The Aftermath of December 14, 2012

“When I was a boy and I would see scary things in the news, my mother would say to me, ‘Look for the helpers. You will always find people who are helping.’ To this day, especially in times of ‘disaster,’ I remember my mother’s words, and I am always comforted by realizing that there are still so many helpers — so many caring people in this world.”

— Mister Rogers
(The Fred Rogers Company, 2011)

Following the December 14 tragedy in Newtown, Connecticut — the murder of 20 children and 6 adults at Sandy Hook Elementary School — many of us in the caring professions quite appropriately put the Newtown’s surviving children and the children in our lives in the forefront of our action plans. When children looked around, they were sure to see many helpers.

In the weeks following, solutions have been discussed at the federal, state, and local levels. In trying to curb gun violence, President Obama is pushing for improved mental health services, a revival of gun-related research, and beewed-up reporting about potentially dangerous people who should not own guns (Dennis & Sun, 2013). These efforts are likely to rely heavily on the states and the public health sector.

As pediatric nurses, we have a powerful role to play in prevention efforts that involve identification of children at risk for violence, and the development and implementation of violence prevention strategies. According to Gance-Cleveland (2001), people who have not initiated serious violent behavior by age 20 are unlikely ever to become serious offenders.

However, what about children who already display violent and threatening behavior? How can we help these children and their families? The first thing: It is time to talk about mental illness, and to discuss it without using pejorative words I have heard used recently in the media, such as “crazy” or “lunatic” — terms that further stigmatize mental illness and create visions from the 1948 movie, *Snake Pit*.

The second thing is a bit more challenging: helping families cope with having a child with mental illness in the home. We often know very little about the day-to-day lives of families of children with mental disorders. However, in the wake of December 14, Lisa Long, the mother of a child with mental illness, broke the silence and spoke out. Although every family’s story of a child with mental illness is unique, this excerpt describes her family’s experience with their 13-year-old son:

I live with a son who is mentally ill. I love my son. But he terrifies me.

A few weeks ago, Michael pulled a knife and threatened to kill me and then himself after I asked him to return his overdue library books. His 7- and 9-year-old siblings knew the safety plan — they ran to the car and locked the doors before I even asked them to. I managed to get the knife from Michael, then methodically collected all the sharp objects in the house into a single Tupperware container that now travels with me. Through it all, he continued to scream insults at me and threaten to kill or hurt me.

That conflict ended with three burly police officers and a paramedic wrestling my son onto a gurney for an expensive ambulance ride to the local emergency room. The mental hospital didn’t have any beds that day, and Michael calmed down nicely in the ER, so they sent us home with a prescription for Zyprexa® and a follow-up visit with a local pediatric psychiatrist (Long, 2012).

According to the U.S. Department of Health and Human Services (1999), about 1 in 10 children live with a serious mental or emotional disorder. One-half of all lifetime cases of mental illness begin by age 14, and three-quarters by age 24 (Kessler et al., 2005). Although there are effective treatments, there are long delays — sometimes decades — between the first onset of symptoms and when people seek and receive treatment (Wang et al., 2005).

The current shortage of psychiatric hospital beds for children in crisis further complicates the issue of getting timely and appropriate treatment. There is often nowhere for them to go. A survey of 603 hospital beds further complicates the issue of getting timely and appropriate treatment. There is often nowhere for them to go. A survey of 603 hospital beds

Editor’s Note: MaryAnn Murtha, a resident of Newtown, Connecticut, asks that as with 9/11, we call the tragedy 12/14 rather than Newtown. She states, “That’s not only the day it happened, it’s also the number of beautiful children and talented educators taken from us. If we call that day: 12 + 14 = 26. If we call that day 12/14, we shift the focus from where these horrors happened to when they happened and how many lives were lost. And sadly, we also know this could have happened anywhere” (Murtha, 2013). She explains that having your town’s name synonymous with an evil act does not aid the healing process, and that, in fact, it adds to the pain and casts shadows. “We need your light, your love, and your support” (Murtha, 2013).

Effectively, the current shortage of psychiatric hospital beds for children in crisis further complicates the issue of getting timely and appropriate treatment. There is often nowhere for them to go. A survey of 603 hospital beds
emergency departments found that 86% of their emergency departments are “sometimes” or “often” unable to transfer behavioral patients to inpatient facilities in a timely manner (Brauser, 2011). In other instances, a bed might be available, but the hospital is not within the patient’s insurance network (Khazan, 2013).

Because children differ from adults in that they experience many physical, mental, and emotional changes as they progress through their natural growth and development, diagnosing mental disorders in children can be tricky. What is considered “normal” covers a wide range of behaviors and abilities. Thus, any diagnosis must consider how well a child functions at home, within the family, at school, and with peers, as well as the child’s age and symptoms (Goldberg, 2012).

Families similar to the Long family often live in isolation, having little interaction with or support from their communities. Most mental disorders are caused by a combination of factors and cannot be prevented. Yet, if symptoms are recognized and treatment begins early, many of the distressing and disabling effects of a mental illness may be prevented or at least minimized (Goldberg, 2012).

I truly believe we could do much more to help families with children already engaging in violent and threatening behaviors. There are excellent programs in many communities effectively meeting the needs of families, but the tragedies that happened at Newtown, Virginia Tech, Columbine – I could go on – are all evidence that there is much more work to be done. If we do the first thing – reduce the stigma that still surrounds mental illness – families won’t be as embarrassed or afraid to speak out.

This will help us to do the second thing: identify these often fragile families that are struggling, encourage them to tell their stories, and – applying an important concept of family centered care – ask them for suggestions on what they think might be helpful to them as a family. We may not be able to prevent mental illness, but in working in partnership with families, we can let them know that we are in this together and will make every effort to assure the best possible outcomes for their child and family.

These are scary times with difficult things to talk about. Our children need to see many helpers, many caring people working together, working as hard as they can to create a safer world.

References