"I'M TAKING HER HOME!"
FIVE COMMON SCENARIOS OF PARENTAL PSYCHIATRIC HOSPITALIZATION REFUSAL AFTER A CHILD'S SUICIDE ATTEMPT

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Case: *A 14-year-old female patient is admitted to a children's hospital after a suicide attempt. She ingested 40 tablets of acetaminophen 500mg and initially required N-acetylcysteine and observation in the pediatric intensive care unit. She admits to having made another suicide attempt in the past, which her parents did not know about. The patient is later moved to the general pediatrics floor, where her mother repeatedly states she is "ready to take her daughter home now." When the consulting child psychiatrist, who is meeting the family and the patient for the first time, arrives to conduct an evaluation, the patient's mother is waiting at the door with her arms crossed, and states immediately: "We're not going anywhere but home."*

Suicide attempts are unfortunately common in American adolescents, with an annual incidence of 8.8%. Not all of these attempts come to the attention of the medical community; between September 2012 and December 2013, 2.7% of American adolescents reported having a suicide attempt requiring medical treatment in the past year.[1] Adolescents with certain psychiatric diagnoses (e.g. depression, bipolar disorder, substance use disorders, and psychotic disorders) are at high risk for suicide. The incidence of suicide doubles when a patient with one of these diagnoses makes a suicide attempt or requires medical attention.[2]

The statistics about the rate of parental refusal of recommended psychiatric hospitalization are not well known; however, most child and adolescent psychiatrists will experience several cases during their careers. These cases can be complex and challenging to navigate successfully. Parental refusal of inpatient psychiatric hospitalization may be prominent following a suicide attempt, particularly in adolescent patients, for a number of reasons, including misinformation (or lack of information) about psychiatric hospitalization, parental denial of the attempt and its significance, the stigma of mental illness, and/or strong parental fears of separation from their child.

The benefits of psychiatric hospitalization following a suicide attempt are numerous. Psychiatric hospitalization allows for clarification of diagnosis, psychoeducation of the patient and family, treatment initiation for previously unrecognized mental illness, and securing of outpatient treatment. Alternative approaches to inpatient hospitalization include intensive outpatient treatment, day treatment, or urgent "next day" child psychiatric evaluation. These are rarely available on an immediate basis and do not offer the same level of safety and intensity of therapeutic intervention that psychiatric hospitalization can provide.

Although laws vary by state, physicians are often required to obtain consent from the family prior to important non-emergent medical decisions regarding youth, including inpatient psychiatric admission for suicide attempt. During the consent process, families learn about available options for treatment and are given the opportunity to make choices consistent with their cultural, religious, and personal beliefs.[4] When parents refuse clinical recommendations to hospitalize their child after a suicide attempt, clinicians may feel trapped between honoring parental wishes and the safety of the patients.

This article provides an overview of parental refusal of transfer to psychiatric inpatient care setting from a medical inpatient hospital (or emergency room) after a child's suicide attempt. First, we will review general communication principles clinicians can use in difficult clinical situations. We will then examine five common phenomenologies of parental inpatient hospitalization refusal after a pediatric suicide attempt. For each scenario, we offer strategies to ensure safety of the adolescent and high-quality family–clinician rapport.

General Communication Principles for Difficult Conversations

It is useful for clinicians to think about a clinical encounter with parents who are opposed to hospitalization as similar to delivering other emotional or tragic news to parents (we will use the term "parents" to denote the wide variety of caregivers that pediatric patients may have). Having a child attempt suicide and/or be diagnosed with a severe mental illness can be a life-changing experience. Rabow and McPhee's "ABCDE" mnemonic[5] can be used as a guide for careful and thoughtful communication in these circumstances.

ABCDE Mnemonic:

- ***Advance Preparation*** is important. When clinicians meet families for the first time in a medical setting, it is important to make sure the medical team has prepared the family for psychiatric consultation

and clarified why the psychiatrist will be joining the treatment team. Clinicians can talk to the medical team in advance to preview the family's wishes. Ideally, he or she should try to secure a private and undisturbed space to speak with the patient and the family. If the conversation occurs in an outpatient setting, it is important to schedule enough time so that pressure to end the conversation prematurely is minimized. Even experienced clinicians vary in their capacity to handle difficult conversations. Mindfulness of one's own mental state, reactions, and attitudes will help child psychiatrists with advance preparation as well as with the management of their own stress.[6]

- ***B*uild a Therapeutic Relationship** with the child and the family. Clinicians should let the family know, without ambiguity, that the priority is to help, and that they care about the patient and the family and respect their values and viewpoints.
- ***C*lear *C*ommunication**: Begin with open-ended questions. Clinicians should listen to parent concerns. When giving recommendations, be straightforward about the nature of the suicide attempt, the child's suspected diagnosis, and the treatment team's recommendations. Clear and concise language is important. For example, if parents ask if their child really needs a psychiatric hospitalization, reply with a simple "yes" before launching into any deconstruction of the recommendation. Allow some time for quiet contemplation and do not elaborate right away. This information may take time to sink in. In place of elaborating or explaining details, you may ask the family to repeat their understanding of the news.
- ***D*eal With Any Type of Child and Family Reaction**: Assess exactly how the news is being handled. Use the technique of active listening. Listen to the family's concerns and ask them to reflect or re-state in their own words what they have been told, to confirm they heard accurately, and to facilitate understanding between clinician and parents.
- ***E*ncourage and Validate Emotions** of the child and family. Use cognitive-behavioral therapeutic techniques to identify and gently guide the correction of any cognitive distortions that they may have. At the same time, validate emotions that the child and parents have related to the current situation.

Common Refusal Scenarios

The following section describes five common scenarios of parental refusal of psychiatric hospitalization, as well as suggested approaches to facilitate communication and improve health outcomes for the child in the context of each scenario. We chose the most common scenarios of parental psychiatric hospitalization refusals based on our consult-liaison experience.

Scenario 1 – Unfamiliarity: Parents don't recognize or understand the need for intensive psychiatric treatment and safety monitoring.

"She's fine now. Why would she need to go to a psychiatric hospital?"

After a life-threatening suicide attempt, the focus of critical care treatment in the hospital is likely to be medical stabilization. For example, after a medication overdose, a patient may be intubated, may be on cardiac telemetry, or on medications to spare their liver or kidneys. The psychiatric evaluation may often occur near the end of the medical stabilization. When the consultant begins to discuss the case with the family, parents may be feeling relieved that treatment is almost over. The primary medical team may already have spoken about discharge or "medical clearance" and parents may have interpreted this as readiness to take their child home. Many parents may also be confused about the need for psychiatric hospitalization simply because this is the first time they are encountering the mental health system.

Method of Approach: It is important to bring up the psychiatric care of the patient with the family early in the course of the hospitalization. The medical team can discuss this aspect of care as being an important portion of treatment of the patient at the early stages of medical hospitalization. This way, the family will understand that psychiatric care is integral to their child's health. Even if the patient is medically ill and unable to be interviewed, psychoeducation with parents can begin. Parents need to be educated about the basic epidemiology of suicidal behavior, including risk factors. The consultant can gradually guide the parents' focus from acute medical procedures to the underlying problems that caused the suicide attempt and what to expect from addressing these problems. The child psychiatrist should appreciate this process and be attuned to parental receptivity. Meet the parents where they are and help guide them through the process ahead.

Parents should know that individuals who attempt suicide are four times more likely to die by suicide than non-attempters. Moreover, there is a 5-15% risk of repeat suicide attempt per year with the greatest risk in the first twelve months following initial attempt.[7] Parents need to understand that the risk of repeat attempt remains high for years after an attempt. Risk factors for repeat suicide attempt and for suicide can be cited,[8] and the clinician can emphasize in particular modifiable risk factors

(including environmental and psychiatric comorbid factors - see Figure 1) that are found in the child they are evaluating. These will be the targets of treatment in inpatient psychiatric hospitalization.

When hospitalization is the next step, help the family understand why hospitalization is the proper course. For example, one must help parents understand that continued suicide risk is imminent or that a less restrictive treatment environment is currently unavailable for their child. It is important that psychiatrists emphasize that they are obliged to pick the least restrictive treatment environment and that inpatient treatment is not recommended unless it is the proper medical decision for an individual child.

Scenario 2 – Denial: The parents are in denial about the suicide attempt and its significance as a life-threatening event.

"But she has cheerleading practice tomorrow!"

Denial presents in different ways. Parents may appear angry with the consultant. They may overly focus on minor life events that the patient *has* to get back home to. They may minimize the patient's symptoms or the significance of those symptoms. A form that denial may take is exceptionalism, i.e., for a parent to claim their child differs from all other suicide attempters. Parents may state that their child is "*different than the other children you send to inpatient units*." Some families may flatly reject that there was any suicidal intent at all, and that it was simply some sort of accident, attention-seeking behavior, or misunderstanding, despite evidence to the contrary.

Methods of Approach: Returning to the ABCDE mnemonic, it is important to be tolerant of any and all emotional reactions and never argue the validity of these emotions. **D**eal with family reaction, and **E**ncourage and validate the emotions behind the denial. A useful approach is to actively validate the parents using Linehan's[10] Dialectical Behavioral Therapy (DBT) technique of uncovering the validity inherent in their emotional response to these events. For example, a useful response to the above cheerleading argument might be, "*I understand how disruptive this is and how distressing it must be for you and your family*." Then stop and listen for their response.

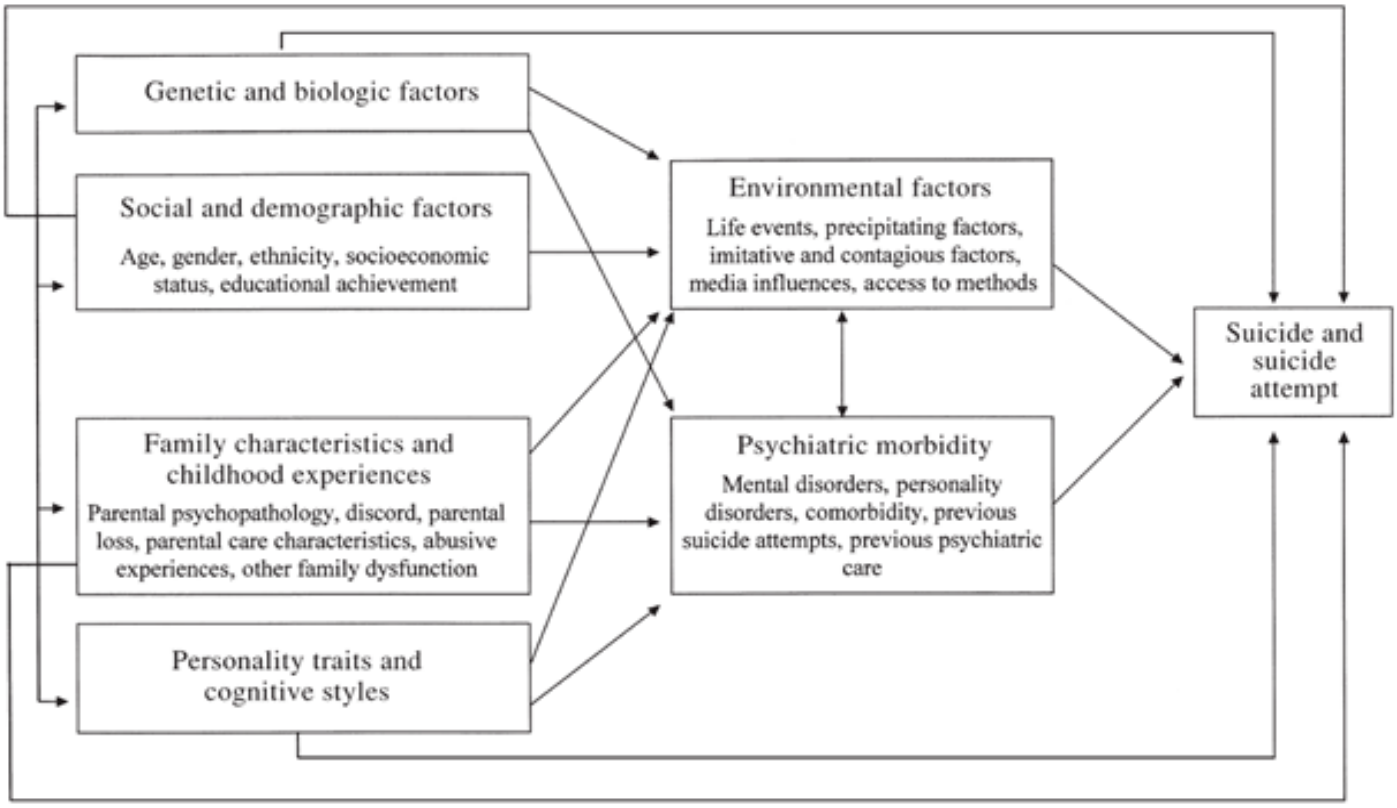

Figure 1. Risk Factors for Suicide. Originally published in Beautrais AL. Risk factors for suicide and attempted suicide among young people. Aust N Z J Psychiatry. 2000;34(3):420-436.[8] Copyright © 2000 by Aust N Z J Psychiatry. Reprinted with Permission of SAGE.[8]

This technique also works well when evaluating and interacting with the patient. By focusing on emotions that family members are feeling, clinicians can align with the family, as opposed to creating an adversarial relationship. Another technique is to describe and reflect the emotion inherent in their statements back to them. Demonstrate empathy, and remember that the families are going through a tragedy. Acceptance of such life-changing events can be difficult. Grief is a multi-step phenomenon[11] that often includes denial. Clinicians should anticipate and be ready to help the family with the emergence of other grief elements, particularly anger, depression, and bargaining (e.g., "*If only we had noticed her symptoms earlier*") when the family moves beyond denial.

Even in a state of denial, the family may remain sensitive to their child's safety. Parents should be involved in all aspects of the safety planning process. They can be a part of your assessment of the youth's resources, coping skills, and relative suicide risk. Parents participating in the creation of a safety plan are focusing on the most important issue at hand – the safety of their child. An effective safety plan includes several components, listed in Table 1. Often, the act of creating this safety plan allows children to uncover strengths that they didn't know they had in such crises. However, if a child is incapable of participating successfully in a safety planning process, this is an indicator of the need for inpatient hospitalization. Parents who have witnessed their child's inability to plan for their own safety may more readily accept the need for hospitalization.

Scenario 3 – Stigma: Perception of mental illness is influencing the parents' decision

"Her life will be ruined if she goes to a psychiatric hospital!"

Resistance to psychiatric hospitalization can sometimes be traced to the strong stigma that mental illness still carries in society. Parents may express fear of stigma in their concern that someone will "find out" what has happened. Patients and parents that speak of "the looney bin" or "padded walls" at the psychiatric facility may also be expressing their view of the stigma attached to psychiatric facilities and diagnoses.

Lack of familiarity with modern psychiatric treatment, coupled with misinformation from multiple sources, results in misconceptions about what will occur during inpatient treatment. Parents may think the hospitalization will be quite long, when in reality, the average youth hospitalization is around six days.[13] Parents may fear the experience will be traumatic or worry that their child will learn "bad habits" from other patients in the hospital.

Table 1: Components of an Effective Safety Plan[12]

- Recognition of warning signs that immediately precede a suicidal crisis
- Internal coping strategies (without the assistance of another person)
- Socialization strategies for distraction and support
- Social contacts for assistance in resolving suicidal crises
- Professional and agency contacts to help resolve suicidal crises
- Means restriction

They may fear that their child will be viewed differently by family and friends as a result of the hospitalization.

Methods of Approach: Use open-ended questions to understand the origin of the child's and the parents' fears. Does the family know someone who they believe was stigmatized for mental illness or mistreated by the medical or mental health system? Has a parent or close relative been psychiatrically hospitalized? Are they very focused on what others will think of them after the hospitalization? Are they afraid their child will be called "crazy" or that they will be labelled bad parents?

If the parents or child describes a form of stigma, help by defining stigma for the family. Explain that stigma causes people not to talk openly about their suicide attempts or of having been psychiatrically hospitalized. This is problematic because if no one talks about mental health issues, they may not be seen as health problems with solutions. Elicit fears related to stigma. Try to allay fears while gently noting that these types of fears can lead away from addressing suicidality and can increase risk for the patient. Affirm that the child and family are entitled to confidentiality. Share with parents that inpatient treatment can help their child decrease suicidal risk by learning distress tolerance and other coping skills quickly, because risk of repeat attempt is particularly high[7] in the wake of a recent suicide attempt.

Scenario 4 – Separation fears: Parents are upset by the idea of separating from their child in the midst of a crisis.

"I don't want her to go if I can't be there with her."

In a crisis, parents may understandably be more likely to want to check on their child to provide care and support. When a pediatric patient is hospitalized, togetherness is typically allowed and fostered, and one or both parents often have full access to their children and the medical facility. They also have direct input into the clinical decisions being made. Psychiatric hospitalizations may be jarring and pull the child from his or her usual parental en-

vironment.

Methods of Approach: It is important to emphasize the integral role the family will play in treatment for their child.

In addition to participating in the creation of a safety plan, parents can also help with finding outpatient providers, encourage adherence, and actively participate in family therapy, among other important roles. Empathize with the child that this will be a different environment for them and that it may be stressful to be separated from their friends and family.

Returning to the ABCDE mnemonic,[5] clear **C**ommunication regarding any of the separation events is helpful. Psychiatric hospitalization separates the child from their usual environment for good reason – in order to make them as safe as possible. Psychosocial stressors, which can sometimes include the parents, are removed from the milieu in order to clarify diagnosis and enhance safety. Explain the other therapeutic effects of the inpatient environment and of inpatient group therapy, which has been shown to reduce deliberate self-harm.[14]

Scenario 5 – Alternative options: They are right and hospitalization may not be necessary at this point.

"Actually, I think we have a better plan."

A family may decline psychiatric hospitalization for appropriate reasons that are aligned with patient treatment and safety. Patients who already have outpatient services (therapy, psychiatry, pediatrics, etc.) may have access to plans as effective as hospitalizations. After you have spoken with the child alone and verified that they have solid therapeutic relationships with these providers, you may agree that there may be a safe alternative to hospitalization.

Methods of Approach: Obtain consent to discuss the patient with outpatient providers. Contact the therapist, psychiatrist, pediatrician, and any other providers who know the patient well and will be a part of the follow-up plan. Often times, it may be helpful for the family to learn that their other, well-known providers agree with the recommendations (e.g., their pediatrician, outpatient therapist, or outpatient psychiatrist). Alternatives to inpatient hospitalization, such as intensive outpatient and partial-day treatment, may also be appropriate in some cases. If, after discussing the case with the outpatient providers, you determine the child can receive a safe and high level of outpatient care, you may incorporating this new information and adjust your formulation of risk.

All efforts should be made to reach consensus on the treatment plan. However, there are times when the parents and physicians simply cannot agree on a treatment plan for the patient. If you feel the patient is in serious danger if discharged (either due to their mental illness, parental mental illness, or parental abuse of the child), you may need to consult with a colleague. Rarely, the team may consider temporarily taking custody of the patient in order to protect him or her from immediate harm. It is imperative that physicians know local, state, and federal rules governing protection from risk and mandating treatment. In this situation, it is important to involve the primary medical team, social work, risk management, child protective services, and any other appropriate services and resources. These cases typically go to judicial review and judges are on call for such circumstances.[4] Physicians must make every effort to clarify to both parents and child exactly why these steps are being taken for the child's safety. Taking custody of a child should always be viewed as an intervention of last resort, since children depend on parents for adherence to treatment, and the risk of alienating parents and child should be weighed carefully.

Conclusion

It is not uncommon for some families to initially resist or outright refuse transfer of their children to inpatient psychiatric services, even in the wake of a serious suicide attempt. The reasons for this refusal are varied. An empathetic and well-prepared clinician who is able to address both the logistical issues in treatment planning and the emotional reasons for refusal with families is more likely to achieve a safe clinical outcome for patients, as well as pave the way for long-term adherence to mental health treatments. Safety of the patient should take priority over any other factor in this situation. Consultants should understand that creating and maintaining good therapeutic rapport with patients and their families is a significant part of safety planning. Power struggles should be avoided, as both parent and clinician are likely, in the end, to have the same goals for the patient's long-term mental health.

Take Home Summary

Families may be resistant to inpatient psychiatric hospitalization for their children, even following suicide attempt. To ensure the safety of the child and future engagement with mental health treatment, child and adolescent psychiatrists should be able to identify and understand the reasons for parental resistance in order to involve the parents in treatment during this critical time.

References

1. Kann L, Kinchen S, Shanklin SL, et al. Youth risk behavior surveillance — United States, 2013. *Morb Mortal Wkly Rep Surveill Summ Wash DC 2002*. 2014; 63 Suppl 4:1-168.
2. Nordentoft M, Mortensen PB, Pedersen CB. Absolute risk of suicide after first hospital contact in mental disorder. *Arch Gen Psychiatry*. 2011; 68 (10): 1058-1064.
3. Gould MS, Greenberg T, Velting DM, Shaffer D. Youth suicide risk and preventive interventions: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatry*. 2003; 42 (4): 386-405.
4. Kon AA. When parents refuse treatment for their child. *JONAS Healthc Law Ethics Regul*. 2006;8(1):5-9, quiz 10-11.
5. Rabow MW, McPhee SJ. Beyond breaking bad news: how to help patients who suffer. *West J Med*. 1999; 171 (4): 260-263.
6. Regehr C, Glancy D, Pitts A, LeBlanc VR. Interventions to reduce the consequences of stress in physicians: a review and meta-analysis. *J Nerv Ment Dis*. 2014; 202 (5): 353-359.
7. Christiansen E, Jensen BF. Risk of repetition of suicide attempt, suicide or all deaths after an episode of attempted suicide: a register-based survival analysis. *Aust N Z J Psychiatry*. 2007; 41 (3): 257-265.
8. Beautrais AL. Risk factors for suicide and attempted suicide among young people. *Aust N Z J Psychiatry*. 2000; 34 (3): 420-436.
9. Santer M, Ring N, Yardley L, Geraghty AWA, Wyke S. Treatment non-adherence in pediatric long-term medical conditions: systematic review and synthesis of qualitative studies of caregivers' views. *BMC Pediatr*. 2014; 14: 63.
10. Linehan M. *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press; 1993.
11. Kübler-Ross E. *On Death and Dying*. [New York: Macmillan; 1969.
12. Stanley B, Brown GK. Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cogn Behav Pract*. 2012; 19 (2): 256-264.
13. Pottick KJ, McAlpine DD, Andelman RB. Changing Patterns of Psychiatric Inpatient Care for Children and Adolescents in General Hospitals, 1988–1995. *Am J Psychiatry*. 2000; 157 (8): 1267-1273.
14. Wood A, Trainor G, Rothwell J, Moore A, Harrington R. Randomized trial of group therapy for repeated deliberate self-harm in adolescents. *J Am Acad Child Adolesc Psychiatry*. 2001; 40 (11): 1246-1253.

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