Clinician Response to a Child Who Completes Suicide

Cheryl S. Al-Mateen, MD[a,b,*], Kathryn Jones, MD, PhD[a,b], Julie Linker, PhD[a,b], Dorothy O'Keefe, MD[a,b], Valentina Cimolai, MD[a,b]

KEYWORDS

• Child • Adolescent • Suicide • Impact on clinician • Postvention • Postsuicide • Reactions to suicide

KEY POINTS

- Suicide is the most likely cause of death for children and adolescents treated by psychiatrists. More than half of psychiatrists experience the suicide of a patient at some point in their careers.
- Psychiatrists and other clinicians often experience strong reactions to patient suicide, including shock, guilt, isolation, insomnia, and self-doubt.
- Trainees are more likely to experience the suicide of a patient and are more affected by the experience.
- Clinicians need specific training on suicide postvention, including legal, administrative, emotional, and professional ramifications.

INTRODUCTION

"There are two types of clinicians; those who have had a patient commit suicide and those who will." –Robert Simon, MD[1]

"Suicide is the major cause of mortality in the realm of diseases with which psychiatrists and other mental health clinicians work.[2]" The possibility that a child and adolescent psychiatrist will have one of their patients complete suicide is real. As many as 68% of consultant psychiatrists have lost a patient to suicide[3,4] and 22% of a group of psychologists acknowledged having a patient that completed suicide.[5] Suicide may be an occupational hazard for mental health professionals.[6]

Disclosure: The authors do not have any direct financial relationships that are related to the subject matter discussed in this article.

[a] Department of Psychiatry, Division of Child and Adolescent Psychiatry, Virginia Treatment Center for Children, Virginia Commonwealth University School of Medicine, PO Box 980489, Richmond, VA 23298, USA; [b] Department of Psychiatry, Division of Child and Adolescent Psychiatry, Virginia Treatment Center for Children, Virginia Commonwealth University School of Medicine, 1308 Sherwood Avenue, Richmond, VA 23220, USA

* Corresponding author. Virginia Treatment Center for Children, 1308 Sherwood Avenue, Richmond, VA 23220.

E-mail address: cheryl.al-mateen@vcuhealth.org

Child Adolesc Psychiatric Clin N Am ■ (2018) ■–■
https://doi.org/10.1016/j.chc.2018.05.006 childpsych.theclinics.com
1056-4993/18/© 2018 Elsevier Inc. All rights reserved.

ARTICLE IN PRESS

The authors attempted to review the literature on the response of clinicians to the suicide of children and adolescents and found it lacking. Therefore, this article reviews the topic of suicide in children and adolescents, and discusses the literature on impact of suicide on mental health clinicians. From our investigation of extant literature, it is useful to consider the aftermath of a patient's suicide as a series of reactions, responsibilities, and interventions, first referred to as postvention activities.[7]

SUICIDE IN CHILDREN AND ADOLESCENTS

In our lifetime, the absolute number of deaths, as well as the age-adjusted suicide rates for all age groups except the elderly, have increased by 24%. For the youngest age group for which data exist, 10 to 14 years old, the suicide death rate has increased by 76%.[8] Thirty-five years ago, suicide was the seventh leading cause of death among children 5 to 14 years old.[9] In 2016, suicide was the second most common cause of death for those 10 to 14 years old, behind only accidental injury.[10] Because the Centers for Disease Control and Prevention National Violent Death Reporting System does not classify suicide as a cause of death for children less than 10 years of age, there are no nationwide data for younger children.[11] For decades, children were not considered to have the necessary cognitive development for suicidality, either because they lacked understanding of the lethality of their self-destructive behavior or because they did not recognize death as permanent. In a study of Canadian children,[12] 10% of first graders, 50% of third graders, and 90% of fifth graders understood the word suicide and the concept of self-initiated death. If the occurrence of suicide has increased in children older than 10 years, a similar increase in younger children seems likely, despite an absence of supportive data.

A psychological autopsy study comparing suicides in Norwegians aged 15 years and younger with matched youth killed in accidents found that only 20% of the suicides met criteria for psychiatric diagnoses and that 12% had prior suicide attempts. In retrospect, stressors were evident but at the time were not thought relevant.[13,14] A review of 15 psychological autopsy or retrospective case studies of children less than 14 years of age who died by suicide identified several unique characteristics[15] (**Box 1**).

Box 1
Literature review of 15 retrospective case studies of children less than 14 years of age who died by suicide: unique characteristics

- Gender asymmetry (male>female) in suicide is *less* marked in children than in adolescents
- Suicide is more prevalent in indigenous populations, especially in children
- Preexisting mental health diagnosis is less common in children than in older teens, as is substance use disorder, which is a significant risk factor for suicide in older adolescents
- Prior suicidal behavior in roughly 20% to 30% of completed child suicides
- Preoccupation with death (thinking, dreaming, drawing) in nearly 50%
- Family mental illness, especially past parental suicidal behavior
- Poor communication with parents; history of physical or sexual abuse
- Outside the home, academic problems and bullying contribute to increased risk
- Fewer than 20% of children who died by suicide had outpatient mental health treatment or school services in the year before their death.

Data from Soole R, Kõlves K, De Leo D. Suicide in children: a systematic review. Arch Suicide Res 2015;19(3):285–304.

Download English Version:

https://daneshyari.com/en/article/10222014

Download Persian Version:

https://daneshyari.com/article/10222014

Daneshyari.com