CHAPTER 2 METHODS

Chapter Overview

In this chapter, the objectives and their rationale will be presented, as well as a research plan.

Problem Statement

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

Research Questions

- 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?

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

- What are the challenges a psychotherapist faces, while working with mothers, who might be experiencing filicidal-suicidal ideation?
Objectives and their Rationale

Four objectives will be presented. They represent a sequence or hierarchy, where an objective can only be properly addressed when the previous objective has been achieved. After each objective, the rationale and the research plan for that objective are described. An overview of the four objectives is included in Table 2.1

<table>
<thead>
<tr>
<th>#</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>To identify, analyze and evaluate information in the literature about the prevalence and content of the various maternal filicidal-suicidal behaviors, from ideation to fatal attempts, the characteristics of the mothers engaging in these behaviors, and other information that may be relevant for the assessment of mfs behavior, such as risk factors and warning signs.</td>
</tr>
<tr>
<td>2</td>
<td>To develop a classification system of maternal filicidal-suicidal behavior based on the clinician’s duty to report potential child endangerment, as well as the presence or absence of prior dangerous behavior and/or symptoms of a thought disorder.</td>
</tr>
<tr>
<td>3</td>
<td>To adapt and apply concepts, findings, and theories developed for the study of simple suicide to those maternal filicidal-suicidal behavior cases that are primarily suicidal rather than homicidal.</td>
</tr>
<tr>
<td>4</td>
<td>To identify the challenges faced by a psychotherapist working with depressed and potentially suicidal mothers of young children (dpsmyc) in terms of evaluating the presence and severity of maternal filicidal-suicidal ideation and behavior.</td>
</tr>
</tbody>
</table>
Objective 1

To identify, analyze and evaluate information in the literature about the prevalence and content of the various maternal filicidal-suicidal behaviors, from ideation to fatal attempts, the characteristics of the mothers engaging in these behaviors, and other information that may be relevant for the assessment of mfs behavior, such as risk factors and warning signs.

Rationale for objective 1

The main rationale for objective 1 is that information about the prevalence and content of mfs behaviors is very scarce and not readily available because it is mostly included in studies that address topics that are broader than mfs behavior. Objective 1 is primarily about compiling information and secondarily about analyzing, and evaluating it because without compiled information, there is nothing to analyze or evaluate. Information will be sought especially about the following aspects of mfs behavior:

- Maternal filicide-suicide as a percentage of all suicides by mothers of young children
- Prevalence of maternal filicidal-suicidal Ideation as a percentage of suicidal ideation among mothers of young children
- Whether mfs is primarily suicide, primarily homicide, or a separate domain
- Information about the contents of mfs ideation and other forms of mfs behaviors, as well as identifying categories or subtypes among mothers with mfs behaviors
- Distinguishing between mfs behavior and mothers with similar symptoms but without mfs behaviors
- Identifying sources of bias and confusion
Maternal Filicide-Suicide as a Percentage of all Suicides by mothers of young children.

Preliminary estimates suggest a percentage between 5 and 15. In addition to being important in its own right, this information might be helpful in estimating the percentage of dpsmyc, who are experiencing filicidal-suicidal ideation.

Prevalence of Maternal Filicidal-Suicidal Ideation as a percentage of Suicidal Ideation among mothers of young children. Mfs behaviors that have been studied have been limited to fatal and nonfatal attempts. The possibility that dpsmyc might be experiencing filicidal ideation in conjunction with suicidal ideation has only been raised indirectly, and not in many studies. However, the fact that fatal mfs attempts may represent between 5 and 15% of all suicides by mothers of young children makes one wonder about the suicidal ideation of mothers of young children. It seems reasonable to estimate that between 5 and 15% of them might have filicidal ideation in addition to their suicidal ideation. Depression, of which suicidal ideation is often a symptom, reportedly affects a relatively high percentage of women, including mothers, between 25 and 40 (Crosby et al., 1999). Therefore, filicidal-suicidal ideation might be much more widespread than previously assumed. For the clinician, it is important to know that many of these mothers are seeking help, and might be among their clients.

Whether mfs is primarily suicide, primarily homicide or a separate domain. Preliminary findings suggest that while certain forms of h-s, such as extrafamilial h-s or spousal h-s of the murderous jealousy variety sometimes are considered primarily homicidal, mfs is regarded as either primarily suicidal or as belonging in a separate domain, somewhere between suicide and homicide (Nock & Marzuk, 1999).
Those arguing for a domain of its own for mfs refer to the simple fact that cases of mfs involve both a suicide and a homicide, while simple homicide and simple suicide do not. In addition, they refer to demographic features, especially age, of the offenders as being different from typical female homicide offenders or suicide victims.

However, information about the mental processes and stressors preceding acts of h-s and mfs indicates that these are similar to what is seen in regular/simple suicide (Palmer & Humphrey, 1980). In fact, those arguing for a domain of its own make ample use of theories developed in suicidology in order to explain h-s behavior (Starzomski & Nussbaum, 2000). If additional findings confirm these preliminary ones, there may be an opportunity to make use of the theories developed in suicidology for formulating and identifying risk factors.

**Identifying categories or subtypes among mothers with maternal filicidal-suicidal behaviors.**

As mentioned earlier, ideation, planning, aborted attempts, or other preparatory behaviors in regards to mfs are not discussed in studies. The only way to obtain information is to examine studies in which mfs is discussed, for remarks or observations that could allude to ideation, planning, and aborted attempts, and have not been included in the findings and conclusions of these studies. This may have happened because the main topic of the study was not mfs. When examining such studies, valuable information can sometimes be found in descriptions of cases, in statistics, or in other parts of the study than the findings. Aspects that I will look for include, but are not limited to the following:
- Behaviors related to the attempt: premeditation, preparation, methods used, outcome, and the presence of suicide notes as well as their contents.

- Victims: number of children involved, their age and gender

- Characteristics of the life of the mothers at the time of the attempt: demographic, stressors, personality variables and the presence of any psychiatric disorders

- Processes leading up to the attempt: ideation, planning, aborted attempts, communication of intentions and motivation, as well as prior attempts at suicide and/or filicide

- Pathways from childhood to the attempt

- Extent to which findings can be generalized to mothers who have not yet made an attempt

Distinguishing between mfs behavior and mothers with similar symptoms, but without mfs behavior. Hawton et al. (1985) reported that 30% of women who had been admitted to an emergency room after having made a suicide attempt were either involved in child abuse, or were considered to be at high risk for abusing their children. In the same vein, women who were known to abuse their children (Hawton & Roberts, 1981) were found to be more prone to attempts at regular suicide. Mfs mothers, on the other hand, have been found to either not abuse their children, or if there is some abuse, it is not the kind of chronic battering that often is associated with fatal child abuse (Alder & Polk, 2001). However, some of the mfs mothers may be similar to the mothers described by Hawton et al. with respect to ideation about and attempts at simple suicide. As a result, it is important that the clinicians who have to distinguish between these two types of mothers are aware of the fact that mfs mothers generally do not abuse their children.

Identifying sources of bias and confusion. Mfs behavior is usually incorporated in studies that address areas and issues that are broader than mfs behavior, e.g. homicide-suicide or filicide.
Often, aspects that are unique to mfs behavior are hardly addressed because the other topics that are included in these studies appear to carry more weight.

Several studies (Sadoff, 1995; Tuteur & Glotzer, 1959) routinely state that mothers who were involved in mfs attempts were mentally ill (in the sense of being insane rather than having a psychiatric diagnosis) and that their thinking contained psychotic components. Often terms such as ‘delusional altruism’ are employed in this regard. This practice has been criticized (Alder & Baker, 1997; Alder & Polk, 2001; Meyer & Oberman, 2001) because before the act, there were often no symptoms of psychosis. There appears to be a belief that mothers who have made attempts at mfs must have been mentally ill and psychotic to do what they did, even though there had not been signs of psychosis or delusion before the attempt.

I have noticed that comparisons between studies in which mfs is addressed are often made without specifying the type of mfs behavior, or the outcome, e.g. fatal or nonfatal. Some studies only include cases where both the mother and at least one of her children died, while other studies only include mothers who are still alive after having made a nonfatal suicide attempt, whereas the filicide attempt was fatal. Various other combinations are found as well. It is easy to see how comparisons between studies without a clear specification of the behavior or population examined in these studies can lead to incorrect and potentially misleading conclusions. The same can happen when results of hospital studies are compared with those of population studies.
Research plan for Objective # 1

The research plan for Objective 1 consists of a review of the literature. Various types of studies, conducted in various countries, will be reviewed: hospital studies, epidemiological studies, theoretical studies, and review studies.

Case studies will be reanalyzed. Reanalysis of cases can yield important information. The focus of a study might have prevented an analysis of a case from the vantage point of mfs. Alternatively, the study might have been published in an era when certain behaviors were not associated with psychopathology, as they are today. This is particularly true for accounts of childhood sexual abuse that were included in case studies, yet were not connected with psychopathology as an adult, especially suicidal and filicidal-suicidal behavior.

Because relevant information about mfs can be found in many different types of studies, it will be necessary to review a great many of such studies. Some studies which contribute to misunderstanding mfs or contain no information on mfs, while their titles suggest they do, will be included in the review in order to demonstrate their potential for creating misunderstandings.
**Objective 2**

To develop a classification system of maternal filicidal-suicidal behavior based on the clinician’s duty to report potential child endangerment, as well as the presence or absence of prior dangerous behavior and/or symptoms of a thought disorder.

**Rationale for Objective 2**

A critical issue in the evaluation of the presence and potential severity of mfs behavior consists of the confidentiality of the relationship between patient and clinician. The clinician might be hesitant to contact the family out of fear of alienating the mother, and possibly driving her out of therapy. At the same time, involving the family in the evaluation process, or having them monitor the mother during periods of increased danger could be an effective or even necessary intervention. This situation can present a real dilemma for a clinician. However, in situations where the potential dangerousness of a mother is known because of prior suicidal/filicidal behavior, and/or the presence of psychotic symptoms of which the family of the mother is aware, breaking confidentiality might be less stigmatizing for the mother. In addition, there might already be a relationship where the clinician consults with the family on a regular basis.

The clinician who is working with a mother whose potential dangerousness is less obvious and who does not present with a history of prior dangerous behaviors or symptoms of a thought disorder, faces a much more difficult task. The mother may have been high functioning, or might still be high functioning in many areas of her life. This mother may have sought help, and, after all, is in therapy, which suggests that she continues to want help. Motherhood is generally seen as a protective factor against suicide, which would be an additional reason not to suspect the presence
of filicidal-suicidal ideation. In addition, this mother may resist having the clinician contact her family. She may have been able to give her family the impression that she is coping with her problems, especially by being in therapy and by being selective about what she has told them.

In a situation, such as the one described in the last paragraph, the clinician's assessment skills are critical. It is important that the clinician recognize that certain behaviors or thoughts expressed by the mother could indicate the presence of a filicidal-suicidal process. In the absence of clear markers of the presence of such a process, it is imperative for the clinician to be aware of events, facts, and behaviors of the mother that represent risk factors (to be defined here as anything that indicates an increased risk regardless of any causal connection) for the presence of mfs ideation. The clinician, who is a mandated reporter, needs to know about those risk factors that would indicate a need to report the mother for potential child endangerment, especially when the mother has no known history of prior dangerous behavior or symptoms of a thought disorder.

The rationale for proposing a classification system around the theme of prior dangerous behavior and/or symptoms of thought disorders is further supported by certain preliminary findings. These findings show an interrelation between the presence of a thought disorder and certain variables associated with the mfs attempt, such as a lack of preparation, more nonfatal incidents, and more frequent use of weapons. Thought-disordered mothers also tend to target children from birth to 16 years old rather than the 1 to 7 year range that appears to be more common among mothers without a thought disorder. The preliminary findings show additional correlations for the thought-disordered mothers, which will be presented in the literature review chapters.
The preliminary findings also showed interrelations between mothers who had made a serious fatal or nonfatal mfs attempt without having shown prior dangerous behavior, and certain personality characteristics, psychiatric symptoms, stressors and socio-demographic features. Some of these characteristics were similar to those of the mfs mothers with a thought disorder, and some were quite different. The preliminary findings that are based on an analysis of case studies from various publications will be discussed in more detail in the literature review chapters.

Knowledge of correlations between personality characteristics, psychiatric symptoms, and stressors on the one hand, and the content and severity of mfs ideation and behaviors on the other hand may help the evaluating clinician in knowing what to look for.

Research Plan for Objective 2

The findings of Objective 1 concerning characteristics and patterns will form the point of departure, to which the results of a re-analysis of case descriptions will be added. I will concentrate on the characteristics of the filicidal-suicidal process, demographic aspects (the age of the mother and the age, gender and number of the victims), as well as other aspects, such as the presence of a psychiatric or criminal history, or having a family history of suicide and criminal behavior. As an example of the type of information extracted from re-analysis of the case descriptions, I present the following case (Alder & Polk, 2001), after which I summarize the items that I consider relevant for this dissertation.
Tina Tsekouras (35 years) was upset about her de facto Marco having an affair while he was in Greece. A friend said Tina spoke about it previously and was considering committing suicide: ‘She had never got over the fact that Marco had the affair ... When Tina accidentally found out about Marco’s affair she was “shattered”, it ruined her trust and affected her confidence.

When Tina and Marco separated, Tina was advised that she would not have sole custody of her daughter Brook (3 years). Tina wanted to keep Marco away from them, as she was concerned that Marco might be assaulting Brook. Friends said ‘She could not bear the thought of Brook being with Marco because she could not trust him.’

Tina was also having problems at work. She talked of committing suicide on several different occasions, commenting that she could always end it and take Brook with her if things became too bad.

Tina drove with Brook to a coastal car park and ran a vacuum hose from an exhaust pipe into the car and started the engine. They’ were both found dead in the rear seat of the vehicle, the child secured in a child’s seat restraint. (Alder & Polk, 2001, p. 48)

Items that I extract from this case as potential risk factors include:

- the presence of relationship problems including separation and divorce
- custody issues
- presence of strong abandonment feelings
- gender of child: daughter
- immigration
- age in 28-35 range
- age of child: 3 years
- fear of daughter being abused by the father in connection with custody issues
- possible fear of daughter being abused by father in case of simple suicide by the mother
- problems in other areas of life: work
- filicidal-suicidal communication to co-workers at several occasions, which implies that this happened over a longer period.
- Suggestion that advantages and disadvantages were compared and weighed (“She could always end it and take Brook with her if things became too bad”)
- Premeditation and planning (“drove to a coastal park and ran a vacuum hose
- Method for filicide (of exhaust gas) possibly perceived as painless, and relatively passive, i.e. after strapping child in seat and connecting exhaust pipe, mother does not have to face or touch child again to make it die.
- Method allows for simultaneous deaths
Additional risk factors will be extracted from the study of other cases.

Tables 2.2 and 2.3 give a preview of what these characteristics might look like. Table 2.2 contains the characteristics of most mothers who have made fatal or nonfatal mfs attempts. Table 2.3 shows how certain characteristics tend to differ based on the presence or absence of known prior symptoms of a thought disorder. Table 2.3 contains the kind of information that could be entered into a classification system to be used by clinicians for evaluating mfs ideation.\textsuperscript{10}

\textsuperscript{10} Currently the exhibit in Table 2.3 only shows two categories, which reflect the absence or presence of symptoms of a thought disorder prior to acts of mfs. There is a possibility that the findings of this study may make it necessary to adjust the classification system as it is described in Table 2.3. For example, there are indications that the category of “no known prior symptoms of a thought disorder” may have to be split in two subcategories based on known prior suicide attempts for the following reason. Someone, who has not shown any symptoms of a thought disorder, might nevertheless have made a suicide attempt in the past. In case the findings reveal that mothers with such prior attempts have a profile that is different from mothers without such prior attempts, it may be necessary, as already pointed out, to split the category “without known symptoms of a thought disorder” based on a history of suicide attempts.
TABLE 2.2
Preview of potential characteristics typical for most mothers making a fatal or non-fatal attempt at filicide-suicide (What the overt and covert subtypes have in common)

- Motive of “altruism”
- Convergence of mental health, personality and external stressors rather than exclusive focus on mental health
- Long-term problems with emotional health, psychiatric history, including comorbid depression and anxiety
- Overconcern about well-being child, sometimes in combination with disabled/sickly child
- Hopelessness, guilt,
- Problems in intimate relationship, sexual problems
- Issues from own childhood reactivated due to having young children, incl. sexual abuse as well as other forms of abuse
- Fear of future/doomsday, real or imagined abandonment or threat of imminent abandonment, reactivation childhood fears

- Family history of depression and suicidal behavior;
- Parental discord
- Moving; Immigration; parental diaspora
- Separation from parents and siblings before age 15
- “Motherless” mothers

- Media reports of mfs cases sometimes have a triggering or contagion effect
- Caucasian mothers are at greater risk than African-American mothers
- Stepchildren and spouse are not attacked by mothers, while they are by fathers

- Presence of communication about intentions to attempt mfs

---

11 PREVIEW TABLE means that this table is presented primarily to give the reader an idea of the format of the information that will be available after the completion of this dissertation. The final version of this table may contain different information than this model.
Table 2.3

Table of characteristics of mothers who have made an attempt at filicide-suicide based on the presence or absence of known prior symptoms of a thought disorder

(Where subtypes differ)

<table>
<thead>
<tr>
<th>Absence or presence of Prior symptoms</th>
<th>Absence of prior symptoms of a psychotic or delusional nature or prior hospitalization for serious mental illness problems</th>
<th>Presence of prior symptoms of a psychotic or delusional nature or prior hospitalization for serious mental illness problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTEMPT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nature of attempt</td>
<td>Premeditation and preparation apparent</td>
<td>Lack of premeditation and preparation</td>
</tr>
<tr>
<td>Outcome of attempt</td>
<td>Intended to be fatal for suicide and filicide. In most cases this is what happens</td>
<td>Suicide attempt often nonfatal. Filicide tends to be fatal more often, when children are less than one year old and/or when guns are used.</td>
</tr>
<tr>
<td>Suicide note</td>
<td>Yes, often written before mfs attempt, sometimes weeks in advance</td>
<td>Generally no suicide note</td>
</tr>
<tr>
<td>Rehearsed</td>
<td>Indications suggest that attempt may have been rehearsed, possibly as an aborted attempt</td>
<td>Greater degree of impulsivity suggests that the final attempt may not have been rehearsed</td>
</tr>
<tr>
<td>To what extent effort to kill all children?</td>
<td>Mother kills or tries to kill all her children</td>
<td>Efforts to kill all children do occur, but are less frequent than in the premeditated category. Often only one of the children is targeted.</td>
</tr>
<tr>
<td>Soft or violent methods</td>
<td>Use of methods perceived as painless, such as gas. The cases suggest a recent increase in the use of firearms.</td>
<td>Often use of weapons, violence, stabbing, firearms etc.</td>
</tr>
</tbody>
</table>

12 PREVIEW TABLE means that this table is presented primarily to give the reader an idea of the format of the information that will be available after the completion of this dissertation. The final version of this table may contain different information than this model.
### Table 2.3 (continued)

<table>
<thead>
<tr>
<th>DEMOGRAPHIC</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital status</td>
<td>Often married</td>
</tr>
<tr>
<td>Education level+ social class</td>
<td>At least high school and lower middle class</td>
</tr>
<tr>
<td>Employment</td>
<td>Quite a few cases were stay-at-home mothers, who had worked prior to motherhood and had enjoyed it.</td>
</tr>
<tr>
<td>Number of children in family as a risk or protective factor</td>
<td>If mother has 4 or more children, low chance of carrying out plan</td>
</tr>
<tr>
<td>Age children</td>
<td>mainly 2-5, sometimes 1 or 6, practically never under 1, very few cases over 6</td>
</tr>
<tr>
<td>Age mother</td>
<td>majority between 27/28 and 33/34, range from early 20’s to late 30’s</td>
</tr>
<tr>
<td>Gender children</td>
<td>Mother more prone to kill daughters, especially if she only has daughters, according to Rodenburg, Marleau Only weak support from data</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENERAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apparent competence behavior</td>
</tr>
<tr>
<td>Life in general</td>
</tr>
<tr>
<td>Types of stressors</td>
</tr>
<tr>
<td>Abuse of drugs or alcohol</td>
</tr>
<tr>
<td>Abuse of children</td>
</tr>
<tr>
<td>MENTAL HEALTH</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Specifics of doomsday fantasies</td>
</tr>
<tr>
<td>Extended social anxiety</td>
</tr>
<tr>
<td>Psychotic symptoms, delusion, schizophrenia</td>
</tr>
<tr>
<td>Previous suicide attempt</td>
</tr>
<tr>
<td>Previous filicide attempt</td>
</tr>
<tr>
<td>Premorbid functioning</td>
</tr>
<tr>
<td>TREATMENT-RELATED</td>
</tr>
<tr>
<td>Hospitalization issues</td>
</tr>
<tr>
<td>Help-seeking behavior</td>
</tr>
</tbody>
</table>
**Objective 3**

To adapt and apply concepts, findings, and theories developed for the study of simple suicide to those maternal filicidal-suicidal behavior cases that are primarily suicidal rather than homicidal.

**Rationale for Objective 3**

While a classification based on potential dangerousness due to known prior dangerous behavior or the presence of symptoms of a thought disorder is helpful in highlighting potential risk factors, there may be a lack of understanding about the impact and interactions of specific risk factors, as well as their etiology. Considering that most forms of mfs behavior are considered primarily suicidal rather than homicidal, the use of suicidology may be helpful. Much has been learned about the suicidal process with its sequence of mild ideation to severe ideation, planning and aborted attempts, and from non-serious attempts to serious attempts and finally to fatal attempts. The concept of a suicidal process, of which the components include prior communication and suicide notes, may provide an important contribution to the understanding of the behavior and the thinking of mothers who are experiencing ideation about mfs. Adapting what is known about the various components of the suicidal process in simple suicide to the mfs situation could highlight the increased importance of an aborted attempt. A mother contemplating mfs does “not have the option” of a non-serious attempt, which persons contemplating simple suicide have, since she would have to start with the children. Because of this, we may expect fewer nonserious, non-secret, “cry for help” type of attempts among mothers with mfs ideation and instead more aborted attempts that are kept a secret.
Knowledge of the suicidal process in simple suicide also shows that in general quite a number of patients who contemplate simple suicide hesitate to discuss this with a clinician (Shea, 1998). Shea reports that many are too ashamed or fearful of being hospitalized. If this is true for those who are contemplating simple suicide, it is more likely to apply to dpsmyc, who are contemplating mfs, especially when there is a history of aborted attempts.

Knowledge of the danger of simple suicide that is associated with various psychiatric diagnoses, and especially comorbid ones, also may clarify our understanding of mfs. Research is needed to examine to what extent specific risk factors that apply to simple suicide apply to mfs. For example, childhood sexual abuse is known to be an important risk factor for suicide among women in general. It is quite possible that it represents a similar or more serious risk factor for a dpsmyc because the mfs mother might be concerned that her own children, especially daughters, might be subjected to childhood sexual abuse. In addition, the mother’s own childhood trauma might be reactivated when her children reach the age at which she herself was abused.

Theories associated with disturbances of the self, such as the escape theory of suicide (Baumeister, 1990), which rely less on explanations rooted in psychopathology and more on the interaction between the self and the environment, have been introduced in suicidology. These theories are being used to explain processes and events that precede and accompany the kind of rapid disintegration, which is often seen in a person prior to a serious suicide attempt. Such theories could be examined for their relevance for mfs by an in-depth psychological autopsy of mfs cases.
Additional rationale for using the concepts of suicidology consists of the fact that suicidology covers suicidal behaviors of many different groups, ranging from adolescent girls to males who have just retired. Therefore, mfs can be seen as one of the many varieties of suicidal behavior covered by suicidology.

Research plan for objective 3

In Chapter 7 aspects of suicidology potentially relevant for mfs will be reviewed as well as the extent to and the manner in which suicidology concepts can be applied to mfs and mfs ideation.

Objective 4

To identify the challenges faced by a psychotherapist working with depressed and potentially suicidal mothers of young children (dpsmyc) in terms of evaluating the presence and severity of maternal filicidal-suicidal ideation or behavior.

Rationale for Objective 4

A mother’s insufficient disclosure of her mfs ideation and behavior has been identified in the previous chapter as a major challenge to a clinician, especially when the clinician has problems in identifying situations that represent an increased risk for mfs ideation. The issue of communication between clinicians, e.g. for consultation, also needs to be addressed, as ineffective communication may compound the other challenges a clinician might face. Examples of inadequate exchange of information will be provided in the literature review chapters. Lack of disclosure and/or effective communication may have serious and even lethal consequences.
Research Plan for Objective 4

I will note and describe remarks in the literature that directly or indirectly pertain to communication about mfs ideation and mfs behaviors. This includes the clinicians' communication with their patients, their patients’ family members, or caregivers, and with other professionals involved in the care of patients. In Chapter 8, I will present a special protocol for the evaluation of mfs ideation. This protocol contains a section on treatment.

Summary of Chapter 2

The four objectives of this dissertation, their rationale, and the research plan to achieve the objectives were described and discussed in this chapter.