In this chapter I will first present a summary of phenomena (found in studies on mfs) that have been associated with mfs by depressed and potentially suicidal mothers of young children (dpsmyc) who were in outpatient, ongoing psychotherapy and who also were described as having a Typus Melancholicus personality structure\textsuperscript{141}. Most of these phenomena can be considered risk factors.

This summary of phenomena will be followed by a special protocol for the evaluation of mfs ideation. This protocol describes interactions between the various phenomena included in the preceding summary. The protocol also contains indicators of the presence of these phenomena\textsuperscript{142}.

\textsuperscript{141} Mothers who made fatal or nonfatal mfs attempts and whose main motive was hostility towards the father of her children as well as mothers known to be suffering from a thought disorder, (including post partum psychosis) prior to the mfs attempt usually were not in outpatient psychotherapy and did not have a Typus Melancholicus personality. If they were in outpatient psychotherapy anyway, then their symptoms would make it relatively easy for a clinician to diagnose the potential dangerousness of these mothers for self and others, especially their children.

\textsuperscript{142} For instance, an indicator of the phenomenon of overconcern for the well-being of the child can be overuse of medical facilities.
Many of these indicators are not included in the findings of the various studies but they are part of the case descriptions that are included in these studies.\textsuperscript{143}

The protocol also incorporates a number of concepts used in the study of simple suicide, suicidology that were not specifically mentioned in mfs studies but could be relevant.

**Summary of Phenomena associated with Mfs**

1. Personality traits that have been associated with Typus Melancholicus: performance orientation, an exaggerated sense of responsibility, obedience, hypernomy (the opposite of anomy), anxiety, depression, as well as a poorly defined sense of self, and concomitant tendencies to over-identify with others and with social roles. As a result, the person with Typus Melancholicus is likely to suffer from rejection sensitivity.

2. Chronic emotional problems often dating back to adolescence and sometimes to childhood.

3. Comorbid presence of anxiety and depressive disorders, particularly shown as social anxiety and rejection sensitivity which may be especially pronounced in individuals with features of Avoidant, Dependent or Borderline Personality Disorder.

4. The presence of fantasies, the use of which is the most important defense mechanism in persons with Avoidant Personality Disorder (Millon, 1996) and/or a sense of a foreshortened future, which is one of the symptoms of PTSD could be associated with thoughts of impending doom and concomitant rescue fantasies, i.e. including one's children in a suicide attempt so they won't have to suffer from the impact of future negative events. Often such rescue fantasies are referred to as delusions, especially delusions of altruism.

5. Overconcern for child's well-being, feelings of inadequacy as a mother, and pathological guilt resulting in the phenomenon of extended rejection sensitivity, where the mother perceives her children being rejected by their peers or expects that this will happen in the near future and will continue for the rest of their lives.

\textsuperscript{143} Information from one particular case that is not included in the literature but with which the author is personally familiar will also be used to illustrate the presence and meaning of the various indicators. All of the information to be used from this case is included in documents which the reader can find in an appendix to the dissertation.
6. Phenomena associated with a suicidal/filicidal-suicidal process:

- Suicidal ideation and prior attempts
- Thorough preparation of mfs attempt and an intention for the outcome to be lethal, knowledge of means and methods, plans to include all children, and the likelihood of rehearsing possibly in the form of aborted attempts
- Communication to family and/or friends
- Communication with doctors and clinicians, although possibly less frequent than with family or friends due to fear of certain interventions such as hospitalization
- Suicide notes, sometimes written prior to mfs attempt as a standby note
- Deconstructed state during the end phase

7. Phenomena associated with treatment (mostly found in case studies)

- Frequent interruptions of therapy, often restarting treatment, and premature terminations
- Prior psychiatric hospitalization
- Fear of (re)hospitalization and the related threat of involuntary hospitalization which often but not always is associated with fear of stigmatization
- Fear of stigmatization can limit disclosures to clinicians
- Involving the family in the evaluation process by asking them about their observations of the mother is strongly encouraged in the literature. The same is true for consultation with colleagues in cases of suspected ideation about homicide-suicide, including mfs

8. Predisposing factors

- Stress resulting from the various mental health issues
- A family history of depression and suicidal behavior appears to increase risk of mfs
- Childhood-related issues such as immigration, abuse (sexual, physical, or emotional), and lack of maternal nurturing (“motherless mothering”)
• Interpersonal issues, perception of being alone

• Presence of a sickly or disabled child (Alder & Polk, 2001; Tuteur, 1959) and related feelings of being overwhelmed by the demands associated with the care involved, guilt and fears that the child will be rejected by its peers

• Breach of perception of continuity due to cultural factors or PTSD

9. Current stressors, precipitating factors

• Experiences related to social anxiety/rejection sensitivity, and a concomitant sense of alienation and isolation

• Interpersonal difficulties, especially when experiencing problems with both current partner and family of origin

• Experiences/fears of abandonment

• Reactivation of childhood trauma

• Issues resulting from doomsday fantasies and extended rejection sensitivity

10. Demographic Aspects

• Age of mother: average: early 30's; range 27-35

• Age of children. Mostly older than 12 months and under the age of 7, while the victims of fatal child abuse rarely are three or older and most often considerably younger. Victims of post-partum filicide, by definition, are younger than 12 months.

• Mothers with daughters at higher risk, especially if only daughters

• Indications of lower risk when a mother has more than three children

11. "Contagion"/"Copy-cat" effect due to publication in media of mfs cases

12. Cultural Issues

• Experience of alienation, isolation or discrimination

• View of filicide/suicide in culture of origin
Special Protocol

In the special protocol I will discuss phenomena and risk factors associated with the following themes:

- Performance orientation
- Extended Rejection Sensitivity or Rejection Sensitivity by Proxy
- Erratic behaviors and fear of the exposure of these behaviors. The notion of arrested flight
- Cognitive issues associated with Rejection Sensitivity
- Lack of continuity due to Cultural factors or PTSD
- Vulnerability to Reactivation of Issues from Mother’s Childhood
- Social and Family Relationships
- Symptoms suggesting the presence of a deconstructed state as described by Baumeister
- Treatment and Hospitalization issues
- Demographic Factors
- The mfs process and the mother’s position in it
- Stressors/Precipitating factors
- Informational issues: Collusion between patient and clinician?

**Performance orientation**

Being performance oriented is one of the characteristics of the Typus Melancholicus personality style, which also includes anxiety, depression, obedience, and hypernomy. Persons with a Typus Melancholicus personality may live in fear of what will happen to them, if they will not meet the performance standards that they believe apply to them.

Performance standards for mothering may be harder to define than for many jobs in regular employment. It is noteworthy that several of the case descriptions (Meyer & Oberman, 2001; Resnick, 1969, West, 1965) refer to women who had left regular, and sometimes fulfilling
and challenging jobs, in which they performed well before becoming stay-at-home-mothers. Haapasalo & Petaejae (1999) also referred to this phenomenon.

In addition, usually the roles in regular employment are such that the behavioral expectations and the extent to which one meets these standards are relatively clear. These reassuring features may appear to the Typus Melancholicus mother not to be present in her “job” as a mother or to be much vaguer. In fact, most mothers experience moments of doubts about their mothering skills. You may also add that most cultures set forward powerful idealizations of how a mother should be and feel.

It is not hard to see how an insecure mother may believe that her mothering is inadequate. The mothering she received from her own mother may not have been adequate. Now she has children herself, she may become aware of the lack of a model. The lack of a model may contribute to the perception that her mothering is not good enough. One possible sign of such a perception is the mother’s overconcern about the “how to’s” of raising children. As a result, she may be preoccupied with questions of mothering.

**Extended Rejection Sensitivity or Rejection Sensitivity by Proxy**

A problem that is closely related to overconcern and feelings of inadequacy as a mother consists of what I have designated extended rejection sensitivity/social anxiety but could also be called, in analogy to Munchhausen by Proxy, rejection sensitivity by proxy.
Extended social anxiety refers to mothers who generalize (extend) their own rejection sensitivity and social anxiety to their children. Since rejection may be traumatic for such a mother, she has not developed skills to cope with rejection. She may not be able to offer her children support and guidance in dealing with rejection. And, this mother may not be able to recognize that her own children are actually capable and successful in dealing with experiences of rejection.

As a result, such a mother may perceive her children being rejected by their peers, while the children are not aware of any rejection. Even when the mother does not perceive any current rejection she may fear for rejection in the future. The mother probably blames herself and her own shortcomings for the fact that her children are being rejected.

Such a mother may also feel that her own problems are genetic and that her children are doomed to suffer from the same problems that she suffered from. In this context, the presence of organic factors such as certain types of depression or PMS as well as a family history of psychiatric disorders and suicidal behavior may constitute a double burden. The mother may be affected by these factors or perceive herself to be affected. In addition, she may believe that her children will be doomed to suffer from these afflictions as well.

When these mothers have more than one child, and they perceive that all (mostly two, sometimes three) of their children are being rejected or are at risk of being rejected in the future, mfs ideation may be more likely and more severe (see also figure 8.1 on p.393). A mother with more than one child who worries that only one of her children will be suffering from rejection may be less likely to consider mfs as a serious option because she would have to leave the “normal”
child or children behind without siblings and a mother. The alternative would consist of killing the other children as well. Both options may be unacceptable. However, these restraints would not play a role when the mother believes or has convinced herself that all her children will be suffering in their future.

Because so many of the mother’s perceptions are related to memories of her own childhood, there is a possibility that the risk of mfs ideation is larger when all her children are daughters (Marleau & Laporte, 1999) since having the same gender may facilitate overidentification with daughters.

A compounding problem may occur when the mother has a child with a disability or chronic illness. First, the mother with a Typus Melancholicus personality may blame herself for the fact that her child is disabled or chronically ill. Subsequently, she may perceive or expect even more rejection for the disabled child. In addition, she may believe that extra mothering skills are needed for this challenge, while she is already suffering from deficits in this area.

Erratic behaviors and fear of their exposure
The notion of arrested flight

The Typus Melancholicus persons’ sensitivity to rejection as well as their tendency to (over)identify with others and with social roles has been described by Okumura & Kraus (1996) in terms of the despair that can be the result when the Typus Melancholicus persons perceive rejection by those with whom they most identify. The implication is that the Typus Melancholicus persons tried hard but could not convince themselves that what they did was enough. However,
what was not discussed by Okumura & Kraus consists of certain behaviors possibly engaged in as part of the overidentification, or the “urge to merge”. These behaviors can become a source of regret and shame after the urge to merge has run its course, i.e. when a period of overidentification ends and is followed by disappointment and disillusion. The Typus Melancholicus mothers might fear that these “shameful” behaviors might be exposed leading to stigmatization and perhaps being ostracized.

For instance, a depressed and potentially suicidal mother of young children (dpsmyc) may have shared with friends or neighbors that in the past she experienced mfs ideation but is doing fine now. The sharing experience may have been partly motivated to strengthen the connection with other mothers experiencing problems. While the dpsmyc may not have come across as dangerous at the time of her disclosure, word of a psychiatric hospitalization probably would alert the recipients of the earlier disclosure of mfs ideation. It is not hard to see how concerned a dpsmyc could be about this prospect. She may fear that these mothers will avoid her and also will keep their children from playing with her children because the “crazy” mother might do something. In addition, she may fear that her children will be affected by her disclosures. Whether or not these fears are realistic or not, it is quite conceivable that a dpsmyc might have them and that they will affect her thinking and behavior.

In a similar vein, the dpsmyc may have been involved in other situations, e.g. dating or employment that cause her to feel shame and fear that whatever may have happened will become public knowledge once attention will be focused on her as a result of people talking about her after they learn about her hospitalization.
Therefore, the clinician might be well advised to realize that the stigma known to be often attached to psychiatric hospitalization represents only the lid of the proverbial container filled with negative facts and secrets that a dpsmyc fears will be emptied exposing her as a desperate, ill-adjusted person.

The strength of this phenomenon may increase for the dpsmyc who has been using running away as a coping mechanism and now realizes that due to being married and having children it is much more difficult to make use of this coping mechanism again. This could be an example of “arrested flight” (Gilbert & Allan, 1998).

A related issue is that a dpsmyc may have the habit of giving others a piece of her story but never the whole story, lest they will think badly of her. However, when these “others” start talking about her, this approach may no longer work.

Several of the erratic behaviors engaged in appear to be associated with abandonment issues and impulsivity, which suggests the presence of Borderline traits in the mothers engaging in these behaviors.

*Cognitive issues associated with Rejection Sensitivity*

*Doomsday fantasies and associated rescue fantasies*

The presence and strength of a sense of a foreshortened future, doomsday fantasies, and superstitions, e.g. specific horoscope-generated predictions of doom might play an important role.
All of these could make the fearful, insecure dpsmyc even more fearful and exacerbate her mfs ideation.

Doomsday related fantasies of rescuing the children from doomsday scenarios by taking them along in suicide figure prominently in the findings of studies that deal with mfs. However, in many studies the fantasies are described as delusions and psychotic features after an mfs attempt, while similar fantasies prior to an attempt might not have merited more than the designation of distorted cognitions.

One scenario that has not been discussed in the literature is that a dpsmyc with mfs ideation who would want to make an mfs attempt but has been hesitant to act on her ideation, might interpret a publicly announced doomsday scenario, such as the news that another hole in the ozone layer has been detected, as providing the justification she needed to carry out a plan for mfs: “If everyone is going to die anyway, why wait and expose my children and myself to a possibly agonizingly slow and painful death” might be the thought guiding some mothers with mfs ideation into acting on their ideation using methods that are perceived as painless by her in contrast to the scenario that she is saving the children from.

A clinician might do well to ascertain what beliefs and possibly superstitions a dpsmyc might be having, to what extent she is experiencing a sense of a foreshortened future, and whether such a sense of a foreshortened future is associated with her family of origin. For instance, the parents of the dpsmyc might have experienced trauma and modeled a sense of a foreshortened future to their children. Knowledge about the presence of pathological guilt also is important for the
Such pathological guilt might make the mother feel that she should be punished and, as a result, she might be prone to interpret certain events as signs of punishment coming her way.

**Fantasies about rescuing survivors**

Selkin (1976) wrote about fathers who believed that killing their wife and themselves would rescue the children from having to deal with the parents and their problems. Selkin referred to this phenomenon as rescue fantasies. I have not identified similar rescue fantasies in the literature dealing with mfs. However, in a case known to me such a fantasy is implied in a standby suicide note (see Figure 8.1). The mother believed that killing herself and her two daughters would free the father to pursue his life unconstrained by his current family obligations.

**Fantasies as a defense mechanism**

In light of the fact that fantasies are the most prominent defense mechanism in Avoidant Personality Disorder according to Millon (1996), and considering that many persons with social anxiety disorder also have been diagnosed with this personality disorder, it is important to have insight into the fantasies that have been employed by the dpsmyc with a Typus Melancholicus personality. This might suggest a pattern and indicate what areas of the mother's life are particularly vulnerable. For instance, being married, pregnancy, and having children are phenomena with a high degree of social approval. The Typus Melancholicus woman who wants to conform to social norms may find it hard to resist these expectations. In fact, she may be vulnerable to buying into a societal myth that meeting these social norms will provide happiness per se.
"Mary [oldest girl, 4 years old, has achondroplasia which limits growth] takes the little balloon, which Barry [son of a neighbor] had given her to school. Yesterday she played with it with Nancy [a friend in school]. In school she gave it to Nancy with a happy face. I thought it was a sweet gesture and told her so.

Jacqueline [one of Mary’s friends in school] wants to play with Mary this afternoon at our place. We make a ‘date’ for three o’clock. I feel sad and panicky. Another child in the house. How am I to entertain them?

Judy [youngest of two children, 3 years old] is afraid. She asked: “Do you love me?” I tell her, that, of course, I love her. I dropped her this morning from my lap when I tried to make it clear to John [the husband] that I don’t feel happy, that I am desperate. I am not able to take care of the children well. I am not a good example for them.

Judy says that Carl [2-year-old son of a neighbor] already can laugh. She meant to say that we never laugh, that I never laugh.

I think that I have difficulties accepting Mary’s handicap. She should be joining little groups and clubs, but I am afraid of the other children. Afraid that they will laugh at her. When I think about it, my throat becomes real tight.

Cozy “social” talk with other mothers. How do you do that? Then you have to act as if you are cheerful. I am turned inward, into myself and I have the feeling that I am stuck. I think that I will be unable to get over it knowing that I am dumb and that the rest of the world will notice that. Now they notice a grouchy person who is avoiding everyone. I wished someone could help me to get out of this. I know that I have to do it myself, but I don’t know how.

The social contacts of Mary and Judy are being limited, because I am afraid.

I think that maybe I am manic-depressive. When my situation was so-called good, I bought an awful lot of things. Spent much money. Bought clothes. For what? I thought that that was part of me. Now I feel that I made myself ridiculous with all those clothes, which I don’t dare to wear. They are so loud, with flowers, and brightly colored, that I don’t dare to wear them now.

Do I have enough summer clothes for the children for when we go on vacation? You will see that they will look funny/weird, particularly Mary. Then all the children in Zeeland will look at her. And I am not doing anything to make sure she looks nice. Why can’t I myself make fun things for her? Things are blocking. I don’t dare. Am I lazy? I guess so. I would like to have a girl friend that can help me to get out of this, who can tell me how to organize everything.

I am not cordial, I forget everything. I could understand why people would not want to spend time with me. It is hard to get me to do fun things. Unable to enjoy the sweet child Mary. She has such a radiant character. Why can’t I let that inspire me? I am afraid that she will be hurting. She is asking whether Jessica (two years younger than Mary) will be growing as slowly as she. I hardly dare to answer that and I mumble that I don’t know exactly. I am afraid to let her know that she is the only one who is not growing hard. The fact that Ronald [friend of Mary in her school] realizes that Judy is taller than Mary: “That’s not the way it should be”, he says. I feel sad.
I bought flowers for Martha [mother of a child in Mary's group in school. Mother looked up to this woman, because she was so socially adapt]. I dropped off the birthday present for Cornelia and a little gift for Victoria at Patricia's [also a mother of a child in Mary's group in school]. She was very nice. I would like to be open to her. It made me feel good that I had the courage to give it. Now I have to go to Martha with the present for Andrew. I knew she was not home. So I will try it in a little bit.

What happened [last] Sunday at the restaurant is what I have been afraid of for the last couple of years? Such a mean child that was scolding Mary and making fun of her because she is small. That goes through marrow and bone. I loose myself in that and become angry with that child. I should stay calm and explain to Mary that it is no problem that she is small.

Sometimes I think that I am mentally abusing them by being so depressed. I have to arrange playmates for them, but really don't know how to.

It is usually other children who want to play with Mary. The children that she will end up with in grade 1 when she is six are mostly not in school yet. Probably they will be younger children and will they accept her as she is?

I would like to do something with those women in the school. Belong. But how to approach that? Just call and ask if we can do something together? But what would that be? So maybe I really should be sowing clothes for Mary?

For John it is of course real shitty that I am this way. He has no problems with the fact, that Mary is small and does have the courage to do everything that needs to be done. He is socially not as incompetent as I am. But why can't he take care of them? Because he has to work, of course.

Working is something I would like to do myself, but I don't have the self-confidence and the brains to start something. I don't know how I can get the children's clothes in order/ready. Buy even more clothes? Spend even more. We are already depleting our resources.

I have to be cordial to the people, then they will be nice to me in return, but I don't know how to make it through coffee or tea visits. I have nothing to talk about, only my worries about Mary and my feeling of helplessness in that regard.

Judy might become as miserable as I am.

Maybe I should end things and let the three of them go on or maybe we can attempt/undertake/do something jointly/together? [The second half of the last sentence suggests the possibility that the mother might kill herself and her children, maybe even her husband. Yet, it can also be interpreted as: “We all should do something to make things better.” That probably is how the note would have been interpreted, if it had been found before the mother’s extended suicide].

I am going to pick up Judy from school and bring flowers to Martha."
In addition, insight into the current fantasies is important because it might be an indication of the severity of mfs ideation. Moreover, insight into the fantasy may suggest the scenarios under which the fantasy might crash and how that might affect the dpsmyc. For instance, most mfs mothers reportedly experience serious problems in their intimate relationships. If their coping mechanism in this regard consists of a fantasy that a specific event will happen, e.g. someone coming to their rescue, one can imagine the setback when that particular fantasy crashes.

**Lack of continuity due to Cultural factors or PTSD**

Close reading of studies on PTSD suggests that certain events can cause certain people to have an overwhelming experience of discontinuity and a loss of meaning. Chandler (1994) described events of a cultural nature such as a major change in one's environment which might make it hard for some people to experience continuity between their life before and after the change. Chandler particularly applied her theory to suicidal behavior in adolescents who had been exposed to major changes in their environment. These findings suggest that traumatic events associated with cultural changes need to be given much weight. These cultural changes might lead to a sense of alienation, a sense of not belonging, as well as a sense of being different from and less than people in one's environment. These phenomena can contribute to or exacerbate rejection sensitivity. Factors that could suggest that the dpsmyc is vulnerable to this type of alienation include immigration, frequent moves, and early separation from the parents such as attending a boarding school and being left with relatives or strangers.
The clinician may not become aware of more subtle issues of cultural differences that the patient may avoid. Examples consist of hardly noticeable biracial features or a background where one of the parents belongs to a minority but strongly adheres to the majority’s norms. This may be confusing for the dpsmyc when growing up.

In addition, growing up in a military or expatriate environment, which can be highly transitional in nature, may also be associated with feelings of alienation when one no longer lives in such an environment and has to adapt to a “regular” environment.

**Vulnerability to Reactivation of Issues from Mother’s Childhood**

As discussed in chapter 7, certain childhood issues are known to increase the risk of simple suicide. Childhood sexual abuse, in particular, has been mentioned in this regard, although physical and emotional abuse also have been implicated.

A mother with a Typus Melancholicus personality style who also experienced deficits in being mothered—described as *motherless mothering* by Crimmins, Langley, Brownstein, Spunt (1997) - may be especially vulnerable to experiencing a reactivation of her childhood trauma, especially when her children reach the age that is connected to her trauma.

Reactivation of childhood trauma might cause or increase a sense of a foreshortened future which the mother extends/generalizes to her children. Her feelings of helplessness about her inability to prevent her children’s future suffering may further contribute to the mother’s despair.
Any experiences of feeling rejected by her peers in her own childhood may be generalized to her children.

A clinician may want to make an extra effort to learn about the details of a mother’s childhood in order to find out what may have been experienced as traumatic and its potential in causing mfs ideation. For instance, in the context of the mother possibly having been exposed to childhood sexual abuse, it might be useful to inquire about behaviors and symptoms that are associated with childhood sexual abuse both as a child, such as late onset enuresis, and as an adult, such as certain sexual problems. In addition, memories of feeling rejected by peers, even when the mother was as young as four or five, may be particularly powerful, especially when the mother is still experiencing rejection sensitivity. Finally, any current events such as suspicion or knowledge that one or more of her children may have been sexually molested might be especially traumatic if the mother has experienced this herself.

**Social and Family Relationships**

Virtually all studies refer to problems in the marital or consortial relationships of mfs mothers. Abandonment or fear of abandonment by the husband is described as a precipitating factor.
Several of the studies also refer to the mothers’ ongoing problems with their own parents. Several studies suggest a pattern, often seen in simple suicide\textsuperscript{144}, where a mother resents both her husband and her parents while, at the same time, she is dependent on them.

Some of the case descriptions paint a similar picture in which the mother is having problems with both the husband and her own parents. Since mothers with marked social anxiety often only relate and interact with their own family members and are otherwise socially isolated, it appears plausible that any experienced problems and conflicts in these relationships result in helplessness and despair. Issues could be marital discord or the deterioration of the marriage or the perception of impending death of a family member.

A clinician may also want to pay attention to the mother’s fears that exposure of her behaviors might bring shame to her parents or extended family, especially when they live in the same community.

Along with a thorough history of the mother’s relationship with her immediate family, particular attention must be given to how the mother dealt with transitions. The clinician may want to learn what stressors the mother encountered and how she coped with them. The clinician may be particularly interested in transitions and events that were experienced by the mother as abandonment from childhood on towards romantic and intimate relationships in adulthood. For instance, if the mother felt overly responsible for certain events which were experienced by her as

\textsuperscript{144} Dr. David Lester remarked during a conference on suicide prevention in Los Angeles on November 22, 2003 that the combination of resentment and dependence is often seen in suicidal persons.
abandonment, she might feel pathological guilt, and also deem herself incapable of dealing with current and future stressors. In being confronted with these stressors the risk of panic is elevated, possibly accompanied by an activation of the sense of a foreshortened future.

Symptoms suggesting the presence of a deconstructed state

In Chapter 7 I have discussed similarities among the concepts developed by various authors in regards to the end phase of the suicidal process: the deconstructed state (Baumeister, 1990), the notion of arrested flight (Gilbert & Allan, 1998), short-term predictors of suicide (Fawcett et al., 1993), the Transactional Vicious Cycle proposed by Linehan (1993) as well as the findings by Shea (1999) about a change occurring in suicidal persons two months prior to a serious attempt. Anxiety and behaviors intended to cope with the anxiety such as ‘tuning out’ one’s environment, moderate alcohol abuse, and resuming smoking after a long period of non-smoking were mentioned as phenomena associated with the end phase.

The clinician may want to be aware of the fact that seemingly everyday activities engaged in by the mother can become signs of the presence of a deconstructed state. An example of this can be an increase in the frequency of routine-like behaviors. Predominance of very specific and concrete behaviors that have a short-term focus are common in the deconstructed state and may function as a distraction from psychic anxiety.
Interruptions of the deconstructed state may exacerbate the underlying anxiety and lead to frantic escape efforts, such as trying to move to a new location or changing doctors. Therefore, ‘tuning out’ behaviors falsely suggesting a calm disposition could be alternated with the kind of frantic escape behaviors, which should be considered particularly alarming.

**Treatment and Hospitalization issues**

Prior hospitalization, sometimes associated with an attempt at simple suicide\(^ {145} \), has been mentioned as a risk factor for mfs (West, 1965). In addition, several case studies refer to previously hospitalized mothers who reject clinicians’ recommendations for voluntary commitment. There are also mothers without prior hospitalization who refuse voluntary commitment. This often is due to the stigma attached to psychiatric hospitalization. Mothers with a Typus Melancholicus personality might be particularly opposed to hospitalization. Therefore, clinicians who assess the risk of mfs might want to inquire whether the mother ever rejected suggestions for voluntary hospitalization.

Many (case) studies refer to the fact that most mfs mothers had received psychiatric treatment (Bourget & Gagne, 2002; D’Orban, 1979; Meszaros & Fisher-Danzinger, 2000). Several of these studies also mention that some of the mothers had received therapy for a long period, yet often had interrupted the therapy with premature terminations. This might be an example of the “flight into health” phenomenon leading people to terminate therapy when they are starting to feel

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\(^ {145} \) Obviously, prior hospitalization in connection with mfs ideation or attempts has to be considered a “red flag” and should raise serious concerns for future behaviors. In terms of a continuum of covert-overt, as described in chapter 6, knowledge by the clinicians of hospitalization for these reasons would place the case of such a mother closer towards the overt end of the spectrum.
better. These terminations could also reflect the ambivalence of a Typus Melancholicus mother who recognizes her need for therapy. Maybe she believes that therapy can help her meet the norms set for her by her environment. At the same time, the Typus Melancholicus mother might fear that engaging in therapy is an admission of weakness and will be held against her by her environment. Therefore, for the clinician a history of psychiatric treatment characterized by interrupted therapies and early terminations could be another indicator of the presence or severity of mfs ideation.

The role of therapy also was described by Paris (2002) who found that women diagnosed with Borderline Personality Disorder who make fatal suicide attempts often are in their early 30’s. Having received much therapy in their 20’s they no longer believe in therapy which may contribute to the hopelessness, known to be a very important risk factor for serious suicide attempts.

A related problem that is only indirectly addressed in the case studies is that these mothers may have several therapeutic contacts at the same time. Such a mother may be sending a different message to each of her mental health experts. She may even complain to one clinician that the other clinicians do not understand her and demand that the clinician who she is complaining to does not discuss her case with the other clinicians. The mother might fear, understandably, that close cooperation between the various clinicians would reveal the whole picture. She may fear that the complete picture might make it necessary for the clinicians to breach confidentiality by informing family members. Worse yet, the clinicians might be seen by the mother as having to hospitalize her.
Therefore, in order to reduce the danger of collusion with the dpsmyc it is important for clinicians to be aware of the possibility that they might be having these thoughts and engaging in these behaviors. Clinicians need to address possible fears around hospitalization. For instance, they may ask the mother for permission to consult with other (mental) health professionals and/or family members. Her reaction could be very informative.

Also, for the depressed and anxious mother, specific future appointments or events scheduled for a fixed date could be perceived as a deadline. For instance, an appointment with a psychiatrist who is thought to have been informed by other clinicians about mfs plans could be perceived by the dpsmyc as a great risk for being hospitalized regardless of whether she keeps the appointment.\(^{146}\)

In addition to the “divide and rule” approach reflected in having several (mental) health professionals, the mfs mother may select clinicians that she believes she can manipulate and who will go along with her approach of raising concerns which she subsequently takes away before they have risen to a pitch where the clinicians will ring the proverbial alarm bells.

In the same vein, the mother might use psychotropic medication because she feels so awful. At the same time, the mother might fear that exposure of her use of these medications could lead to disapproval by others. In fact, she may fear that it is a sign of weakness and an admission that she is mentally ill. This, in turn, she fears, could lead her family members to have a

\(^{146}\) The mother might fear that if she does not keep the appointment the psychiatrist will have her hospitalized anyway because he or she has been made aware of the mother’s dangerousness to self and others.
consultation with the mental health experts, where the subject of mfs ideation and maybe even specific mfs plans might come up. In other words, everyone would become aware of how serious the situation really is. Part of the mother might welcome the protection that might be the result of this, while another part might fear the associated stigma.

At the same time, improvement by the mother due to medication, the use of which is not known to the family, may raise the family's hopes and expectations in regards to the mother. This might put additional pressure on the mother who believes that she might be misleading her family members, and may not be able to keep up the improvement that she has shown. While clinicians may be aware of the mother's medication issues, they may overlook the possible issue of the family members' raised expectations.

Nock & Marzuk (1999) strongly encourage the clinician to contact the family of persons deemed at risk for making an attempt at h-s in order to arrive at a more accurate evaluation. Often the family is said to have information of which the seriousness has been minimized by them but which could be very informative to the clinician. In cases of mfs ideation, a clinician may want to ask the mother how she feels about the clinician contacting her family and her friends and their possible reactions in the event that the mother might have to be hospitalized.

Many of the treatment issues discussed so far can represent obstacles to clinicians who are trying to assess the presence and severity of mfs ideation. The most important aspect of the assessment of the potential for homicide-suicide consists of considering the very possibility (Nock & Marzuk, 1999). A clinician who does not take the possibility of h-s into account might
inadvertently convince the patient of how unthinkable and outlandish his or her ideation is. This, in turn, might further increase the patient’s tendency to see himself or herself as bad or insane, which may further exacerbate the severity of the patient’s pathology.

The threat of involuntary hospitalization might act as a trigger for acts of homicide-suicide in some cases (Nock & Marzuk, 1999). The potential for this represents a risk factor in its own right.

In addition, it might also be worthwhile to point out that dpsmyc might present so many issues, all of which seem very pressing that it might be easy to overlook issues pertaining to mfs ideation, unless the patient brings these up herself.

The following phenomena also can become obstacles to the clinician:

- The mother is eager for help, but hesitant to comply
- Unimaginability of mfs for clinicians
- Absence of symptoms associated with other forms of filicide misinterpreted as sign of health
- Wearing out clinicians
- Communication with clinician: raising concern and taking it away
- Appearing to be high-functioning causing clinicians to underrate severity of pathology
Demographic Factors

The potential importance of age, gender, and number of children as well as the age of the mother has been discussed in previous chapters. In general, because mfs is primarily suicide, all risk factors for simple suicide by women in the relevant age group, e.g. race, apply to mfs. The main exceptions consist of having children and being married, both of which normally are considered protective factors. A clinician easily might be misled by these protective factors when faced with a dpsmyc. Therefore, the potential for being misled by these protective factors can be considered a risk factor for suicide in its own right.

As to social class, there are indications that mfs is more associated with middle class (Felthous & Hempel, 1995) and fatal child abuse with lower social class (D’Orban, 1979). In addition, mothers of young children in outpatient, ongoing psychotherapy may be more likely to be middle class, unless the therapy is court ordered for reasons of child or substance abuse. An issue associated with social class is that of employment. There are indications, which were discussed in previous chapters that mothers who are in outpatient and ongoing psychotherapy who are employed may be at a lower risk for having serious mfs ideation, unless they are the sole breadwinner and are struggling with the combination of long hours at the job and too little income to provide their children with what the mother believes they need.


Where the mother is in the mfs process

One of the methods Shea (1999) suggested for probing the depths of ideation about simple suicide is referred to by him as a behavioral analysis. Shea would ask specific questions about potential triggers currently and in the past, expectations of the outcome of a suicide attempt, and the details of methods contemplated. Such specific questions will result in much more complete and useful information than global questions about a patient's intentions to hurt themselves.

Such questions, when asked in the right way and with empathy, would not just make it harder for a patient to avoid giving correct information, it would also make it easier than the patient might have expected it to be. In fact, a patient might feel better about him or herself and be less inclined to act on the ideation after having had an opportunity to discuss the motives and the details associated with a possible suicide attempt.

A similar approach might be valuable when dealing with dpsmyc. Issues which a clinician might want to address with such a patient include the following:

- (Standby) suicide notes written?
- Mfs attempts aborted
- Degree of preparation
  - Knowledge of various methods and their pro's and cons
  - Thoughts about the best time and the best location
  - Other specifics of plans
    - with which child to start?
    - “plan B” if method for filicide fails
  - Method for suicide, if different from filicide
- Plan B if method chosen for suicide fails

- Ideation about simple suicide
  - How long
  - How strong
    - at time of evaluation
    - “worst point”

- Prior attempts at simple suicide
  - While having children vs. Prior to having children

- Openness/Secrecy about past suicidal behavior as well as past and current mfs ideation and plans
  - With other mental health professionals, seen either simultaneously/currently or previously
    - Willingness to give evaluating clinician permission to consult other and previous clinicians as well as a release of information to all clinicians involved
  - With husband and immediate family
  - With friends
  - With acquaintances or strangers

**Stressors and Precipitating Factors**

The cases suggest that the following factors, all of which have been discussed already, have the most potential to increase mfs ideation and might trigger an attempt.

- Events reminding the mother of trauma in her own childhood, e.g. a suspicion or awareness of sexual molestation of her own children

- Perception of pending exposure, confrontation or of secrets being disclosed especially when linked to fixed dates such as a child’s start in elementary school or certain doctors’ appointments

- In general, events activating and/or strengthening a sense of a foreshortened future which might also be associated with superstitions about impending violence and war. This could include medical problems of self, one’s children or of one’s family
• Vulnerability to organic, medical and medication related symptoms, such as PMS that can exacerbate the mother’s distress

• Anything that involves problems associated with a transition for which there is no clear solution

• Incidents highlighting/exacerbating difficulties in interpersonal relationships, especially difficulties with both the husband and the parents. Considering that family is crucial for social anxiety, a fear of abandonment or disruptive problems can be catastrophic.

• Contagion due to stories about mfs attempts in the media

Informational issues: Collusion between patient and clinician?

The patient has many reasons for not disclosing information, as pointed out. Likewise, the clinician may have reasons for not looking for relevant information or for not hearing the mother when, in fact, she does suggests, implies or even explicitly mentions mfs ideation.

The combination of the mother’s reluctance to fully disclose and the clinician’s limitations to gather the necessary information may result in a treatment impasse, stagnation, or even treatment failure with the danger of leaving mfs ideations untouched and the mother losing hope and surrender to her ideation.

In summary, a clinician should be aware of specific concerns around lack of knowledge. He or she may lack the experience, training, or assessment skills for these types of situations. In addition, countertransference could limit the availability of accurate information. As to countertransference, the clinician may not want to deal with patient reactions of anger, fragility, or
the possibility of the patient leaving or refusing treatment. At the same time, the clinician may be unable or unwilling to consider the possibility of suicide, mfs, or mfs ideation.