This dissertation addresses the question to what extent depressed and potentially suicidal mothers of young children (dpsmyc) might be experiencing ideation about including one or more of their children in a possible suicide attempt. This question will be approached from the vantage point of clinicians working with dpsmyc on an ongoing, outpatient basis. The possibility that a dpsmyc may not be sharing her ideation about maternal filicide-suicide (mfs) with her clinician, or only partially so, could be of key importance to the therapy. Therefore, the clinician needs to consider the causes for the lack of disclosure, as well as the consequences for everyone involved. Clinicians might also have to assess their own role and actions, and how they would be able to tell whether a dpsmyc might indeed be experiencing ideation about mfs, and what risk factors could be involved. This dissertation intends to shed some light on the aforementioned factors.
Note about terminology

In this dissertation, I am adopting the terminology proposed by Canetto (1997) for referring to suicide attempts. Therefore, I will not use expressions, such as successful suicide or attempted suicide that generally denotes a fatal, respectively a nonfatal attempt. Instead, I will use the term fatal suicide attempt, respectively nonfatal suicide attempt. Similar terminology will be applied when referring to filicidal behavior.

Background of the problem

Prevalence

Filicide-suicide, the killing of one’s child and one self, contains two words, each of which elicits feelings of horror and disbelief. The combination of the two in one hyphenated term suggests an interaction and an exponential effect. When one hears of parents killing one or more of their children, and especially when the parent is a mother, it remains unimaginable to almost anyone. Yet, in many developed countries approximately half of the homicides of children between the ages of one and seven are committed by fathers or mothers, who make a fatal or nonfatal suicide attempt afterwards (Haapasalo & Petaejæ, 1999; Somander & Rammer, 1991; Vanamo, Kauppi, Karkola, Merikanto, & Rasanen, 2001). Rates of maternal filicide-suicide tend to be similar in most countries, while rates of other forms of filicide, especially fatal child abuse tend to show considerable variation. Prevalence of maternal filicide-suicide in the USA may, therefore, not be very different from that of other countries, although there is some disagreement (Nock & Marzuk, 1999) about this. There are no national statistics on homicide-suicide, including filicide-suicide, in the USA, while these are available in a number of European countries. However, fatal child abuse
in the USA, in comparison with other industrialized countries is known to be exceptionally high
(Christoffel & Liu, 1983).

The literature up to now does not show efforts made to estimate the prevalence of mfs
ideation. However, as cases of maternal filicide-suicide may account for 5 to 15% of suicides
committed by mothers between the ages of 28 and 35, maternal filicidal-suicidal ideation might
affect a similar percentage of mothers with suicidal ideation. To get an idea of the potential size of
the problem, one would have to know more about the rate of suicidal ideation.

Crosby, Cheltenham, & Sacks (1999) found that 6.9% of the general population between
the ages of 25 and 34 had had suicidal ideation during the 12 months prior to a telephone
interview, and that 2.8% had a specific suicide plan. The data for all age groups combined were
similar to the ones in the 25-34 age group. Male and female responses for the population as a

1 According to Barraclough & Harris (2002), 0.43% of all female suicides in England and
Wales during the five-year period from 1988 through 1992 were accounted for by 19 female-
perpetrated incidents of homicide-suicide. Of these 19 women, 18 were mothers of young children
who made fatal attempts at both filicide and suicide. These mothers generally are to be found in
the relatively narrow age bracket of 28-35, where the suicide rate of mothers of young children
reportedly is lower than that of women without children.

Based on this information, it appears realistic to estimate that 5 to 15% of mothers of
young children who make fatal suicide attempts will also make a fatal filicide attempt at one or
more of their children.

2 The percentage of mothers with suicidal ideation who are also suffering from filicidal-
suicidal ideation is hard to estimate. It could be higher or lower than the 5 to 15% of mothers who
made a fatal filicide attempt in addition to a fatal suicide attempt.

One could argue for it being lower because filicide-suicide may imply a degree of
hopelessness and unhappiness that might be rarer than the hopelessness encountered in simple
suicide. One also could argue for it being higher, because an act of mfs would be so drastic that a
plan for it is less likely to be implemented.
whole were similar while it is not clear whether this was also the case for the 25-34 age group. The same study reported that 0.7% of all 5238 respondents had made a nonfatal suicide attempt during the past 12 months. Therefore, a clinician may have one, or maybe more than one, female patient suffering from mfs ideation, especially when the clinician is practicing in an area with many young families.

To estimate what percentage of a clinician’s dpsmyc patients who are seen on an ongoing, outpatient basis, might be harboring mfs ideation, it may be necessary to disaggregate data and to revisit the figure of 5 to 15% of suicidal mothers in the 28-35 age bracket who also made a filicide attempt. Women in this age bracket who make a fatal suicide attempt usually are depressed, and, in addition, many of them have one or more of the following conditions:

- They were known to have been (at high risk of) suffering from psychosis, for instance because they were postpartum.
- They were involved in substance abuse (Canetto, 1991)
- They were suffering from a terminal disease
- They were involved in child abuse or at high risk for it.\(^3\) (Hawton, Roberts, & Goodwin, 1985; Hawton & Roberts, 1981; Roberts & Hawton, 1980)

None of these conditions appears to be particularly prominent among mothers who have made mfs attempts where both the suicide and the filicide attempt were fatal (*fatal/fatal*). In \(^3\)Hawton & Roberts (1985) report that 29% of mothers who had made a serious nonfatal attempt at simple suicide were abusing their children or were at high risk of doing so. Earlier, they had reported (Roberts & Hawton, 1980) that 18 of 114 mothers involved in or at risk for child abuse had made a suicide attempt during the period studied, i.e. while they were abusing their children or thought to be at risk for abuse. Therefore, considering the high prevalence of child abuse there are likely to be many mothers making suicide attempts.
addition, with the possible exception of terminal illness, these conditions are not likely to be seen very often in ongoing, outpatient psychotherapy. On the other hand, many of the mfs mothers had been or still were receiving psychiatric help at the time of their mfs attempt.

Therefore, it might be possible that mothers making fatal/fatal mfs attempts, while accounting for 5 to 15% of all suicides by mothers of young children, might make up a larger percentage of suicides by mothers who do not meet any of these four conditions. In other words, a clinician who is working with a dpsmyc on an ongoing and outpatient basis is likely to be working with a mother, whose main psychopathology does not include these four conditions. The chance that the mother would include one or more of her children in a suicide attempt may be higher than 5 to 15%. While this may appear irrelevant because the chance of a serious mfs attempt is extremely low, it might be relevant with respect to the percentage of a clinician's dpsmyc patients who are harboring filicidal-suicidal ideation.

_Lack of information about maternal filicidal-suicidal ideation_

Maternal filicide-suicide (mfs), in this study, is defined as a fatal filicide attempt followed by a serious and fatal or nonfatal suicide attempt. Mfs is widely regarded to be motivated by suicide rather than homicide (Felthous & Hempel, 1995; Marzuk, Tardiff, & Hirsch, 1992; Nock & Marzuk, 1999), as will be explained later. Yet, there are hardly any studies about mfs ideation or related behaviors, such as planning and aborted attempts. Meanwhile, many studies about ideation and (non-fatal) suicidal behaviors are available to aid in the assessment of the risk of simple suicide.
(Blumenthal, 1990; Maris, 1995, 1997). Some possible reasons for the lack of specialized studies into mfs ideation will be explored in the following paragraphs.

Only by coincidence did Lukianowicz (1972) hear from women that they had made non-fatal attempts to kill one of their young children (on average between 16 months and 3 years old), and that several of them had attempted or planned to commit suicide in conjunction with the filicide attempt. This took place when he was examining mothers hospitalized for mental health problems who, prior to the examination, were not known to have issues around attempted filicide or filicide-suicide. Lukianowicz reported that there were no studies on attempted filicide and that mothers who have attempted filicide will deny it, or speak of it as an accident.

Other reasons for the lack of systematic exploration of mfs ideation, not mentioned in the literature, could be the low prevalence of mfs (2 to 12 mothers per year in a general population of 15 million). In addition, there is a widely held belief that for mfs to occur, the presence of psychotic or delusional symptoms is a necessary condition. (Sadoff, 1995; Tuteur & Glotzer, 1959)

A belief that mfs cannot happen without psychotic or delusional symptoms may make it difficult for most people to imagine that there has been serious ideation prior to the mfs attempt. This, I would hypothesize, would apply especially to mothers having the kind of ideation that exists in many cases of simple suicide, where someone may go through a long period of weighing the pro's and con's of suicide before making an attempt, and not necessarily do so in an irrational or impulsive manner (Shneidman, 1990). In other words, the idea that a mother might be thinking about whether or not, and how to kill her children and herself, may appear unimaginable even to
scientists in the field, especially when the deliberations occur over a long period and appear to contain a certain degree of rationality.

Based on newspaper reports, I hypothesize that the unimaginable, taboo-like nature of mfs behaviors, especially when the mother has made an attempt in which both she and the child have died, leads to shock and resignation. However, mothers who express filicidal-suicidal thoughts are likely to encounter reactions of disbelief and dismissal from their environment, especially when they are not known for being psychotic or delusional. This mother will experience reactions, such as “I don't even want to think about it”, “You must be kidding”, or “Mothers don't kill their children”.

Therefore, I assume that it can be no surprise that mothers will be very reluctant to share mfs ideation, let alone the full extent of it, with anyone, including a clinician, lest she be seen as premeditating a murder and should be arrested or locked up in a mental ward. When the mother does share some of her ideation, and receives the sort of reactions just quoted, she may stop sharing her thoughts. Instead, she might try to convince herself that she should not think like that, and that the fact that she does, must be evidence that she is mentally ill or morally degraded.
Clinicians working with mothers, who experience maternal filicidal-suicidal ideation

It is unlikely that clinicians, including general practitioners, can be entirely free of the public sentiment just described (Resnick, 1969). Based on anecdotal evidence, I would hypothesize that the risk of simple filicide may not occur to many clinicians, as long as they do not see signs of psychosis or delusions in a patient, or any of the risk factors associated with fatal child abuse. It may also be hard for a clinician to conjecture the possibility of filicidal ideation as an extension of suicidal ideation (Resnick, 1969), unless the mother brings it up herself, or unless she has a history of psychotic symptoms and/or attempts at suicide or filicide. Therefore, those clinicians who have not been introduced to the possibility of ideation about mfs as part of their training are unlikely to consider the possibility of a dpsmyc having filicidal-suicidal ideation, let alone attempting mfs (Resnick, 1969).

On the basis of what has been discussed so far, I would hypothesize that mothers experiencing ideation about mfs, the presence or the seriousness of which they cannot disclose to their clinician, not only might be suffering from whatever it was that caused the filicidal-suicidal ideation in the first place, but also from the ideation itself, especially the filicidal aspect. The mothers may easily feel that the very existence of their filicidal-suicidal ideation is evidence of mental illness or moral degradation, which could push them further into despair and suicidality. The lack of support for and validation of their suffering can lead to isolation or exacerbate already existing patterns of isolation. Partly because of the mothers' inadequate disclosure clinicians treating dpsmyc who are suffering from filicidal-suicidal ideation might not be aware of (the seriousness of) their patients' ideation.
As to therapy with mothers experiencing mfs, clinicians who are unaware of the ideation will also be unaware of how the ideation might be affecting the mother’s life and her therapy. In such cases, we probably can speak of masked pathology. Obviously, therapy cannot be very effective against this background.

Some clinicians may only become aware of the phenomenon of mfs and the ideation around it when one of their clients makes a fatal or nonfatal attempt at mfs. Clinicians who are aware of the potential presence of mfs ideation will have to deal with clinical as well as legal and ethical issues regarding the confidentiality of their relationship with the mother. These issues may involve decisions about the mother’s family members, who might need to be warned or asked to monitor the mother during periods of increased danger. Alternately, they may involve adherence to reporting laws with respect to potential child endangerment. The manner in which the clinicians handle these issues will depend on the communication between the clinician and the mother. The

\footnote{It is the clinician’s responsibility to assess whether someone is in a suicidal danger zone (Maris, Berman & Maltsberger, 1992) and to make the appropriate interventions, when that is the case. In most states, including California, most of these interventions do involve breaking confidentiality (Bongar & Greaney, 1994). Depending on the contents of the case and the laws of a specific state, such interventions might include carrying out the requirements stipulated in so-called “duty to warn” (“Tarasoff”) laws.}

In many states, certainly in California, a clinician’s first responsibility consists of ensuring the safety of not only the client, but also of those dependent on the client. In most cases where the client is a mother of young children, this refers to her ‘under-age’ children. Therefore, a clinician suspecting mfs ideation may have to make interventions for the protection of the children, such as reporting the possibility of child endangerment, to Children Protective Services. Legal and ethical considerations make it likely that interventions involving the violation of the confidentiality of the relationship between the client and the therapist will be required sooner when there is a danger for others, especially children than when there only is danger to the self.
extent to which the mother discloses her ideation will play a central role in this communication process.

Many of the case studies of mothers who made a fatal filicide attempt and a non-fatal or fatal suicide attempt describe events that clearly indicate the presence of attempting behavior and ideation during 1 or 2 years prior to the mfs attempt. Yet, there has been no concerted effort to extract risk factors or warning signs from this material that other clinicians treating dpismyc could use.

**Resnick’s 1969 study on filicide**

Resnick (1969) was one of the first American clinicians to draw attention to the fact that a parent might have had filicidal-suicidal ideation prior to an attempt at filicide-suicide, and that it might have been possible to prevent filicide and suicide by including filicidal ideation in the assessment. Up to then, as pointed out earlier, filicide-suicide had been described as requiring the presence of psychotic symptoms (Sadoff, 1995; Tuteur & Glotzer, 1959) and as result, so I assume, was largely unresponsive to the traditional assessment methods used for simple suicide.

Resnick published a landmark study, for which he reportedly examined all cases of filicide published in 13 different languages in the world literature of the previous 200 years. He proposed a new system of classification of filicide that, with only minor changes, is still in use. Resnick assigned most cases of filicide-suicide to the category of motivated by altruism, filicide-suicide variety because most parents apparently were motivated by a belief that it would be best for their
child or children if they were to be included in their parents’ suicide. The only other cases in the *motivated by altruism* category were so-called mercy killings that were not followed by suicide, for instance when a parent killed a severely disabled child. Resnick also assigned a few filicide-suicide cases to the category of *motivated by revenge against spouse*, where a parent would first kill the child to spite the spouse and then make a suicide attempt. Other categories included *accidental death due to child battering, killing of newborns, killing of unwanted children and acute psychotic episode*. The last category, where the parent killed under the influence of hallucinations, epilepsy, or delirium, was the only one where the element of motive was not present or ascertainable after the fact.

Resnick assigned 42% of the maternal filicides to the *altruistic* category, *filicide-suicide* variety, which Resnick associated with a known motive, and only 24% to the *acute psychotic episode* category (no motive present or ascertainable afterwards) without letting the reader know whether any of the maternal filicides in this psychotic category were accompanied by a fatal or nonfatal suicide attempt. This suggests that Resnick may have believed that the majority of the parents were not in an acute psychotic episode when they made a filicide-suicide attempt.  

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5 Resnick (1969) also reported to have found psychotic symptoms in 67% of all maternal filicide cases in his sample, which would include the 24% that had been labeled ‘acute psychotic episode’. Resnick was not clear about the role of these psychotic symptoms in cases that were not designated ‘acute psychotic episode’. By assigning cases to only one of six categories and by using five categories based on motive, and one, *acute psychotic episode*, where the motive could not be ascertained Resnick may have implied that the psychotic symptoms were not dominant in cases outside of the *acute psychotic episode* category. Resnick does not give information whether or not there were any cases of filicide-suicide among those in the *acute psychotic episode* group. Parents assigned to the *acute psychotic episode* category were reported to have killed due to hallucinations, epilepsy, or delirium, and may have made fatal or nonfatal attempts at filicide-suicide.
However, studies of hospitalized parents, especially mothers, often convey the impression, that the
parents were in a psychotic state (Santoro, Dawood, & Ayral, 1985; Tuteur & Glotzer, 1959).

The altruism designation indicates that Resnick (1969) believed that the mothers who
killed their children as part of their own suicide saw it as an act of altruism. If left living, the children
would suffer from having to live without their mother, in addition to their grief over a mother who
had committed suicide. In the mother's perception, therefore, the children would suffer so much
that it would be selfish not to include them in her suicide.

Resnick noted the high incidence of filicide-suicide in comparison with other forms of
filicide, and attributed it to clinicians overlooking the possibility of filicide when treating suicidal
mothers of young children. In fact, Resnick suggested that clinicians might be ill equipped to deal
with filicide-suicide, the ideation, and behaviors preceding a real attempt. Resnick made this
suggestion based on his observation that professional or popular journals provided very little
information on the subject, possibly “due to the repugnance of the theme” (p.332). Resnick also
referred to his experience with the hostile, uninformed attitude that hospital staff had towards
mothers who had been admitted to a mental hospital after a filicide attempt that usually had been
fatal and a suicide attempt that had been non-fatal. Because of his experiences, Resnick urged
clinicians to ask depressed mothers of young children, if they had any reason to suspect ideation

6 The fact that Resnick noted a relatively high incidence of filicide-suicide is probably
associated with the way, in which the data were gathered. Collecting cases of the preceding 200
years, as Resnick did, implies that one will get many cases of parents, who were hospitalized after
a non-fatal suicide attempt. Parents, who killed a child without a suicide attempt, probably are
under-represented in Resnick’s study. They may have been executed or given prison sentences.
Alternatively, their act may not have been recognized as filicide, which may have included cases
that later were to be designated as battering.
about regular suicide, a direct question about the fate of their children which might “be helpful in assessing the inseparability of the parent-child bond” (p. 332).

Until Resnick’s publication, the study of filicide-suicide in the USA had been mainly limited to small samples of hospitalized mothers that, by definition, did not include cases where the mothers had died as a result of the suicide attempt. These studies were heavy on psychoanalytically interpreted psychopathology, but included little information on epidemiology. 7 Typical demographic data, such as the age of the child-victim, the age of the parent, the method used for the filicide, social-economic status, years or education, marital status were not included on a regular basis.

The hospital studies didn’t contain the kind of information that would have alerted the average clinician to the possibility that filicidal-suicidal ideation might be present among patients that, up to then, had appeared to be ‘merely’ depressed mothers of young children. The reason for this could be that the psychopathology of the mothers in these hospital studies, especially the older

7 While Resnick speaks of 37 mothers’ filicide (42% of his sample of 88 mothers) as being associated with suicide, only four of these mothers made a fatal suicide attempt. An important reason why there were only four suicide attempts among these 37 mothers probably was that most of Resnick’s 88 cases of maternal filicide came from hospital studies, where the mothers, by definition, had survived a suicide attempt, if they had made one. Resnick apparently included only one population study (Adelson, 1961). Adelson (1961) referred to 28 parents, 17 fathers and 11 mothers, who were responsible for the death of 34 children. Slightly more than half of these 34 children were killed by 13 parents, who subsequently or simultaneously made a suicide attempt. Five of these 13 parents were mothers, of whom three made a fatal suicide attempt, and eight were fathers, of whom five made a fatal suicide attempt. Therefore, while Adelson’s study accounted for only 11 of the 88 cases of maternal filicide, and 5 of the 37 filicides followed by a fatal or nonfatal suicide attempt, it nevertheless provided the information for three of the four mothers who made a fatal suicide attempt after their filicide attempt.
studies, may have contained a relatively large psychotic component. Many of their victims were younger than one year, and only 2.9% of mothers killing children under the age of one are reported to make a fatal suicide attempt (Nock & Marzuk, 1999). The age of many of the mothers’ victims in these hospital studies suggests the possibility of postpartum psychosis, which may account for the diagnoses of schizophrenia or “other psychotic symptoms” that apparently were frequently used in hospital studies. It is interesting that the study in which Resnick recommended clinicians to ask about suicidal and filicidal-suicidal ideation apparently was based on a review of studies that contained very few fatal suicide attempts. The cases in these studies were not typical of the sort of cases where both the suicide and the filicide attempt are fatal. In fact, the two case studies from his own practice that were included in his study were mothers who had made a nonfatal suicide attempt or had not carried out plans to do so.

Resnick concluded that the psychodynamics of filicide-suicide were different from other forms of filicide, that suicide rather than homicide was the dominant force in most cases, and that preventing suicide would have prevented filicide. Resnick also must have concluded that a significant number of the filicide-suicides committed by the mothers were preceded by filicidal-suicidal ideation, and that eliciting such ideation was crucial.
Resnick regards as potentially dangerous those depressed mothers of young children that “have fears about harming their children and overconcern\(^8\) about their children’s health” (p.333), although he does not explicitly link that with mfs. In addition, any open expression of filicidal or filicidal-suicidal ideation or plans should be taken seriously by the clinician.

Resnick may have made clinicians aware that they should concern themselves with filicide-suicide because it may occur among parents who do not have overt symptoms of severe psychopathology. It is important to note that Resnick paid as much attention to risk factors associated with the assessment process and the role of the clinicians, as to risk factors associated with the filicidal-suicidal mothers themselves.

*Increased interest in filicide and filicide-suicide:*

*Demographic studies, few explanations*

Resnick’s pioneering work was published seven years after the publication of another pioneering study in a related field, “The Battered Child Syndrome” (Kempe, 1962). The increase in the interest in child abuse that was created by Kempe’s work may have generated so much interest in related phenomena, such as fatal child abuse and other forms of filicide, that it became necessary to draw attention to differences between these various forms.

\(^8\) Resnick draws here on one major study (McDermaid & Winkler, 1955), which refers to this behavior as *child-centered obsessional depression* that sometimes is seen in mothers who kill their children. This study does not explicitly link this syndrome to filicide followed by suicide, although several of the cases described in the McDermaid study involve nonfatal suicide attempts.
A difference between filicide-suicide and child abuse, in addition to prevalence, is that in the USA, dissemination at the clinical level of Resnick's ideas appears to have been slow, while dissemination and implementation of the ideas about child battering have been very rapid and widespread. In the USA, many studies were published about the general topic of child homicide, which often only dealt with fatal child abuse without mentioning filicide-suicide as a possible cause of child homicide (Copeland, 1985; Kaplun & Reich, 1976). At the same time, a growing number of publications about homicide-suicide, which generally would contain some cases of filicide-suicide, provided some evidence of increased interest in filicide-suicide in the USA, although cases of spousal homicide-suicide (h-s) were much more numerous and tended to overshadow filicide-suicide cases.

In other developed countries, however, the ideas suggested by Resnick and similar ideas espoused in other publications received more attention, and may have contributed to the significant increase in studies about filicide, filicide-suicide and homicide-suicide (Bourget & Gagne, 2002; D'Orban, 1979; Somander & Rammer, 1991; Wilczynski, 1997b). Many of these were so-called population studies using unselected samples, i.e. every case of filicide or homicide-suicide in a certain area during a certain period.

These population studies contained a variety of data (see Table 1.1). In the literature review in chapters 3-6, it will become clear that not all population studies contain the same type of data or use the same format to present data. For instance, the age of children included in studies varies from 0-4 to 0-18.
Table 1.1 Information included in population studies

<table>
<thead>
<tr>
<th>TYPE OF INFORMATION</th>
<th>CONTENTS OF INFORMATION</th>
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<tbody>
<tr>
<td>Demographic information on the mother</td>
<td>• age at time of mfs&lt;br&gt;• social-economic status&lt;br&gt;• years of education&lt;br&gt;• marital status&lt;br&gt;• religion&lt;br&gt;• race</td>
</tr>
<tr>
<td>Information on mother’s family of origin</td>
<td>• number of siblings&lt;br&gt;• birth order of mother&lt;br&gt;• criminal and psychiatric history&lt;br&gt;• immigration status</td>
</tr>
<tr>
<td>Information on the mother’s children</td>
<td>• number of children in family&lt;br&gt;• number of children attacked&lt;br&gt;• number of children killed&lt;br&gt;• age, gender and birth order of children</td>
</tr>
<tr>
<td>Potential stressors in mothers’ lives</td>
<td>• criminal history&lt;br&gt;• immigration or cultural issues&lt;br&gt;• financial problems&lt;br&gt;• housing problems&lt;br&gt;• psychiatric history</td>
</tr>
<tr>
<td>Mental illness factors</td>
<td>• history of psychiatric treatment&lt;br&gt;• hospitalizations for mental illness&lt;br&gt;• diagnoses prior and after the mfs act&lt;br&gt;• mental status at the time of the act</td>
</tr>
<tr>
<td>Information related to the mfs attempts</td>
<td>• methods used in filicide and suicide attempts&lt;br&gt;• presence of a suicide note&lt;br&gt;• presence of prior communication&lt;br&gt;• motives given by mothers in notes, prior communication or in person, if alive</td>
</tr>
</tbody>
</table>
The increased availability of epidemiological data could have led to proposals to designate certain sociodemographic features as risk factors for mfs. This has not happened, possibly because most of the studies containing potentially useful data were not primarily descriptive and did not yet aim at converting epidemiological data into inferences about clinically relevant risk factors for filicide-suicide. In addition, differences in findings between studies were sometimes attributed to the quality of the research, while the possibility of legitimate reasons for the differences was not explored.

The lack of interpretative publications and the unexplained differences in some of the findings, which found their way to a publication, may affect the work of clinicians. Clinicians who are trying to get clinical guidance from the literature and are reading more than one study about the possible role of certain characteristics, such as the number of children killed by a mother, the age of the child victims or the age, marital status and social class of the mother, may end up having more questions than answers. On the other hand, clinicians reading only one study and applying its conclusions to the treatment of their filicidal-suicidal clients may fail to recognize certain risks to the lives of their filicidal-suicidal patients and their potential victims.
Reanalysis of studies; interesting correlations; overt and covert subtypes

However, when one examines the various (population) studies carefully, it is possible to identify information relevant for the formulation of risk factors that has not been included in the findings for a variety of reasons. When one identifies such information and combines it with the findings presented in the study, interesting patterns can emerge with respect to the characteristics of the mothers and their children prior to the mfs attempt, as well as to the nature and the outcome of the attempt.

As already mentioned, virtually all mothers were the biological mothers. They were depressed and potentially suicidal, and their children were generally under 13. Suicide as a motive was clearly dominant over homicide (Nock & Marzuk, 1999).

Combining the information from various studies about one country, England and Wales, (West, 1965; Gibson & Klein, S., 1961; Gibson, 1975; Barraclough & Harris, 2002; Brown, 1979) significant interrelations emerge between certain aspects, such as the availability of certain means and the prevalence of mfs attempts where both the suicide and the filicide attempt were fatal (fatal/fatal). For instance, when the available methods are easy to administer, lethal and associated with a painless death, such as toxic domestic gas, the number of fatal/fatal mfs attempts tends to be relatively high. When such methods or comparable substitutes are no longer available, there tends to be a drop in prevalence.
In reanalyzing the data there also appears to be an interrelation between certain aspects of the attempt at mfs (such as number of victims, methods used, degree of preparation, outcome) and certain demographic data (such as age and social class of mother, age of children). At the same time, there seems to be a connection between these same aspects of the attempt at mfs and aspects of the psychopathology (severity, the extent to which the pathology is known to the environment and specific diagnoses, especially their comorbidity).

It may be possible to extract risk factors from these data, and to identify subtypes of mfs mothers, for which different risk factors apply. This might help to explain some of the differences in findings among studies that had been designated as contradictory for lack of other explanations. The interrelation between the nature of the attempt and the severity of the psychopathology prior to the act seems particularly promising for a better understanding of mfs behavior. The extent to which the clinician and the environment are aware of the psychopathology of a potential mfs mother may play a key role here.

Combining the information gathered from a number of studies as part of a critical review of the literature, a picture emerges, which will be fully described and referenced in the chapter dedicated to the literature review. This picture shows two types of mothers, to be designated for the time being overt and covert. The coverts and overt shows differences in their psychopathology, as well as in their behavior, both prior to the mfs attempt and in the manner in which the mfs attempt is carried out.

9 Potential patterns described here are based on information that was reconfigured after it had been gleaned from a number of studies. Therefore, it is not possible to link the patterns with specific studies.
The psychopathology of overt mothers, prior to an mfs attempt, tends to be overt and often severe (violent behaviors, prior filicide attempts, symptoms of a thought disorder) and therefore usually known to clinicians and family members. In contrast, the psychopathology of covert mothers tends to be known only partially to a clinician or the family, if at all, and less severe, at least without specific violent incidents, such as suicide or filicide attempt.

Characteristics of the mfs attempts carried out by overt mothers can include impulsivity, a lack of planning, violence, use of weapons, relatively frequently a nonfatal outcome, targeting of only one of her children as well as various other aspects to be discussed later. Characteristics of covert mothers’ mfs attempts often include thorough preparation, 'painless' filicide methods, no use of weapons, and targeting all her children, with a frequent fatal outcome.

**Contributions from suicidology**

During the last 30 years, parallel to the publication of population studies in both homicide-suicide and childhood homicide, several concepts were developed for the study of simple suicide, suicidology, that may be helpful in the search for risk factors in mfs. The convergence of mental health issues, various types of stressors and personality features appears to be as relevant in the study of mfs as it is in regular suicide, for instance. Some of suicidology’s concepts that are potentially relevant for mfs include pathways from childhood events to adult suicidal behavior (Maris, 1981) as well as the suicidal process (Runeson, Beskow, & Waern, 1996).
The suicidal process describes how a person’s thoughts and behaviors, in interaction with external events, can move a person from their first serious encounter with the possibility of their own suicide to a final and serious attempt. Components of the suicide process include suicidal ideation and its contents, e.g. voices of suicide (Firestone & Seiden, 1990), suicide notes, prior communication, preparatory behaviors, as well as nonserious and aborted attempts. Some of the recent approaches and theories in suicidology represent a process-orientation (Baumeister, 1990; Palermo, 1994) and might be particularly relevant for mfs. These approaches as well as various other suicidology concepts will be discussed in more detail later in this paper.

There is also a possibility that subtypes among mfs mothers have characteristics that are similar to the characteristics of other groups that have been studied in suicidology. For instance, mothers that disclose little about their planned filicide-suicide attempt, and make one attempt that is fatal for the children and for the mother may have certain characteristics in common with persons, who make one final and fatal attempt at simple suicide, such as the elderly. Some of these categories have been well studied, and the findings of these studies might contain interesting clues for mfs. More research needs to be done in this area.

All of the previous information revolves around the central question that will be designated the “problem statement”.

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**Problem statement**

What is the relationship between identifiable precursors of maternal filicidal-suicidal ideation and the presence and severity of such ideation among depressed and potentially suicidal mothers of young children?

**Research Questions**

1. What patterns can be identified in the life and behavior of mothers of young children who have made fatal or nonfatal filicide-suicide attempts with respect to aspects of the attempt, characteristics of the mothers and their victims, and pathways and processes leading up to the attempt?

2. How can concepts, findings, and theories of suicidology be employed to explain the filicidal-suicidal process and behavior among mothers of young children?

3. What are the challenges a psychotherapist faces, while working with mothers, who might be experiencing filicidal-suicidal ideation?
Application of Results

This study takes the vantage point of clinicians working with depressed and potentially suicidal mothers of young children (dpsmyc). The clinicians might be wondering to what extent they should be evaluating the mothers for filicidal-suicidal ideation. More complete and accurate information about risk factors for ideation, as well as about the contents of the ideation and other behaviors, such as plans and aborted attempts, might aid the evaluation. For instance, it might enable the clinicians to help the mothers in disclosing any ideation they might have.

The conclusions of this study might show the need and lay the groundwork for a future empirical study, such as a survey among mothers of young children.

Theory

Studies addressing mfs behavior generally are somewhat descriptive in nature and do not contain much in terms of explanations or theories. Some of the recent theories addressing regular suicide (Baumeister, 1990; Linehan, 1993) several of which Starzomski & Nussbaum (2000) has applied to spousal homicide-suicide, may provide helpful insights into mfs. Generally, these theories not only pay attention to sociodemographic features and psychopathology, but also to interactions between suicidal persons and their environment during the period preceding an attempt. Such theories may help in recognizing and understanding specific behaviors of mothers experiencing mfs ideation.

Theories used here include the Dialectic Behavioral Theory (Linehan, 1993), Beck’s Cognitive Theory (Beck & Weishaar, 1990), the Theory of Entrapment or Arrested Flight (Gilbert &
Allan, 1998), Shneidman's Psychological Theory of Suicide (Shneidman, 1999) as well as several theories dealing with 'Disturbances of the Self', of which Baumeister’s Escape Theory (Baumeister, 1990) appears to be the most prominent.

The theory of Entrapment or Arrested Flight (Gilbert & Allan, 1998) appears especially relevant to persons whose main coping mechanism has consisted of running away from problem situations, and who can no longer resort to that when they have children. This theory might be particularly relevant to persons with Borderline Personality Disorder. The combination of DSM-IV symptoms of identity issues, impulsivity, and fear of abandonment easily can lead to hasty, ill-informed decisions to change course in one's life.

The last of Sheidman's (Shneidman, 1999) “10 commonalities of suicide” discusses suicide in the context of life-long patterns of coping with stress.

Linehan (1993) has introduced two concepts, transactional vicious cycle, and apparent competence, in order to explain the interpersonal dynamics that are often associated with women with Borderline Personality Disorder, many of whom are suicidal, according to Linehan. These two concepts, which will be described in more detail later on, might be helpful for a better understanding of the dynamics in the relationship between mothers who are experiencing mfs ideation and their environment, including clinicians. The concepts may also partially explain why some mothers with mfs ideation are able to reassure persons in their environment by convincing them that they have overcome earlier psychological or personal problems, including mfs ideation.
Baumeister (1990) very clearly describes how people may become suicidal by respectively making unfavorable comparisons between (perceptions of) their own performance and what they believe is expected of them. They blame themselves for this discrepancy, become more self-conscious, and anticipate rejection. This is followed by becoming depressed, and escaping from the depression into a state referred to as ‘deconstructed’, which describes a generalized numbness. When this deconstructed state cannot be maintained, people tend to react with disinhibited behaviors that can include suicide attempts.

In addition to the explanatory approaches represented by these theories, I will also present a number of approaches that are commonly used in suicidology, but that generally are not referred to as theories. An example of this is the psychiatric approach (Fawcett, 1988, 1992; Fawcett et al., 1987; Fawcett, 1990) that involves the study of the relationship between suicidal behavior and various psychiatric diagnoses or their combinations. Other approaches that will be employed include the diathesis-stress model (Bonner & Rich, 1990), the psychological vulnerability model (Shneidman, 1999), developmental/life span approach (Yufit & Bongar, 1992; Blumenthal, 1990) and the genetic/organic/biological/hormonal approach. (Roy, 1993, 2001, 2002; Mann, 2002, Mann et al., 1999; Mann, Waternaux, Haas & Malone, 1999)
### Definitions + Abbreviations

#### Table 1.2 Definitions

<table>
<thead>
<tr>
<th>Definition</th>
<th>Description</th>
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<tbody>
<tr>
<td>Aborted Attempt at suicide or filicide-suicide</td>
<td>Aborted attempt refers to an attempt at suicide or filicide-suicide that has been planned and that one is at the verge of carrying out, at which point one stops.</td>
</tr>
<tr>
<td>Child Centered Obsessional Depression</td>
<td>Term coined by McDermaid &amp; Winkler (1955) indicating a combination of anxiety and depression with symptoms of overconcern for the child and feelings of inadequacy as a mother.</td>
</tr>
<tr>
<td>Covert Profile</td>
<td>Mother is who not know to be suffering from a thought disorder or other disorder necessitating hospitalization.</td>
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<tr>
<td>Extended suicide</td>
<td>The act where a person commits suicide and includes others who are deemed dependent on him or her in the suicide. While extended suicide is a form of homicide-suicide, not all forms of homicide-suicide are extended suicide.</td>
</tr>
<tr>
<td>Maternal filicidal-suicidal behavior (Mfs behavior)</td>
<td>Mfs behavior refers to any behavior with respect to filicide-suicide from ideation to fatal attempts by a mother.</td>
</tr>
<tr>
<td>Maternal filicidal-suicidal ideation (mfs ideation)</td>
<td>Mfs ideation refers specifically to the ideation that a mother might be experiencing with respect to filicide-suicide.</td>
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<tr>
<td>Mixed covert-overt profile</td>
<td>Mother with elements of both an overt and a covert profile.</td>
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<tr>
<td>Overt profile</td>
<td>Mother who is known to be suffering from a thought disorder or other psychiatric disorder necessitating hospitalization prior to an mfs attempt.</td>
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<tr>
<td>Suicidal process</td>
<td>Period between first instance of serious suicidal ideation and the first serious, potentially fatal attempt at suicide, during which certain behaviors tend to occur, such as ideation, planning, and aborted attempts.</td>
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#### Table 1.3 Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CCOD</td>
<td>Child Centered Obsessional Depression</td>
</tr>
<tr>
<td>Dpsmyc</td>
<td>Depressed and potentially suicidal mother of young children</td>
</tr>
<tr>
<td>ff</td>
<td>Fatal-fatal refers to mfs attempt where both suicide attempt and at least one filicide attempt are fatal</td>
</tr>
<tr>
<td>fn</td>
<td>Fatal-nonfatal refers to mfs attempt where suicide is nonfatal, while at least one filicide attempt is fatal</td>
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<tr>
<td>h-s</td>
<td>Homicide-suicide</td>
</tr>
<tr>
<td>Mfs</td>
<td>Maternal filicide-suicide</td>
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<tr>
<td>mfs behavior</td>
<td>Maternal filicidal-suicidal behavior</td>
</tr>
<tr>
<td>Mfs ideation</td>
<td>Maternal filicidal-suicidal Ideation</td>
</tr>
<tr>
<td>ss</td>
<td>Simple suicide</td>
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</tbody>
</table>
**Preview of the Study**

In Chapter 2 the objectives, their rationale and the research plan to achieve them will be presented. The literature on mfs will be reviewed from the perspective of homicide-suicide (h-s) in Chapter 4, and from the perspective of filicide in chapter 5. In Chapter 3, an introduction to issues in the research of mfs is presented. Meanwhile, in Chapter 6 a summary of the findings of Chapters 4 and 5 is presented as well as a synthesis of the findings of these two chapters. In addition to the traditional review, where information of various studies is compared and contrasted, the review presented in Chapters 4 and 5 will heavily focus on identifying and compiling information about the various aspects of mfs. In Chapter 7 and 8 the findings of the previous chapters will be compared and contrasted from the vantage point of suicidology. Information extracted from case studies will be included here. Chapter I also contains a special protocol for the evaluation of mfs ideation. Chapter 9 contains Summary, Conclusions, and Recommendations.

**Chapter Summary**

The issues involved in the study of maternal filicide-suicide, especially the lack of knowledge about mfs ideation were described and explained in this chapter.

The need to approach issues involving mfs and mfs ideation from the perspective of suicidology was described as central to understanding mfs and mfs ideation.