of those who don't tell their stories, have you seen that they've a breakdown or have you had,
71 they've had to come back to the hospital? What normally, do we know what happens to those
72 who don't tell their story?

73 T: Yeah, for those that don't tell their story, but are distressed and are having symptoms, some of
74 'em kind of do end up reaching a breaking point. And you know, it's, it's not uncommon, you
75 know, in the hospital, patients are dealing with a lot, right? They were just shot. Many of them
76 report that they thought they were gonna die and this was the most fearful thing that ever
77 happened to them and that's scary enough itself. Plus, they might have tubes in, coming in and
78 out of their body. They might be having to have multiple surgeries. They might have to go home
79 with medical equipment attached to them that they never thought that they would have before.

80 D: Wow.

81 T: It's a lot that a lot of them have to deal with physically that sometimes patients just, that's
82 enough. Like, trying to deal with the emotional aspect of the trauma sometimes isn't the right
83 timing, which we respect because people need to be in the right place to also focus on their
84 emotional recovery after a traumatic event. So, we make it very clear that, you know, "If at any
85 point you feel like you need to talk about what happened or if you keep having these symptoms
86 and they don't go away, you can come see us on an outpatient basis." You know? Some patients
87 inpatient immediately take to, "Oh yeah, that makes sense. If I, if I kind of hold this in, I could
88 see how I could kind of become, the pressure could build and I might explode like a volcano."
89 Where others might feel that focusing on it causes them to explode.

90 D: Okay.

91 T: Okay? So, we, we educate people about emotional recovery after trauma, but also respect
92 where they're at. And for some, it's enough to hear that, "Okay, so, I have a couple people in my
93 family. If you're telling me I need to talk about what happened, I've got some good friends, or
94 some good family members that I can talk to about this with." And sometimes, we'll even pull
95 those family members in and kind of talk to the family and the patient together about why this is
96 important. And so, but sometimes people don't have that person they can lean on, or don't feel
97 like they wanna burden their loved ones with the story of what happened to them. And so, that's
98 when we'll kind of establish a longer term relationship with those patients to, to do treatment if
99 necessary.
100 D: I didn't know the Medical College did all of this.
101 T: I know, we've been doing this for like, so, I started the program almost, it'll be eleven years in
102 September. Yeah.
103 D: A well-hidden secret.
104 T: Yeah. (laughter)
105 D: Well, one that you don't wanna find out.
106 T: Yeah, yeah, exactly. That's what my husband always says.
107 D: Yeah.
108 T: When if, if it's a day that you have to talk to me, it's probably not a good day for that person.
109 D: Exactly.
110 T: Yeah.
111 D: So, what would you say are some of the ways that we could, we could do to reduce gun
112 violence?

113 T: Yeah, I think the number one priority for reducing gun violence is to first and foremost view
114 gun violence as a disease. And it's a disease because when a gun, gun violence happens it
115 spreads. And that's similar to any other disease, like the flu. You know, when you have an
116 affected individual, they are likely or increased risk to infect the ones that are closest to them and
117 around them, right?
118 D: Mhmm.
119 T: It's the same with gun violence. We see individuals who might have been a victim of gun
120 violence and there's family members or the, the patients themselves that might desire to retaliate
121 or they might be in a situation where they could be at risk after, you know, once they discharge
122 from the hospital because they're still alive. And so there are outbreaks of gun violence that
123 happen and we need to treat it as a disease, just like we treat any other disease. And I think the
124 medical community needs to adopt this and I think the greater public needs to adopt gun violence
125 as a disease because we all have a role in preventing the spread of disease. And we need to
126 embrace the prevention of gun violence as a whole community, as a whole state, as a whole
127 country in order to prevent gun violence from occurring at the rates that it's occurring at.
128 D: Could you think of an example of how we could approach gun violence as a disease?
129 T: Absolutely. So, we recently partnered with the Office of Violence Prevention and Reggie
130 Moore is the director of the Office of Violence Prevention. And h-they have adopted the cure
131 violence model that started at Northwestern University with Gary Slutkin and in Chicago. And
132 it's really taking this public health approach to gun violence and gun violence as a disease, where
133 you employ individuals who have experience with violence and have credibility in the
134 communities where the violence is happening to respond when the outbreak occurs, to try to
135 prevent the spread of violence. So, the way that's happening, it's a program that's been funded in

136 the City of Milwaukee called 414 Life. And, they've been in the community now for five months
137 where they are trying to be as responsive as immediately as possible to incidents of violence,
138 especially gun violence, to try to deescalate the situation, to try to come up with mediation
139 agreements between the parties so that the violence doesn't spread. The piece that we're
140 partnering with, with Reggie and the 414 Life Team, is when a gunshot wound survivor comes to
141 Froedtert Hospital and when they're between the ages of fifteen and thirty-five and when they're
142 from the city of Milwaukee, our social workers in the emergency department will immediately
143 page a 414 Life hospital responder, who's apart of Reggie's team. They will come to the
144 hospital, they will meet with the patient to talk about the incident that occurred and if there's an
145 avenue for them to intervene, to, to prevent the spread of violence that may take the form of
146 helping to negotiate peace between the parties that were involved in the conflict. And then they
147 will also work with family members because it's often that there's stories of when family is so,
148 emotionally overwhelmed by the fact that their loved one almost died, that they wanna do
149 something. And so, sometimes people's response is to retaliate. So, they also wanna make sure
150 that there's no retaliation that occurs because that's the spread, right, of the violence.
151 D: Yes, makes a lotta sense.
152 T: It does.
153 D: You just solved it. (laughter) You guys just—
154 T: I hope so.
155 D: —You guys just solved it. (laughter) What legislation, if any, would you suggest to
156 lawmakers?
157 T: Oh. (laughter) I would suggest that we ban assault rifles, I don't think there's a place in our
158 country for the need. There is nothing more deadly with an individual with assault rifle. It's

159 every, almost every day that I am with a patient or a family member who either lost a loved one
160 because of gun violence or is so terrorized by the, almost losing their life, that they're paralyzed
161 in life. The amount of suffering that I've seen at the hands of gun violence is unbelievable. And
162 it needs to stop. And I think assault rifles need to be banned. I also think that we need to
163 recognize the mental health outcomes of gun violence. That we have individuals who maybe
164 were, were victims of gun violence, who survived, but then are, are incapacitated because
165 psychologically they're dealing with a tremendous amount of symptoms and distress which
166 makes them constantly fearing for their lives, which makes it hard for them to go to work, which
167 makes it hard for them to have interpersonal relationships, which makes it hard for them to
168 contribute to society. So, from a state legislation standpoint, I think we need to see programs that
169 offer services to individuals who, who need that long-term mental health support. And as well as
170 resource support. Maybe they need to get out of the place that they were living because that's
171 where they were shot. We need to have immediate funds available to relocate people for safety.
172 We had an incident a couple months ago where there was an individual who, he was shot
173 fourteen times and he survived.
174 D: Hmm.
175 T: And yet, he knew that if he went home, he would be a target for a, a second shooting because
176 of who shot him. And they knew, and he was shot in his home. Imagine what it would be like to
177 go back to the home where not only you were just shot and almost lost your life, but you also
178 knew that the shooters knew where you lived.
179 D: Oh my god.
180 T: And so, we need to have better resources and emergent resources available. We have a great
181 crime victim compensation program at the state level, but that takes time to get those services

182 approved. And to get resources allocated to those who deserve those resources. We need more
183 emergent crisis resources available to help relocate families and individuals that survived
184 gunshots.
185 D: That's excellent.
186 T: Yeah.
187 D: That's what they do for probation and parole.
188 T: Yeah.
189 D: So, why can't we do it for this?
190 T: Exactly. And, and we need, we need to recognize that individuals m-may not be fully
191 functional after a gunshot wound even after their physical health has recovered because their
192 mental health directly affects their quality of life and their ability to engage in society.
193 D: Hmm. Is, just getting rid of that, is there anything you'd like to add?
194 T: (pause) I think one thing that's really important to understand in the city of Milwaukee is that
195 two things, one, I don't think many people understand the role that the trauma center at Froedtert
196 Hospital plays in treating gun violence. We have an amazing resource in the city of Milwaukee.
197 It's the only adult level one trauma center in the city. The only other level one trauma center in
198 the city is at Children's Hospital. So, they treat, they treat children. Froedtert Hospital treats
199 adults. And, and trauma centers are a tremendous resource for the community because not only
200 does, do those individuals are highly trained to be able to treat the most severe injuries, but
201 they're also the individuals who look to preventing the disease. And so, because you know what,
202 they would love to see less patients, (laughter) from a trauma standpoint, come through the
203 doors. And so, I think that's the second point, which is really people educating themselves about
204 understanding that trauma and gun violence is a disease and that we all need to talk about it in

205 that way and educate each other and others about violence as a disease. And, and talk about both
206 the, the physical outcomes of trauma, but also the mental health outcomes of trauma. You know,
207 when somebody survives an experience where they thought they were gonna lose their life,
208 there's a lot of strength that comes from that survival, but there's also distress and suffering that
209 can come from that, that survival. Because it was such a fearful experience. And we need to be
210 able to provide resources to support those individuals as they recover.
211 D: Wow. Even our schools.
212 T: Ugh, yeah. Yeah.
213 D: That's a project I wanna take on, but I just don't see how I could fit it in.
214 T: Yeah, yeah.
215 D: Well, thank you!
216 T: Yeah, thank you!
217 D: Wow.