The consequences of maternal overdoses on children

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The children of women who take overdoses may suffer due to the same factors that predispose to the overdose, to witnessing the event and the immediate and long-term consequences of it. We examined what arrangements had been made for the children of 21 women admitted to hospital after an overdose, and enquired into the explanation that the mother planned to give the children. Children of mothers with psychiatric disorder were more likely to have witnessed the overdose. Mothers preferred that the children did not know about the overdose. The importance of this for the psychological development of the children is discussed.

Deliberate self-poisoning remains the most common reason for emergency admission of women to general hospital (Hawton & Catalan, 1987). Two-thirds of the cases are of people under 35 years of age and therefore likely to have young children. It is important to understand the effects of this event on the children. These will depend on the experience of the child at the time of the overdose (their understanding of the situation and care arrangements) and on the difficulties in the family or environment for which the mother's overdose is a pointer. The finding that the risk of child abuse was increased among the mothers who attempted suicide (Hawton *et al*, 1985) supports this last point.

Shepherd & Barraclough (1976) studied the aftermath of parental suicide for children and found that the psychological morbidity was greater than for a control group, with a few children showing marked disturbance at follow-up. Immediately after the suicide, anxiety seemed the most frequent recalled reaction and some children were reported to appear frightened. They also studied how the surviving parent tried to explain to the child what had happened. In approximately half of the cases the parent attempted to be open with the child, while one-fifth of the children received no explanation. In the remaining cases the children were not told that their parent had committed suicide. Young children who had not been told the truth were more likely to appear frightened immediately after the suicide. Pynos & Eth (1985) interviewed 30 children whose parents had attempted suicide. In the majority of cases the children had discovered the attempt and some children developed post-traumatic stress disorder after witnessing a parent's attempt.

This study seeks to clarify some of the consequences of maternal overdoses for their children, whether mothers had plans to explain the event to their children and the relevance that psychiatric diagnosis and the reason for admission has for the experience of the child.

The study

Twenty-one women with children under 16 who were admitted to hospital after an overdose were interviewed when they were medically fit for discharge, usually 12 to 24 hours after the overdose. The interviews were done on sequential admissions to one inner city hospital when this was practicable. They were diagnosed according to DSM–III–R (American Psychiatric Association, 1987) criteria and given an extended semi-structured interview regarding their children. They were compared with seven controls (women without a psychiatric diagnosis who had been admitted to hospital as an emergency for a physical problem).

Findings

Demographic data

Two women refused to be included in the study. The 19 women included had a total of 41 children under 16. All women were born in the UK. Two women were Afro-Caribbean, the rest were white. The age range was between 18 and 48. (Fourteen women (74%) were under 35-years-old and five women were 35 or older.)

Of the women included, ten were married or cohabiting, three separated, three divorced, and three were single. Two had learning difficulties.

Stressors

By far the most common precipitating event prior to the overdose was an argument with husband or partner (n=9, 47%). A recent (six months or less) break-up in a relationship had occurred in four of the women (20%). Other acute stressors

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were notice of eviction, late termination of pregnancy because of foetal abnormalities, a car accident, an argument with children, and an assault.

Chronic psychosocial difficulties occurred in 15 of the women (79%), and in nine of these there were problems in the marital relationship or relationship with boyfriend.

Arrangements for the children

None of the medical notes nor the majority of the nursing notes contained information about where the children were at the time of the overdose and about where they were at the time of admission.

All overdoses were impulsive. Four women (25%) reported that at least one of their children had seen them taking the tablets, in another case the eldest daughter called an ambulance after finding her mother unconscious. One woman could not remember whether her children saw her taking the overdose. In the rest of the cases (n=13, 68%) the children were away from the home or in another room.

The patients were asked if they knew where their children were at the time of the interview. Two women (11%) were uncertain about their children's whereabouts. Seven women (32%) said the children were at home being looked after by a partner or relative, eight women (42%) said the children were away from home and two (11%) had one child at home and the other away. In four cases (22%) the arrangements were made by the women themselves after taking the overdose, seven women (32%) said it was their partner/father of the children who organised this after they took the overdose; in the case of six women (32%), friends, neighbours or their general practitioner (GP) organised for the children to be looked after by a relative or friend; in one case the local authority made arrangements and one mother did not know who made the arrangements.

In the case of mothers who were married or cohabiting the arrangements were made by the father of the children (n=6), the women themselves (n=3) or others (n=1). When the mothers were not married or cohabiting the arrangements were more likely to be made by other agencies (n=6) than by the mother (n=1) or the father (n=1).

The seven women admitted as an emergency for a physical problem were also interviewed regarding their children. These mothers made arrangements for their children in six cases. All the children stayed with mothers' partner or relatives.

Relationship between psychiatric diagnosis and arrangements for children

Thirteen women (68%) had a psychiatric diagnosis on Axis I or II. Six of these women had long-standing personality difficulties and were less likely to be married or cohabiting (n=4).

None of the children of women without a psychiatric diagnosis on Axis I or II (n=6, 32%) had seen their mother taking the tablets or been involved with the emergency services. The four women whose children had seen them taking the tablets had different psychiatric diagnoses (two women had adjustment disorder, one major depression, and one personality disorder).

The arrangements for the children of three women with personality difficulties (n=6, 32%) were made by neighbours instead of their mother or her partner.

Explanation regarding the overdose and the relationship with psychiatric diagnosis

Four women (22%) said that they were sure that all their children did not know about the overdose or about the admission. They were not concerned about their children finding out and therefore did not think any explanation was required.

Of the rest of the women (n=15, 78%) a minority (n=3) thought that it was very important for them to be honest with their children. Two of these women suffered from major depression (one of them with personality disorder). They both thought that this would not cause major psychological distress to their teenage children.

The majority of the women (n=12, 64%) preferred that their children did not know about the overdose and were divided between those not wanting to explain anything (n=4), those (n=9) who would say to the children that they went to hospital because of a physical problem and three women who said they would try to have a conversation and ascertain what the children already knew and what they wanted to know. If they appeared to know about the overdose they said they would try to reassure them. Psychiatric diagnosis did not seem to be associated with any of these options.

In general there was a tendency for most women to deny that their children would understand the significance of the overdose, even when it was clear to the interviewer that the children had witnessed the event and were old enough to understand. In the cases where one child had witnessed the overdose but not the other siblings, the women thought about giving a different explanation to this child from the others and did not appear to think that the children may talk to each other about it.

Six women thought that their partner or a relative had talked to their children about their admission to hospital and in two cases they were aware that the children had been told that this was related to being 'upset' or 'nerves'. Both of these cases had a past history of depression and the children were said to be aware of this.

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Relationship between reason for admission and concerns for the children

Fifteen of the women who overdosed thought their children would know about their admission. Their main concern was that this might make them anxious or worried (n=7), although all except one felt able to reassure them. Two were concerned that Social Services may decide to take their children into care, and two were concerned that their teenage daughters may imitate them. There was no relationship between their concerns and psychiatric diagnosis.

None of the women admitted for a physical problem were concerned that their admission would have any psychological effect on their children, even in the case of a woman whose daughter called the ambulance after finding her mother unconscious. These women were asked the hypothetical question of what they thought women who had taken an overdose should tell their children. Most mothers (n=5) thought it would be better for the children not to know about the overdose and be told that their mother had gone to hospital because of a physical problem. Two women thought it was very important to be honest and that children should be told the truth.

Comment

Ounsted (1975) noted that suicidal behaviour may be forewarning of child abuse although more frequently the child may be adversely affected by the lack of planned care during mother's admission, anxiety about the situation and the issues behind the overdose. A high proportion of mothers in our study had chronic problems in their relationship with their partner.

Compared with the controls in this study, a higher proportion of the women taking overdoses left the arrangements for their children to other people. This was particularly important in the case of women with a psychiatric diagnosis, who left the arrangements to neighbours, friends or GP and in the case of women without a partner.

The tendency for women to deny that their children would understand the significance of the overdose was also found by Pynos & Eth (1985). They also found that some of these children suffered from post-traumatic stress disorder. Seeing parents attempting to commit suicide disrupts children's sense of security. Clinical impressions suggest that some of these children feel that they have to protect their parent at all costs, even if this means not having their emotional needs met and gives them an amount of responsibility that they may find difficult to handle. The split between women who thought that their children should not know anything, should be told that their mother had gone to hospital for a physical problem or should be told the truth is of interest. Shepherd & Barraclough (1976) found that some children have known about their parent's suicide from the press or from overhearing relatives talking about it. Children who learn to keep 'secrets' in families may be learning to avoid conflicts and not to talk about distressing events in a way that is not helpful for their development and future relationships.

Cassell & Coleman (1995) point out that some parents who attempt suicide may also attempt to harm their children and recommend that when a parent is communicating suicidal ideation assessment should include any concerns they may have about harming the child as well as the relationship with the child.

Casualty officers, GPs and psychiatrists should regularly enquire about the children of adults admitted to hospital after an overdose and be particularly concerned about the children of single parents, parents with history of aggressive behaviour and parents with psychiatric illness.

It may also be useful for clinicians assessing parents after an overdose to explore how much the children know and what the parents are going to explain.

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