Introduction

This dissertation was inspired by my efforts of processing a personal tragedy. Fourteen years ago, my wife killed our two daughters, age 3 and 4, as well as herself.

During the last three years of her life she had been receiving treatment from several clinicians, although there were several interruptions. The diagnosis that was provided by the psychotherapist who had treated my wife for about two years can best be summarized as a combination of depression and a serious character disorder. There never has been a suggestion from her clinicians or anyone else, prior to or after the filicide-suicide (mfs) that my wife was suffering from a thought disorder.

At several occasions between May 1990 and the fatal mfs attempt in August 1991, my wife had spoken about her mfs plans to her psychotherapist, the family doctor and probably other mental health workers as well as to some of her friends and to me. She obviously had been experiencing mfs ideation during this period. There are indications that her fears about being involuntarily hospitalized as a result of her mfs ideation may have been the reason that she would minimize the seriousness of earlier communications about mfs plans. These fears also may have influenced her choice of clinicians and may have contributed to her decision to carry out her long-held plan. Ideation and communication about mfs were closely intertwined with her therapy, probably much closer than the clinicians were aware of.
Initially I wanted the dissertation to be a single-case study focused on my late wife’s motives, her history, and her stressors. I had a wealth of information available thanks to numerous interviews with people who had known her, a “standby suicide” note written 55 days prior to the mfs and access to documents associated with official complaints that I had submitted against some of her clinicians. These documents included the complete police report, the family doctor’s files on my wife and the notes of a psychiatrist who saw her once and was scheduled to see her for a second time on August 29, 1991. In addition, there were replies from the various clinicians to my complaints and conclusions from the officials investigating my complaints. After completing the research on my wife’s case and after writing a first draft of my understanding of the events, I decided not to include my wife's case in the dissertation for several reasons, primarily the protection of the privacy of persons who had known my wife. In addition, my wife’s case had enhanced my understanding of mfs and mfs ideation. This enabled me to more effectively review and evaluate the literature as well as to analyze case descriptions included in the various studies.

Parallel to processing my wife’s case, I had reviewed the literature on homicide-suicide, filicide, suicide as well as on interpersonal violence. I found that filicides involving parental suicide attempts were usually attributed to one of the following three phenomena: schizophrenia (incl. postpartum psychosis), fatal child abuse, or suicide as a primary motive. I also found that studies that followed the last approach (the suicide motive) demonstrated that there was a great deal of commonality in the cases contained in these studies.
Almost all maternal filicide cases in which the mother succeeded in killing herself and her child(ren) showed careful planning, deliberate implementation, communication prior to the mfs, prior psychiatric treatment and in close to half of the cases prior attempts at simple suicide. In addition, almost all mothers had had long-term emotional problems and serious issues in their interpersonal relations. What was conspicuously lacking was a known presence of thought disorders prior to the filicide-suicide.

There were strong indications in the cases that ideation about mfs might have been present or ongoing for many months, maybe years. Yet, none of the studies dealing with mfs addressed the issue of mfs ideation. Even though it was acknowledged that the mfs attempts were primarily suicide rather than homicide, concepts of suicidology were never applied to the study of mfs. One of the important concepts in the study of simple suicide is that of ideation. For every person that makes a fatal attempt there are between seven and ten persons making a serious nonfatal attempt, and many more who make nonfatal attempts which are not serious. Finally, there are those who have suicidal ideation but may not make an attempt, yet they suffer and they are at risk. As ideation usually precedes attempts, it is obvious that many persons are experiencing ideation about simple suicide. It is, therefore, likely that for every known mfs attempt, fatal or not, there are many mothers who are suffering from mfs ideation. In light of the fact that most of the mothers who made fatal suicide attempts were receiving psychiatric treatment, often on an outpatient basis, I concluded that the number of mothers in outpatient psychotherapy who might be experiencing mfs ideation could be considerable.
In light of the possibility that the number of mothers of young children in outpatient psychotherapy indeed might be considerable, it is important for the clinician to be aware of the fact that even when mothers may not be driven to act on their ideation, the mere fact that they have the ideation puts them at risk when stress increases. Furthermore, they are likely to be suffering from having the mfs ideation, and, therefore, it would be clinically important to help them process the ideation and address the issues that are underlying the ideation.

I believe that the fact that the case of my late wife has much in common with the cases in the literature has enabled me to identify phenomena that could be signs of the presence and severity of mfs ideation. As a result, I believe that sharing my knowledge about these signs and risk factors with other clinicians within the framework of a dissertation in clinical psychology should be my contribution to the field. I hope that my tentative conclusions will lead to further research.