RISK FACTORS FOR MATERNAL FILICIDAL-SUICIDAL IDEATION

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by
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A few months ago, when she was doing well, she told me that a year earlier she had planned to kill herself and the children but decided not to when she ran into her psychotherapist in the mall. When I saw the ambulance this afternoon, I feared the worst. (From interview conducted by the police with a friend of a woman who had killed herself and her two daughters earlier that day)
Preface

It may be helpful for the reader to know that this dissertation has been motivated by the fact that the mother mentioned in the epigraph on the previous page was my wife, and the mother of my children.

The epigraph has been included to demonstrate that mothers who kill their children and themselves may be thinking about a maternal filicide-attempt for at least a year prior to an actual attempt.
Acknowledgements

In one way or another I have been working on this dissertation since August 1991, when my wife killed our two children and herself. Many people have made it possible for me to reach the point where I am about to finish this project. First I want to thank the people who have enabled me to survive as well as I have in the first year after the tragedy, especially my friends Corneli\'e van Wel, her husband Reinier Rijke, and their children David, Els and Justus who took me into their home for the first six months.

I also need to acknowledge all the people who have provided me with information for what in hindsight was a psychological autopsy study.

Having converted from a psychotherapy patient to a psychotherapist has become a critical part of the journey. Of the many people who have guided me on this path I want to express my deep gratitude to Joe Geraci, clinical co-director of the Hollywood Sunset Free Clinic, and Trudy Moss, formerly of California Graduate Institute, for their support and for being wonderful role models.

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Introduction

The study of maternal filicide-suicide (mfs) has received increasing attention during the last 15 years. Yet, mfs is still often associated with fatal child abuse or postpartum psychosis, while there is strong evidence that it is very different from these two phenomena. In addition, while there is growing recognition that mfs is primarily suicide rather than homicide, no effort has been made to
apply suicidology to the study of mfs and mfs ideation. The possibility that for every mfs attempt there might be many more mothers experiencing mfs ideation has not been addressed. This possibility has implications for clinicians whose ability to recognize and evaluate mfs ideation is essential for prevention of mfs as well as for effective psychotherapy in general.

In this dissertation, studies on filicide and on homicide-suicide have been reviewed and evaluated. This includes a reanalysis of cases that contained data that were not reflected in the findings of the studies of which they were a part.

Findings

The majority of mothers who made a fatal suicide attempt after having killed one or more of their children were high functioning and known as ‘perfect’ mothers, without known symptoms of a thought disorder and not involved in child or substance abuse. They prepared the mfs attempt thoroughly and implemented it deliberately, i.e. not in an impulsive manner. They tended to target and kill all of their children, and use methods that are perceived as painless such as gas or drowning. For the suicide attempt they tend to use the same method as for the filicide. When that is not feasible, they often use methods that are violent such as guns or hanging.

In terms of contents of mfs ideation, these often include the mother’s belief that she needs to rescue her child(ren) from having the same kind of miserable life that she has had.

The prevalence of mothers making fatal or serious nonfatal suicide attempts after having killed one or more of their children shows a remarkable similarity between countries and over time,
i.e. one mother per year for every three and a half to six million of the general population. Rates that exceed this narrow range primarily occur when the social culture is relatively tolerant of mfs, as in Japan, or when methods are available such as domestic coal gas that are perceived as painless, and allow for thorough preparation and simultaneous death of the mother and her children.

As to mothers who make a nonfatal suicide attempt after filicide, some have a profile that is very similar to that of mothers whose suicide attempt is fatal. Yet, many of them have characteristics that are rather different, e.g. they may be known to be suffering from a thought disorder, including postpartum psychosis.

The mfs mothers whose suicide attempt was fatal often were experiencing rejection sensitivity and other symptoms of social anxiety as well as depression. Phenomena seen in the lives of mfs mothers often include a long history of emotional problems, childhood abuse, as well as ideation about and prior attempts at simple suicide.

Other predisposing factors include most risk factors seen in simple suicide by women, including cultural issues that can lead to alienation, such as immigration. Precipitating factors reportedly consist of abandonment issues and the occurrence of events that make the mother fearful of an impending disaster.

Suicidology, the study of simple suicide, can be applied to the study of mfs. A remarkable parallel can be observed in the female suicide rate and the mfs rate. In addition, the escape theory of suicide developed by Baumeister (1990) appears to be particularly relevant for mfs. Everything
that could be perceived by the mother as relevant for her children’s future is observed through the filter of fear that is characteristic of the escape theory. This can lead to seriously distorted cognitions about the children's ability to survive, let alone thrive as their life unfolds. Meanwhile, some risk factors identified by the escape theory as relevant for simple suicide may carry a different weight in mfs because the mother’s concerns about her children may change what she pays attention to in her own life and that of the children.

The main challenges for clinicians are to become aware of the possibility of the presence of mfs ideation, to assess its potential severity, and to take into account the impact of ideation on the course of therapy, even when the patient ultimately does not act on her ideation. This challenge is made more difficult because of the inaccurate image embedded in many studies suggesting that mfs is related to fatal child abuse, postpartum psychosis and other thought disorders as well as to anti-social personality disorder, where the mother kills her children mainly to spite their father.

An important aspect of mfs that is rarely mentioned, let alone discussed or studied is the likelihood that for each known mfs attempt there might be many more mothers experiencing mfs ideation without being detected and/or appropriately treated. The fact that most mfs mothers had received psychiatric treatment, often in the form of outpatient, ongoing psychotherapy illustrates the challenge for clinicians to adequately assess ideation and if necessary take preventive measurements to prevent harm.
One challenge for clinicians is that traditional warning signs for filicidal or suicidal behavior such as the presence of a thought disorder, child abuse or prior attempts at simple suicide often are absent among mfs mothers. This absence may cause a clinician to underestimate or even overlook the presence and severity of mfs ideation. Therefore, clinicians need to be alert for other signs than the traditional warning signs, and need to be trained in recognizing specific risk factors, symptoms, and behaviors.

Clinicians are also faced with countertransference challenges such as the fact that for emotional or cultural reasons it is difficult for them to imagine that a mother might be experiencing mfs ideation, let alone act on it, especially when she appears to be high functioning as so many mfs mothers. The fact that a mother with mfs ideation might not disclose (the full extent of) her ideation out of fear of being judged further complicates the process of evaluating mothers of young children for the presence and severity of mfs ideation.

Conclusions and Recommendations

A special protocol which clinicians can use for the evaluation of depressed, potentially suicidal mothers of young children has been included. Recommendations for research include conducting psychological autopsy studies of more mfs cases. Further research could also determine the extent and severity of mfs ideation among mothers of young children who are currently receiving outpatient, ongoing psychotherapy.
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.
CHAPTER ONE
NATURE OF THE STUDY

Introduction

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 & Petaejae, 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
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

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4 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 dpsmyc 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.\(^5\)

\(^5\) 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.

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. 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

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 mfs 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 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.

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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>
</tr>
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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 overts and coverts. The coverts and overts show 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.

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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”.

26
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>Term</th>
<th>Definition</th>
</tr>
</thead>
<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 known to be suffering from a thought disorder or other disorder necessitating hospitalization</td>
</tr>
<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>
</tr>
<tr>
<td>Mixed covert-overt profile</td>
<td>Mother with elements of both an overt and a covert profile</td>
</tr>
<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>
</tr>
<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>
</tr>
</tbody>
</table>

**Table 1.3 Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<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>
</tr>
<tr>
<td>h-s</td>
<td>Homicide-suicide</td>
</tr>
<tr>
<td>Mfs</td>
<td>Maternal filicide-suicide</td>
</tr>
<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>
</tr>
</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.
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.\(^{10}\)

\(^{10}\) 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
Preview 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→characteristic</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>

Note: 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.
### DEMOGRAPHIC

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Often married</th>
<th>More often divorced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education level+ social class</td>
<td>At least high school and lower middle class</td>
<td>Same as premeditated group, but with more exceptions in all directions</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>
<td>More often forced to work because of one-parent situation; Work sometimes helps to stabilize life, and sometimes it becomes part of the problem.</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>
<td>Number of children makes no difference for mother, as she is more likely to want to kill one child.</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>
<td>With post-partum symptoms child is under 1; children up to 12 or 15 years old included.</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>
<td>From early 20's to early 40'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>
<td>No clear pattern</td>
</tr>
</tbody>
</table>

### GENERAL

<p>| Apparent competence behavior | Ability to convince self and others that things have improved and will continue to improve thanks to new found goal/project. | Ability may be present, but often less credible because of symptoms of thought disorders. |
| Life in general             | Appears to be relatively orderly | chaotic |
| Types of stressors          | Interpersonal, social anxiety, shame, hopelessness | Interpersonal, financial, hopelessness |
| Abuse of drugs or alcohol   | Very little or none; needs to be re-examined for last couple of months prior to act | Quite prevalent |
| Abuse of children           | Appears to be quite rare | When there is abuse, it rarely is of the 'chronic battering type'. The mother occasionally might lose her self-control due to pressure or thought disorder and possibly hurt the child. |</p>
<table>
<thead>
<tr>
<th><strong>MENTAL HEALTH</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specifics of doomsday fantasies</td>
<td>Appear to be somewhat like superstitions.</td>
<td>Are more specific, sometimes in the form of hallucinations</td>
</tr>
<tr>
<td>Extended social anxiety</td>
<td>Mother fears rejection for herself and her children and blames herself for her inability to protect her children.</td>
<td>May be present, but less consciously so</td>
</tr>
<tr>
<td>Psychotic symptoms, delusion, schizophrenia</td>
<td>Not known to have had these symptoms. Mother may have had a psychotic experience and not discussed it out of fear for making a bad impression. If there was a psychotic experience, the fear of re-occurrence combined with non-disclosure could be a problem.</td>
<td>Their lives are more chaotic because of psychotic symptoms. Psychotic symptoms may have been present at and contributing to act of mfs.</td>
</tr>
<tr>
<td>Previous suicide attempt</td>
<td>30% made previous sc attempt, 70% did not.</td>
<td>Quite often, maybe 40 to 60%</td>
</tr>
<tr>
<td>Previous filicide attempt</td>
<td>Not mentioned in cases or in studies</td>
<td>A few cases were mentioned</td>
</tr>
<tr>
<td>Premorbid functioning</td>
<td>Often quite high level of functioning before having children</td>
<td>More often a chaotic existence, although there are cases, where it was high</td>
</tr>
<tr>
<td><strong>TREATMENT-RELATED</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization issues</td>
<td>No prior hospitalization for psychiatric disorders. Mother may have been advised to hospitalize herself, and the advice was rejected. Stigmatization played major role in such rejections.</td>
<td>Often prior hospitalization. In addition, quite a few cases, where a mother refused to be hospitalized again, and where the threat of that happening anyway may have pushed her over the edge. Stigmatization played much less of a role here.</td>
</tr>
<tr>
<td>Help-seeking behavior</td>
<td>Tends to look for help from professionals</td>
<td>May not get treatment, unless committed to a hospital or court-mandated to do outpatient psychotherapy.</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.
CHAPTER THREE

REVIEW OF THE LITERATURE:
TWO APPROACHES TO THE STUDY OF
MATERNAL FILICIDE-SUICIDE

Introductory Remarks

Objective of the Literature Review Chapters

The purpose of the four chapters on literature review (Chapters 3, 4, 5, and 6) is to identify, analyze and evaluate information in the literature about the prevalence and content of the various maternal filicide-suicide (mfs) behaviors from ideation to fatal attempts, as well as characteristics of mothers engaging in these behaviors, their environment and the children, who are their victims. The intention is to use this information to identify risk factors and warning signs of mfs behavior that are helpful to a clinician assessing for mfs ideation and behaviors.
Two vantage points for the study of maternal filicide-suicide: 
Homicide-suicide and filicide

Maternal filicide-suicide (mfs) is usually addressed in studies with a focus on broader topics than mfs. The two topics that most prominently address mfs are homicide-suicide (h-s) and filicide. In Chapter 3, studies will be reviewed that address mfs from the perspective of h-s, and in Chapter 4 the review will be done from the perspective of filicide.

Studies from the perspective of h-s only deal with persons who have made fatal or nonfatal attempts at homicide/filicide and suicide. Only two studies (Byard, Knight, James, & Gilbert, 1999; Shaughnessy, Bradley, & Brown, 2001) have been located that deal specifically with filicide-suicide, which includes maternal and paternal behaviors. While cases of mfs tend to be included in most studies about overall h-s, they are often overshadowed by cases of spousal h-s, which tend to be 10 to 15 times as numerous as mfs cases.

In Chapter 4, mfs from the vantage point of filicide, attention will be paid to studies on subjects that are broader than filicide, such as child homicide or on subjects that are related to filicide, such as fatal child abuse. Studies on child homicide are often so-called population studies, which generally do not include the details of individual cases, such as the motivation of the offenders and the stressors that affected them. Instead, they tend to provide demographic and epidemiological information, such as the age of the offenders and the victims, time of day, or methods used. Often, they compare various types of child homicide, such as neonaticide (killing newborns during the first 24 hours of life), infanticide (killing of children under the age of 1), fatal
child abuse, filicide-suicide, or peer related murders. Child homicide studies can allow for interesting comparisons between countries regarding the prevalence of various types of filicide.

Studies on filicide usually focus more on individual filicidal behaviors and their etiology. Several recent studies (Alder & Polk, 2001; Alder & Baker, 1997; Meyer & Oberman, 2001) describe and analyze individual cases of filicide-suicide, from which they derive valuable overviews of socio-demographic and clinical features. These features are the building blocks of the classification system for assessment of mfs ideation that I am developing.

Organization of the Review Chapters

In terms of the organization of the review chapters, Chapters 4 and 5 contain the traditional review of the literature, where information from various studies is compared and contrasted. In addition to the review function, these chapters are dedicated to identifying and compiling information about mfs from many different sources. Some of the information in the various studies may allow me to suggest some tentative conclusions that were not part of that study's original findings.\(^\text{13}\)

In Chapter 6, the information from Chapters 4 and 5 will be summarized. Comparison and contrasting of findings also takes places in chapter 6, as well as in chapters 7 and 8. As mentioned

\(^{13}\) For instance, the possibility that a large family size might be a form of protection against mfs was never mentioned in any of the studies. However, comparing information about the average family size of filicidal mothers with filicidal and filicidal-suicidal behavior suggested the possibility of an interrelation between the number of children a mother has and the danger of a mother making an attempt at mfs.
earlier, comparing and contrasting of findings in Chapters 7 and 8 is done from the vantage point of suicidology. The following aspects will be addressed in Chapters 6, 7, and 8.

a. Quality of the information reviewed

b. Definition and nature of h-s and mfs, which includes a discussion on extended suicide and altruism, intent and typologies of h-s. It also includes a discussion of the phenomenology of h-s, and especially mfs, i.e. the contents of mfs behaviors and ideation, as well as the concept of a process preceding mfs acts, during which interactions between the mfs mother and her environment may trigger certain mfs behaviors and ideation.

c. Prevalence and epidemiology of the various behaviors, including demographic and other characteristics of the mothers, their victims, and their environment. The question of whether there is a ‘tip of the iceberg’ effect here will be addressed: To what extent does the prevalence of known mfs attempts reflect the presence of mfs ideation among mothers?

d. Etiology, incl. psychiatric aspects, and their interaction with personality features and stressors.

e. Assessment and interventions, where special attention will be paid to the communication between a clinician and an mfs mother and the extent to which she is able to disclose her mfs ideation, as well as her mfs behaviors.

f. Risk factors associated with the aspects of h-s and mfs that are enumerated under a-e in this list will be summarized.

g. Discussion of relevant aspects that may not have been discussed in the various studies. For instance, studies about suicide in general hardly ever refer to h-s or filicide-suicide.

The location of comments and evaluation

Comments associated with a reexamination or reanalysis of information in a particular study will be made immediately after the summary of the contents of that study. Comments about the relevance of the study to the research objectives sometimes also directly follow the summary of the study. In addition, they can sometimes be found at the end of a section, and, of course, in Chapters 6, 7, and 8.
Definitional and measurement issues

Calculation of rates

A number of rates are used in the literature to indicate the prevalence of filicide, suicide, homicide-suicide, and filicide-suicide. For filicide, the rate usually is the number of children killed per 100,000 children. For suicide, a similar method is used. However, some issues remain, especially for h-s and filicide-suicide.

Number of offenders and victims. There is a lack of clarity whether a case or incident of filicide or h-s refers to the number of offenders or to the number of victims. For instance, ‘five cases of filicide’ could mean any of the following:

- Five families, each with one or two parents and one or more children: In each of these families, one child is killed by a parent. (Five victims and five offenders)
- Five children being killed by one parent (five victims, one offender)
- Five different parents killing or trying to kill one or more of their children (five offenders and possibly more than five victims)

The term “victim”. There is a lack of clarity about the term victim: Victim sometimes refers to all children who are the object of a filicide attempt regardless of whether the attempt is fatal or nonfatal and sometimes only to children who are killed.

Ages of children included in studies. Age limits used in child homicide and h-s studies vary between 4 and 21. Unfortunately most studies quoting other studies do not report what age limit was used in the study that is being quoted.
The basis of comparison. There is a lack of clarity about the basis of comparison. For instance, mothers making attempts at filicide-suicide predominantly are in the 28-35 year age-bracket. An increase in the number of mothers in this particular age bracket, e.g. due to a baby boom 30 years earlier or to an increased percentage of women becoming mothers, probably will lead to an increase in the number of mfs mothers. However, most publications reporting such an increase will not take into account the increased number of mothers of young children in this particular age bracket.

Lack of disaggregation. There is a lack of disaggregation. For instance, filicide-suicide among African Americans, especially women, is much lower than among Caucasians in the USA, while ‘simple’ filicide is considerably higher among blacks (Goetting, 1988, 1990). Therefore, population studies about filicide and filicide-suicide in large metropolitan areas with a large black population will show rates for both filicide and filicide-suicide that are different from rates in studies that involve an entire state, such as California (Chew, 1999). Without specific information about some of these demographic factors, it is often difficult to understand differences in findings between studies.

Time lag between homicide and suicide. In the definition of what constitutes h-s, studies vary somewhat with respect to the time lag between homicide and suicide. However, as the great majority of suicides take place within hours of the homicide, this issue is unlikely to cause significant distortions in comparisons of the studies' findings.

According to some authors, the higher filicide rate among blacks is primarily related to poverty and not to race.
An alternative method of calculating rates

I have found that the number of children killed in conjunction with a fatal or nonfatal suicide attempt by one or both of the parents per 1 million of the general population per year is remarkably similar between studies as well as over time. This number fluctuates between 0.4 and 1.1, while the majority of studies are in a narrow range that runs from 0.5 to 0.8. For instance, the rate in California during the decade of 1981-1990 was 0.95, and was based on the following data (Chew, 1999): 279 child victims where homicide-suicide was reported to have been a precipitating factor, 10 years, and a general population of, on average, 29 million. This method does not allow for variations in the size of the age cohorts that might be most associated with filicide-suicide, yet the similarity in results between locations and the stability over time are truly remarkable.

An aspect of this calculation method that has not been used before consists of the use of the number of child victims as a measure. Usually the emphasis is on the number of mothers or fathers who are involved in filicidal-suicidal behavior. Another relatively novel aspect is that both victims of fatal suicide and nonfatal suicide attempts are taken into account. Finally, this measure combines the victims of paternal and maternal filicide-suicide attempts, although I may have made a virtue out of necessity here because many studies do not publish separate data for paternal and maternal filicidal-suicidal behavior.

Chew (1999) does not report how many offenders were involved in the homicide-suicide of these 279 children, although he reports that there were many cases of multiple killings, which usually is associated with filicide-suicide. Neither does Chew report how many of the offenders were parents. However, it is commonly known that the offenders in cases of homicide-suicide usually are parents.
CHAPTER FOUR

MATERNAL FILICIDE-SUICIDE FROM THE PERSPECTIVE OF HOMICIDE-SUICIDE

Definitions and categories used in homicide-suicide

H-s studies deal with acts where there was a fatal or nonfatal homicide attempt, and a fatal or nonfatal suicide attempt. In most cases, the intention to commit suicide was present before the homicide attempt was made. As a result, h-s studies have a different focus than studies in which cases of h-s are addressed from another perspective, such as filicide.

Categories most often used in homicide-suicide include spousal/consortial, filicide-suicide and extrafamilial (Hanzlick & Koponen, 1994; Marzuk, Tardiff, & Hirsch, 1992; Nock & Marzuk, 1999) Spousal is sometimes subdivided in morbid or murderous jealousy and due to declining health (Nock & Marzuk) or in accusatory and despondent (Daly & Wilson, 1988). People who kill their children and their spouse are usually referred to as committing familicide. Women are hardly ever involved in familicide as the perpetrator. One of the specifiers refers to altruism. More information on classification systems will be provided later in this chapter (see also Tables 4.1 and 4.2)
Organization and overview of Chapter 4

Two types of studies will be reviewed, population studies and explanatory studies. Population studies on h-s report on all h-s cases in a specific area during a specific period, where both the homicide and the suicide attempt were fatal. These studies tend to be more descriptive than explanatory. The population studies reviewed describe h-s in England and Wales, the USA, Australia as well as other countries.

Explanatory studies include a wide array of studies, from hospital studies to theoretical contributions, and generally have as their main objective to explore patterns and suggest explanations. The explanatory studies include the following:

- Studies about theories about the prevalence of h-s (Coid, 1983; Marzuk, Tardiff, & Hirsch, 1992; Milroy, 1995a; Nock & Marzuk, 1999)
- Psychological autopsy studies of selected samples of cases where both the filicide attempt and the suicide attempt were fatal (Goldney, 1977; Graser, 1992)
- German and Austrian hospital studies about mothers who made a nonfatal suicide attempt after having killed one or more of their children (Marneros, 1997; Meszaros & Fischer-Danzinger, 2000; Okumura & Kraus, 1996)
- Studies about the Japanese view of filicide-suicide (oyako shinju), which is of special interest because of the very high prevalence of filicide-suicide, and especially mfs in Japan (Bryant, 1999; Iga, 1996; Sakuta, 1985)
- Other studies about typologies, theories and various aspects of h-s. This includes a study describing a proposal for the typology of various kinds of dyadic death (Berman, 1996) as well as a contribution of the discipline of evolutionary psychology to the study of h-s (Daly & Wilson, 1988)
• Studies that focus less on socio-demographic features and psychopathology, and more on the interaction between individuals and their environment, especially during the weeks or months preceding acts of h-s (Palermo, 1994; Starzomski & Nussbaum, 2000)

Population Studies

Population studies pertaining to England and Wales

West (1965)

West (1965) reported on 31 cases of mfs (out of a sample of 78 h-s cases, 34 of which were perpetrated by women, of who 31 were involved in mfs) between 1954 and 1962 in the Greater London area. Almost half of them had killed or attempted to kill more than one child and 90% had used domestic gas for the filicide, as well as to a somewhat lesser degree, for the suicide. West suggested that the easy availability of the gas and the perceived painlessness of its use accounted for this. West did not provide much information on the age of offenders and their victims, or on the number of offspring who may have survived an attack.

In terms of diagnosis, 9 of the 34 women involved in homicide-suicide were found to have been not abnormal, 21 were severely depressed, psychotically or neurotically, 2 schizophrenic, and 2 represented marked instability. West believes that 2/3 of the women would have been found not guilty by reasons of insanity, if they had survived the suicide attempt. An analysis of West's study provides additional information suggesting the following:

• Most of the nine "not abnormal" mothers had shown depressive features, but not enough to meet criteria for a psychiatric diagnosis.
• The description of the two cases of “marked instability” suggested that these mothers might have suffered from a personality disorder. However, the description did not contain symptoms of psychosis.

• For 15 of the 21 cases of severe depression, psychotic or neurotic, a case description was provided. Close reading of these descriptions suggests that in 7 to 9 cases the mother may have had psychotic symptoms prior to the mfs, which sometimes were associated with earlier suicide and/or filicide attempts. Therefore, it is quite possible that there are at least 7 or 8 mothers without prior psychotic features among the 21 severely depressed mothers.

• The information that was just provided suggests that at least half of the women in West’s sample did not show psychotic symptoms prior to their final act.

West remarked that the danger for homicide-suicide was greatest when the women were most suicidal, and that women in the homicide-suicide group were higher functioning than women in control groups consisting of suicide victims and homicide offenders.

For the purpose of describing characteristics and formulating potential risk factors, it is also necessary to point out that West reported that endogenous depressives tended to commit h-s early in the morning, and that the rate in the fall was half of that in the summer.

*Milroy (1995b)*

Milroy (1995b) examined homicide-suicide cases that occurred during a 17-year period (1975-1992) in the counties of Humberside and Yorkshire in England and Wales. This is a mixed rural and urban area with a population of 5 million. Milroy found 49 cases perpetrated by a male. He also found three cases perpetrated by women. These mothers were 30, 39 and 40 years old and each had killed her only daughter, aged respectively 3, 5, and 10 years.
Milroy compares these three mfs cases with the 60 cases\textsuperscript{16}, reported on by West (1965), which occurred in the Greater London area between 1946 and 1962. Milroy attributes the difference in prevalence (3 vs. 60) to a number of factors. These factors include the larger size of the general population studied by West (12 million, while 5 million for Milroy's study), differences between urban and rural patterns, as well as the general decrease of the female suicide rate. The female suicide rate fell from 9.0 per 100,000 in 1961 to 3.6 in 1991 in all of England and Wales, while the male suicide rate only decreased from 13.3 to 12.2 during the same period.

Gibson

Gibson's studies (Gibson & Klein, 1961; Gibson, 1975) consist of statistics for the incidence of homicide, suicide, and homicide-suicide in England and Wales. He reported 70 mfs cases for all of England and Wales for the 6-year period from 1957 through 1962, and only 25 for the five-year period year from 1967 through 1971. This means that the average number of mfs cases per year dropped from 12 during the first period to 5 during the second period.

Barraclough & Harris (2002)

Barraclough & Harris (2002) reported 18 cases of maternal filicide-suicide (mfs) in England and Wales during a five-year period from 1988 through 1992, while the total number of female-perpetrated h-s cases was 19. The 19 cases accounted for 0.49\% of all cases of female suicide.

\textsuperscript{16} West had added the 70 h-s cases from the same area that had occurred between 1946 and 1954 to the main sample of 78 h-s cases that occurred between 1954 and 1961. Generally, there are no descriptions of cases of the earlier period.
The 18 mfs mothers killed 27 children under the age of 15. The mothers' ages ranged from 19 to 47 with a mean of 31. The following additional information was provided:

- The total number of incidents for fathers plus mothers was 40, of which 25 incidents were with 1 child, 13 with two children, and 2 with 3 children.

- Of the 57 children killed by either parent, 6 were younger than one, 28 from 1-4 years old, 14 from 5-9 years old, 5 from 10-14 years old, while four were over 15. The average age of mothers' victims was four, and of fathers' 3.5 (not counting the four children, who were older than 15, all of whom were killed by their father).

- Of the 147 persons suspected of h-s (including spousal h-s), 68% belonged to the three lowest social classes (III, IV or V), while 51% of the victims and 42% of the general population did. Male offenders, who numbered 128 vs. 19 female, were referred to as men from the lower social classes. No specific remarks were made about the social class of women.

- Of the suspects (not broken down by gender), 15% were born outside of England and Wales. The percentage of the general population born outside England and Wales is reportedly considerably lower than 15.

- Information about methods used is not broken down by gender.

- Filicide-suicide (by either parent) as a percentage of all homicides of children amounted to 2.9% for children under the age of one, 20% for children between the ages of one and five, and to 19% for children between the ages of 1 and 15.

- The findings reportedly are similar to those of smaller samples in various countries.

- In addition, homicide-suicide attempts where the suicide attempt was not fatal are said to represent the same clinical picture as h-s attempts where the suicide attempt was fatal. The authors do not elaborate on this, and do not cite references in support.

- Finally, the authors announce that a follow-up study using the same data will address additional issues, such as stressors and mental illness.

Comments on the epidemiological studies in England and Wales

It appears that the rates for male-perpetrated homicide-suicide have largely remained the same, while those for females first dropped by 60% during the mid-1960's (from 12 cases per year
to 5), and then continued to drop: from 5 in the early 1970’s to 3.6 during the five-year period from 1988 through 1992. The decrease in the mfs rate parallels that of a drop in the female rate for simple suicide, although the drop in the mfs rate appears to be more pronounced.

The drop in the rate for simple suicide by women has been widely attributed to the detoxification of domestic coal gas (Kreitman, 1976; Brown, 1979) as well as the removal from the market of certain prescription drugs often used for suicide attempts by women (Brown, 1979). It was also found that the number of non-fatal attempts at simple suicide by women had increased, but not enough to account for the drop in the numbers for fatal suicide attempts (Brown, 1979). It was also suggested by Brown (1979) that the women appeared to have overestimated the lethality of the coal gas, the detoxification of which only occurred gradually, while other methods the women may have used to substitute for coal gas, may have proved more difficult to implement than anticipated.

Another point raised by Brown (1979) was that when coal gas was first introduced in England and Wales, it was used as a method of suicide by a category of persons, especially women, who were not known to be suicidal. In other words, gas was not used instead of another less convenient method, and had the gas not become available, these persons probably would not have made a suicide attempt. Brown (1979), therefore, wonders whether the drop in female suicide rates between 1969 and 1979, as well as the apparent drop in the over-all number of serious suicide attempts (both fatal and nonfatal) by women might be associated with the fact that these women are less prone to use other methods as a substitute for gas. Apparently, potential mfs
mothers may share certain characteristics with respect to suicidality with women who have given up on the idea of simple suicide after they had become aware of the detoxification of coal gas.

The possibility that the detoxification of coal gas may have been associated with the drop in mfs rates has been suggested (Allen, 1983), but the kind of research that was done regarding the drop of the simple suicide rates was not done for mfs. There are some indications in a study by d’Orban (1979) that there may have been an increase in nonfatal mfs attempts for the same reasons that there was an increase in nonfatal attempts at regular suicide by women.

The rather sudden, yet persistent, drop in mfs rates that appears to be associated with the detoxification of coal gas highlights the importance of the availability and the nature of means for mfs behavior. Therefore, it would be critical to know how various types of potential mfs mothers would be affected by a change in the availability of certain means used for mfs. For instance, it could be helpful to know that, according to West (1965), as well as other authors (Graser, 1992), most mfs mothers wanted to use methods for filicide that were perceived by them as painless, so that a reduced availability of means used for painless methods might lead to a decrease of the incidence of mfs. Such a decrease might be mediated through other factors related to means such as reversibility and ‘handling’. These factors, which reportedly play a role in simple suicide (Lester & Clarke, 1989), easily could play a major role in mfs as well. For instance, reversibility would allow a mother to start the process of mfs believing that she could still reverse it simply by opening a window.

The image of the mental state of mfs mothers in many studies (Marneros, 1997; Tuteur & Glotzer, 1959) is dominated by impulsivity and delusions, especially at the time of the mfs act.
(Tuteur & Glotzer) As a result, the image of these mothers is that they are unlikely to pay attention to the availability of methods or the ease with which they could be used. This image appears to loose much of its credibility in the face of the data about the decrease of mfs rates after the detoxification of coal gas.

Population Homicide-Suicide Studies in the USA

Homicide-Suicide studies conducted in various locations in the USA, which included all cases of homicide-suicide where both the attempt at homicide and the attempt at suicide were fatal, seem to suggest (Nock & Marzuk, 1999) that mfs is less prevalent in the USA than it is in most European countries. These studies also report that there is no national registration system of homicide-suicide in the USA at the national level, and that while several states have statewide registration systems, other states do not. The following population studies into h-s have been conducted in the USA during the last 30 years.

Population studies conducted in the USA

Selkin (1976) examined two selected samples from police records in Denver and Los Angeles. The criteria for selection were not mentioned. There were several cases of filicide-suicide, but none perpetrated by the mother. Selkin introduced the notion of rescue fantasies held by perpetrators of homicide-suicide. This refers to the belief that survivors, for instance the children of a couple, of which the husband is planning to kill the wife and himself, will be better off after the h-s because they no longer have to deal with the parents.
Palmer & Humphrey (1980) found that there were six h-s cases involving victims under the age of 20 among the 66 cases of intrafamilial h-s in North Carolina between 1972 and 1977. In terms of relationship of victim to offender, the authors reported that four sons were killed, and one daughter. It is likely that the four sons and the one daughter are among the victims of cases involving victims under the age of 20. However, there was no specific information on the race, gender, the exact age, or the methods used for the homicide of the six persons under the age of 20.

In addition, Palmer & Humphrey had adopted the method of reporting an offender-victim relationship of one offender and one victim for cases of h-s, even when there were multiple offenders and/or multiple victims. In these situations, they would only report the relationship of the first victim and of the first offender, if known. As a result, the six cases involving victims under the age of 20 may have resulted in more than six victims under the age of 20.

Of all the h-s perpetrators, 94% were male. Palmer & Humphrey (1980) concluded that the act of h-s, as it was observed in their study, was primarily suicide. “It appears that homicide offenders who killed themselves were likely, except for being married, to have characteristics similar to suicide-only individuals and dissimilar to homicide-only offenders.” (p. 117)

Hanzlick & Koponen (1994) found no mfs among the 12 cases of h-s that had occurred between 1988 and 1991 in Fulton County, Georgia. Two males had killed a child. Hanzlick & Koponen proposed an expansion (Table 4.2) to the classification system that earlier (Table 4.1) had been proposed by Marzuk et al. (1992) and later by Nock & Marzuk (1999). The proposed expansion included more aspects of the act, the background of the perpetrator and the environment.
Table 4.1
Clinical Classification of Murder-Suicide proposed by Nock & Marzuk (1999), p.193

<table>
<thead>
<tr>
<th>Type of Relationship</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Spousal or Consortial&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Perpetrator</td>
<td></td>
</tr>
<tr>
<td>1. Spouse</td>
<td></td>
</tr>
<tr>
<td>2. Consort</td>
<td></td>
</tr>
<tr>
<td>Type of Homicide</td>
<td></td>
</tr>
<tr>
<td>i. Uxonicidal (spouse-killing)</td>
<td></td>
</tr>
<tr>
<td>ii. Consortial (murder of lover)</td>
<td></td>
</tr>
<tr>
<td>II. Familial&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Perpetrator</td>
<td></td>
</tr>
<tr>
<td>1. Mother</td>
<td></td>
</tr>
<tr>
<td>2. Father</td>
<td></td>
</tr>
<tr>
<td>3. Child (under 16 years)</td>
<td></td>
</tr>
<tr>
<td>4. Other adult family member (over 16 years)</td>
<td></td>
</tr>
<tr>
<td>Type of Homicide</td>
<td></td>
</tr>
<tr>
<td>i. Neonaticide (child &lt; 24 hours)</td>
<td></td>
</tr>
<tr>
<td>ii. Infanticide (child &gt; 1 day, &lt; 1 year)</td>
<td></td>
</tr>
<tr>
<td>iii. Pedicide (child 1 through 16 years)</td>
<td></td>
</tr>
<tr>
<td>iv. Adult family member (&gt; 16 years)</td>
<td></td>
</tr>
<tr>
<td>III. Extrafamilial&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Class</td>
<td></td>
</tr>
<tr>
<td>A. Amorous jealousy</td>
<td></td>
</tr>
<tr>
<td>B. &quot;Mercy killing&quot; (because of declining health of victim or offender)</td>
<td></td>
</tr>
<tr>
<td>C. &quot;Altruistic or extended suicides&quot; (includes salvation fantasies of rescue and escape from problems)</td>
<td></td>
</tr>
<tr>
<td>D. Family financial or social stressors</td>
<td></td>
</tr>
<tr>
<td>E. Retaliation</td>
<td></td>
</tr>
<tr>
<td>F. Other</td>
<td></td>
</tr>
<tr>
<td>G. Unspecified</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.2.
Classification System for Murder-Suicides, With Example, proposed by Hanzlick & Koponen (1994), p.172

<table>
<thead>
<tr>
<th>Relationship of victim to perpetrator</th>
<th>Anuit</th>
<th>Child</th>
<th>Infant</th>
<th>Neonate</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Spouse by marriage</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B) Common-law spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C) Unmarried partner in relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D) Extramarital consort (lover)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E) Heir or perceived rival lover</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F) Parent</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>G) Offspring</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H) Sibling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I) Grandparent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J) Grandchild</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K) Next of kin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L) Aunt/nephew</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M) Cousin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N) Family member other than those listed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O) Acquaintance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P) Stranger</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q) Same gender as perpetrator</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R) Opposite gender of perpetrator</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S) Same race as perpetrator</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T) Different race than perpetrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U) Lives in same household</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>V) Lives in different household</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W) No living witness(es)</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>X) Living witness(es)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y) Shot</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Z) Stabbed/cut</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A) Beaten</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B) Other (asphyxia, drugged, etc.)</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Cofactors:
- a) Impending divorce
- b) Previously divorced
- c) Real or perceived loss of nonmarital partner in a relationship (boyfriend, lover, etc.)
- d) Jealousy or retaliation for partner's real or perceived involvement with another person
- e) Retaliation against a real or perceived rival lover
- f) Mercy killing
- g) Altruism (to save from "evils of the world")
- h) Financial stressors
- i) Family stress or dysfunction
- j) Perpetrator intoxicated with alcohol
- k) Perpetrator intoxicated with drug(s) other than alcohol
- l) Perpetrator had known history of psychiatric illness
- m) Unspecified, other, or unknown factors

Special classifications:
- n) Family annihilator
- o) Dyadic
- p) Triadic
- q) Followed a mass murder or serial murders committed by the perpetrator

Example: An alcohol-intoxicated white man shoots his adult wife (white), strangles a 15-year-old white girl whom he suspects is involved in a lesbian love affair with his wife, and then shoots himself. The event takes place in his home and there are no witnesses. Note: For the perpetrator, race (W), the digit code for age and gender (1), and the Arabic cause of death code (W) are included after the victim information, and the incident would be coded as shown in this example: 142447202222122W4E4F4Q4T4H4Z(W1W)dep. All codes take the general format >> #Dead(Victim codes) (Victim codes) [Perpetrator codes]Cofactor codes.
Hannah, Turf, & Fierro (1998), who applied Hanzlick’s proposal for a classification system, compared the epidemiology of h-s in two counties in Central Virginia in the 1980’s and the 1990’s. They found two cases of mfs in the first period, and one in the second which was a rare case where a woman committed familicide killing her children and her husband. Hannah et al. noticed that in the entire h-s sample there was an increase in the prevalence in rural areas. They recommended to update Hanzlick’s proposed classification system on a regular basis and to add variables for phenomena which had not occurred earlier or which had not been noticed.

Campanelli & Gilson (2002) found that of the 16 h-s cases in New Hampshire between 1995 and 2000, there was only one mfs case.

Fishbain, Rao, & Aldrich (1985) studied all 10 cases of female-perpetrated h-s (out of 133 cases of h-s) that occurred in Miami between 1956 and 1982. Children were not involved in any of these 10 cases. Fishbain et al. reported that the average age of these 10 women was 48, 4 of them had left a suicide note, half lived in mobile homes, and 4 had been depressed. There were no signs of psychosis or impulsivity, and the h-s had been well planned.

Allen (1983) found two mfs cases in the city of Los Angeles between 1971 and 1980, while six filicide-suicide cases were perpetrated by a father. Allen compared her findings with those of West’s study (1965) of homicide-suicide in the Greater London area between 1954 and 1962. She reported that women accounted for a much larger share of h-s in England and Wales than in Los Angeles because of their involvement in mfs.
Berman (1979) reported that there were no cases of filicide-suicide\textsuperscript{17} when examining the police records for h-s in Baltimore, Philadelphia, and Washington DC during the two-year period of 1974 and 1975.\textsuperscript{18}

In a study of h-s in Kentucky (Currans et al., 1991) from 1985 to 1990, there were 2 cases of female perpetrated h-s out of 67 h-s cases. No additional information was provided on these two cases. It also was reported that there was no statewide registration system for h-s cases, and that a complicated procedure was needed to get the information required for the Morbidity and Mortality Weekly Report (MMWR) study.

Felthous et al. (2001) did not find any cases of mfs in a study of h-s in Galveston, Texas.

Aderibigbe (1997) did a database search of six major newspapers for h-s during a six-year period from 1990 through 1995 and found 16 cases of mfs, where both the filicide and the suicide were fatal. The authors recognized that their method would only capture a part of the h-s in the USA.

\textsuperscript{17} Berman spoke of infanticide-suicide. However, in the context of the study it is likely that he was referring to filicide-suicide. The term \textit{infanticide} had been used frequently for the filicide of children that were young rather than for the killing of children under the age of one, which is the current meaning.

\textsuperscript{18} Berman found 15 h-s cases for these two years and added 5 cases from adjacent years in order not to have the problem of small numbers.
Malphurs & Cohen (2002) searched various newspaper databases for cases of h-s during the three-year period of 1997 through 1999 and found 673 incidents, 674 perpetrators and 779 victims. They reported that newspaper surveillance will result in an underestimate, but is valuable because it may give insight in where and how the h-s events take place.

Based on an analysis of the professional literature on h-s, they believed that a more reliable estimate of h-s in the USA would be 405 homicide deaths and 830 suicide deaths due to homicide-suicide by persons younger than 55, and 200, respectively 215 among persons older than 55, resulting in approximately 1650 deaths due to homicide-suicide per year.

This estimate reportedly was based on information suggesting that annually 2.5% of homicides perpetrated by persons younger than 55, and 12% of those older than 55, as well as 3.8% of fatal suicide attempts by persons younger than 55, and 2.4% of those older than 55, would be committed in the context of h-s.

*Comment on Malphurs & Cohen (2002).* The authors had explained that their findings represented an underestimate of the number of h-s events. Yet, they do not make an effort to explain the discrepancy between the finding in their study of a ratio of 674 suicide deaths vs. 779 homicide deaths, and their estimate based on guidelines provided by others, which resulted in 605 suicide deaths vs. 1045 homicide deaths.

Stack (1997) conducted a population study into h-s in Chicago between 1965 and 1990, and found that in 7.6% of the 267 cases of h-s the victim was a child. Males were the perpetrators of h-s in 97% of the 267 h-s cases. There was no additional information on the gender of the parents involved in filicide-suicide. Stack regards h-s as an act where one commits homicide, after
which one is driven to suicide because of the guilt and loss one feels after the homicide. It is not clear to what extent Stack's opinion extends to filicide-suicide. Stack takes a different position from most authors who tend to regard h-s as one act with two parts, where a person has decided on the suicide before committing the homicide.

A review study about h-s in the USA by Nock & Marzuk (1999)

Nock & Marzuk (1999) contributed a chapter to the Harvard Medical School Guide for the Assessment and Treatment of Suicide about murder-suicide. This chapter contained much clinical information on the various forms of homicide-suicide, including filicide-suicide, as well as data on prevalence and the demographics of the offenders, especially in the USA, for which they had reviewed many studies.

Their review study has already been quoted several times in this dissertation. With respect to the prevalence of h-s and some of its components in the USA, Nock & Marzuk reported the following:

- Sixteen to 29% of filicides were followed by the mother's suicide, and 40 to 60% by the father's. For homicide of children under the age of one (often referred to as infanticide) the percentages were 2.5 for the mothers and 10.5 for the fathers.

- Homicide-suicide incidents accounted for 1.5% of suicides and 5% of homicides in the USA.

- Spousal h-s, murderous jealousy variety accounted for 50 to 75% of h-s in the USA.

- Mothers are most at risk of killing a child during the first six months of the child's life, although most of such killings are not followed by a suicide attempt. Depression and psychosis associated with the postpartum period often play a role here as well as fatal child abuse.
• In cases of spousal h-s, 19 to 26% of males commit suicide after killing their wives, while only 0 to 3% of females do so after killing their husband.

• Mothers killing their children as part of mfs are said to use “gassing, drowning, suffocating, beating and defenestration” (p.196).

• With respect to familicide, defined as a parent killing all children, spouse and self, the authors report that the perpetrators are men in over 90% of cases.

• Annually four million women have life-threatening injuries because of spousal/consortial violence, while there are only 1000 to 1500 victims of h-s per year. Nock & Marzuk concluded that h-s is a rare outcome of domestic violence.

Comments on the data in the review study by Nock & Marzuk (1999)

Nock & Marzuk remarked that 16 to 29% of mothers and 40 to 60% of fathers made a fatal suicide attempt after their fatal filicide attempt. These percentages are likely to be higher for parents involved in filicides of children older than 12 months because the percentage of filicides of children younger than 12 months that are followed by suicide are only 2.5 for mothers and 10.5 for fathers. At the same time, there is a possibility that the percentage of parents making a fatal suicide attempt after the filicide of a child under the age of one might be much higher than 2.5 for mothers and 10.5 for fathers when only those filicides are taken into account that are not associated with fatal child abuse or postpartum conditions. There has been no study investigating this possibility. However, postpartum conditions almost by definition are limited to the first year after delivery, and fatal child abuse drops off sharply after the child's first six months, and even more after the child's first twelve months.
In addition, rates of filicide-suicide are also likely to be higher for whites than for blacks because blacks have lower suicide rates than whites and because black mothers hardly ever appear to be involved in mfs.

Finally, Nock & Marzuk were only referring to incidents of filicide-suicide where both the filicide attempt and the suicide attempt were fatal. The percentage of filicides followed by suicide of the parent would rise, when fatal filicide attempts followed by nonfatal suicide attempts would be taken into account. This is likely to apply more to mfs than paternal filicide-suicide. Fathers appear to more often use methods that are likely to be lethal, e.g. guns, than mothers.

With respect to the number of deaths due to suicide and homicide as a result of h-s, Nock & Marzuk provide information that seems to be contradictory. First, they mentioned a study by Time magazine in 1989 that had found 11 firearm related homicide-suicide incidents in one week resulting in 22 deaths, presumably 11 due to suicide, and 11 due to homicide. Nock & Marzuk commented that in order to extrapolate these data to an annual figure one had to take into account that some h-s perpetrators have more than one victim.

Secondly, Nock & Marzuk reported that in 1995 there were 22,552 suicide and 31,284 homicide deaths, and that 1.5% of suicides and 5% of homicides occur in the context of h-s in the USA. This would result in 468 suicide deaths and 1127 homicide deaths in the context of h-s, i.e. a ratio of 2.4 homicide deaths for every suicide death. The difference between some h-s perpetrators having more than one victim and a ratio of 2.4 homicide deaths for every suicide death is not explicitly mentioned by Nock & Marzuk, let alone explained.
The figure of four million women incurring life-threatening injuries each year at the hands of their male partners is staggering. It suggests a degree of intra-familial violence so extensive that it is unavoidable for mfs and mfs ideation not to be part of this. The image of the tip of an iceberg appears, first for the relationship between domestic violence and spousal h-s and by extension for the relationship between mfs ideation and mfs, where spousal h-s and mfs would represent the proverbial tips of icebergs that consists of respectively domestic violence and mfs ideation. Yet, close examination of the data suggests that the link between the presence of all this violence on the one hand and h-s and especially mfs on the other hand is weak.

- Males involved in spousal h-s generally are motivated by suicidal wishes (Palermo, 1994), often they have already prepared suicide notes long in advance (LeComte & Fornes, 1998), and they have planned the h-s act, or more precisely, they appear to have a stand-by plan for the h-s, of which the suicide note is a witness. The event that triggers the h-s act often happens (somewhat) unexpectedly, which can lead to an impulsive execution of the earlier designed plan. (Lecomte & Fornes, 1998)

- Lindqvist even reported that the 10 males who had killed their spouse and then made a fatal suicide attempt generally were not associated with domestic violence. It is not clear whether most of these 10 males were of the so-called accusatory/jealous variety or of the despondent variety. Few had an age where they were likely to have been associated with h-s due to declining health.

- In addition, 90 % of the males committing spousal h-s use a gun, which suggests that there was lethal intent. I assume that it is unlikely that guns were used by males who caused 4 million women to have life-threatening injuries except in cases where they went off accidentally. Of course, guns also may have been used to threaten.

Although the figure of 4 million might not be accurate, and although the link between domestic violence and homicide, including h-s, might be weak, the figure of 4 million and figures of similar magnitude about child abuse in the USA do reveal that behaviors commonly regarded as
extreme, in fact, are not exceptional. It may be helpful to consider estimates of mfs ideation and mfs behaviors other than known attempts against this background of the widespread nature of extreme behaviors.

Other comments on the epidemiological studies in the USA

Nock & Marzuk (1999) suggests that there may be less filicide-suicide (paternal and maternal) in the USA than elsewhere, while there may be more consortial/spousal homicide-suicide in the USA. However, certain observations, some of which will be discussed in more detail in the next chapter indicate that the prevalence of filicide-suicide may not be lower in the USA. For instance, the manner of registration of h-s cases, which is absent at the national level and amounts to ‘no registration’ in many states, makes it vulnerable to inaccuracies and underreporting.

In addition, findings of studies on child homicide conducted over a time span of almost 5 decades and in various parts of the USA (Adelson, 1961; Adelson, 1991; Chew, 1999; Myers, 1967; Myers, 1970) suggest that the number of children killed in the context of h-s is about 0.4 to 0.9 child per million of the general population per year. These h-s cases usually refer to filicide-suicide where the father and/or the mother were the perpetrators. Most studies conducted in developed countries suggest similar rates.

Additional reasons to interpret rates of filicide-suicide in the USA with the utmost caution are the wide discrepancies in the results of population studies into child homicide that used the same data, or covered, more or less, the same population. An example of different reporting on suicide by perpetrators of child homicide while using the same data is provided for Dade County,
Florida by Crittenden & Craig (1990), who reported that 17 of the 149 perpetrators had committed suicide, while Copeland (1985) did not include the possibility of suicide in his publication.

An example of different reporting on suicide by studies that cover, more or less, the same population is provided by Chew (1999), and the study by Sorenson, Richardson, & Peterson (1993). Chew, who examined all child homicides in California between 1981 and 1990, found that the death of 279 out of 1495 victims of homicide of children under the age of 15 had occurred in the context of homicide-suicide. Meanwhile, Sorenson et al. examined race and ethnicity patterns of child homicide in Los Angeles City between 1980 through 1989, where they found 246 cases of child homicide. Yet, they never referred to suicide of the perpetrator as a factor in child homicide.

While Copeland and Sorenson et al. did not mention the possibility of suicide as a factor in the child homicides, Crittenden & Craig (1990) and Chew (1999) did. In fact, Crittenden and Chew reported numbers that suggested the possibility that the incidence of child homicide, which was accompanied by suicide of the perpetrating parent may have been within the same range as it was in many studies in and outside of the USA, i.e. between 0.4 and 0.9 per million of the general population.

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19 The data are so insufficient that it is necessary to provide several hedges and qualifiers, as I have done. For instance, Crittenden reported that 17 of the 149 perpetrators could not be prosecuted because they had committed suicide. Considering that most suicides after the murder of children are committed by parents, it is likely that these 17 perpetrators or at least most of them were parents, to which a certain number of parents making nonfatal suicide attempts should be added. In addition, the population of Dade County grew from 500,000 in the early 1950’s to 1.7 million in the early 1980’s according to Milroy, who studied the same population for h-s. By averaging the population at 1.1 million during the 26 years of the study covering 1956-1982, I conclude that Dade County probably was within the “normal” range of 0.4 to 0.9 child per million of the general population killed each year in conjunction with parental suicide.
Although more information needs to be obtained about the methodology used in the various studies, there are indications that the overall prevalence of filicide-suicide in the USA is similar to what is seen in other countries. Further research is needed to check the validity of these preliminary findings, as well as to determine to what extent the share of mfs of all filicide-suicide is also similar to the share seen in other countries.

For instance, Chew's finding that approximately 25% of the homicides of infants were associated with suicide, while this usually is less than 10%, suggests the possibility that nonfatal attempts were included or that there were other special circumstances. Information is being gathered with respect to this issue.

There are some indications that paternal filicide-suicide may be more prevalent in the USA than elsewhere, as spousal h-s by a father who includes the children (also referred to as familicide) could be more prevalent in the USA. This might be associated with the fact that access to guns is easy in the USA and males tend to use them more often than females. There are no indications to what extent the prevalence of mfs is similar in the USA to that in other countries.
Epidemiological studies pertaining to Australia

Milroy, Dratsas, & Ranson (1997)

Milroy, Dratsas, & Ranson (1997) reported four cases of mfs during the five-year period from 1985-1989 in the Australian province of Victoria. The mothers' ages varied from 18 to 35. It is not clear whether the mothers killed four or six children. There is no further specific information on these four mfs cases. The general discussion focused entirely on the 33 cases of male-perpetrated h-s. It is interesting that mental illness was considered responsible for only 20% of all 39 h-s cases, where it was associated mainly with depression and morbid jealousy. The population of Victoria doubled in 20 or 30 years, mainly due to immigration. Many of the h-s perpetrators were immigrants, or children of immigrants.

Byard et al. (1999)

Byard et al. (1999), whose study only contained cases of filicide-suicide, reported that the perpetrators' average age of 31 was much younger than that in other h-s studies. Most of the perpetrators in such general h-s studies are involved in spousal h-s and not in filicide-suicide. The authors also observed significant differences between cases of filicide-suicide perpetrated by fathers and those by mothers. Fathers tended to also kill their spouse, while mothers did not, and the fathers used more violence for both the suicide and the filicide than the mothers did.

Byard et al. found that the mfs cases fitted the description of 'extended suicide', since many of the women had 'altruistic' ideas about protecting their children from a bad fate. The fact that in a number of mfs cases benzodiazepines had been given to the children prior to the killing further supported this, according to the authors, who also referred to demographic studies that
confirmed the ‘extended suicide’ concept. No additional information was included in the findings.

Byard et al. presented brief descriptions of all cases.

Cantor & McTaggart (1998)

Cantor & McTaggart (1998) found that of the 34 cases of murder-suicide in the Australian province of Queensland from 1990 to 1995, only 12% of the perpetrators had more than a 0.05 blood alcohol level compared with 17% in a control group of simple suicide victims/perpetrators. No further information was provided on the age or gender of the h-s perpetrators and their victims. Cantor found that if there was a disinhibiting effect facilitating the h-s behavior, it was not due to alcohol. Based on the similarity of the blood alcohol levels of those involved in h-s and those involved in simple suicide, as well as several demographic observations Cantor concluded that h-s and simple suicide had much in common.

Comment on Cantor. Cantor’s study is one of several studies (Alder & Baker, 1997; Alder & Polk, 2001; Lindqvist & Gustafsson, 1995; Meyer & Oberman, 2001) that show that most h-s acts are not associated with impulsivity, and disinhibited behaviors, and, in fact, are often planned in advance, at least on “a standby” basis (LeComte & Fornes, 1998) In addition, several studies tend to refer to demographic and behavioral similarities between h-s perpetrators and victims of simple suicide and, as a result, propose that h-s is more motivated by suicide than homicide.
Population studies pertaining to other countries than England and Wales, the USA and Australia

British Columbia, Canada. Cooper & Eaves (1996)

Cooper & Eaves (1996) reported that from 1984 to 1992 there were only two cases of female-perpetrated h-s in the Southwestern part of British Columbia. One was a highly unusual case of familicide where the mother killed the husband, as well as her two sons, before committing suicide,

All involved in the investigation of the familicide concluded that the perpetrator was suffering a psychotic break, perhaps exacerbated by immigration stress. . . .[The other case was labeled ‘mental illness’ because the mother who had killed her daughter and herself using gas] had been consulting a physician for depression. . . her suicide note indicated extreme sensitivity to slights from members of her family. . . . The suicide note had also mentioned revenge as a motive, including her ex-boyfriend, who had blamed her for an almost fatal suicide attempt made by him. . . . It would seem that the daughter’s death was incidental to the mother’s suicide. (p. 104)

Cooper & Eaves concluded that both women probably were somehow suffering from paranoid delusions and that the concept of insanity hypothesis, as proposed by Daly & Wilson (1988, 1998) to describe women who kill their own biological children probably applied to both of them.

Cooper’s conclusions confirmed those of other studies about female perpetrated homicides and suicide. Women who kill their children in the course of abuse, often referred to as accidental filicide, rarely make a suicide attempt in conjunction with the filicide. The same applies to women who kill their husbands in the context of chronic violence perpetrated by the husbands.
As a result, the prevalence of female-perpetrated h-s in comparison with male-perpetrated h-s is even lower than that of female simple suicide versus male simple suicide.

Quebec, Canada. Buteau, Lesage, & Kiely (1993)

Buteau, Lesage, & Kiely (1993) reviewed police and coroners’ files and found for the three-year period of 1988-1990 39 cases of h-s, 2 of which were mfs. No further information is provided about these two mothers, except that one of them killed both daughters without any sign of warning to the husband. The general discussion focused mainly on the 36 males and their motives and background.

Switzerland. Haenel & Elsaesser (2000)

Haenel & Elsaesser (2000) compared all known h-s cases in the Zurich area in Switzerland that occurred between 1928 and 1948, with all known cases in the Basel region that occurred between 1971 and 1990. Haenel et al. only reported on cases of spousal h-s. It is not clear whether the absence of mfs cases in Haenel’s study means that there were no cases in the two constituent studies. The authors also comment on the similarity of precipitating factors between h-s and simple suicide,

Double suicide [which refers to suicides as a result of a suicide pact, RJS], and homicide-suicide are infrequent and are different in psychopathology from that of a single suicide. However, precipitating factors for double suicide and homicide-suicide are similar to those found in single suicide. Depression, borderline disturbances, and narcissistic neuroses in combination with stressors such as physical illness, isolation, and social losses can lead to homicide-suicide. (p. 122)
The authors also comment, “Homicide-suicide in the West is probably difficult to prevent, since the persons involved do not often consult psychiatrists, family doctors, or health institutions before the suicidal act” (p. 125). Comments like this one are often quoted in other studies about h-s in general, without mentioning that the study is probably limited to (mostly male) perpetrators of spousal h-s. Male perpetrators of h-s generally have less contact with mental health specialists than mfs mothers. However, Lindqvist reported that 10 of the 12 perpetrators of (spousal) h-s were being treated by mental health experts, although this may be associated with the era and cultural differences in the acceptance of psychiatric help.

Sweden. Lindqvist & Gustafsson (1995)

Lindqvist & Gustafsson (1995) described all 12 h-s cases that occurred between 1970 and 1981 in the northern part of Sweden, which contains close to 1 million inhabitants. Two of the cases were female-perpetrated, only one of whom killed her child and herself. This results in only one case of mfs. This woman was reported to be very dissatisfied with her marriage, to have at least one, and possibly two parents, who had been suffering from undefined mental disorders, and to have killed a 13-year old child, after whose birth she had suffered from a postpartum psychosis. It is not clear whether this child was her only one.

Of the 12 offenders, 10 had been subjected to a psychiatric evaluation prior to the act. Five had been diagnosed with a major mental disorder, and another five with substance abuse. Based on their findings, the authors argue that the results of their study do not confirm the predominant notion in Sweden that cases of h-s are “primarily performed by individuals with major depression.
and acting on altruistic ideation” (p. 22). In this regards, the authors are probably correct because the type of h-s that is most strongly associated with altruism, mfs by mothers with a covert profile, is not represented in their study. The mother in the only case of mfs included in the study has many characteristics of an overt profile. However, it is not clear whether the authors believe that altruism can be a viable motive in a different h-s population than the one described in their study.

Even though the discussion and the recommendations about further research are largely based on the 10 male cases committing familicide or spousal h-s, they are worth reviewing for their potential applicability to mfs cases.

- About the role of psychiatric disturbances:

  The explanatory value of any particular psychiatric disturbance, including alcohol abuse, is therefore low, since the panorama of psychiatric disorder was so diffuse in both the present study and the literature as a whole. However, these fatal acts would not have occurred without the presence of severe mental disturbance. (p. 23)

- About child battering:

  .. Neither the children nor their mothers appeared to have been battered by the offenders previously or in connection with the homicide. This may suggest that perpetrators of homicide—suicide do not belong to that group of people who are repeatedly violent towards their families. In contrast, the battered child syndrome is reported to be common in cases in which a parent kills a child of their own but does not commit suicide. (p. 23)

- About marital discord: “The domestic nature and the crucial role of marital discord and psychosocial stress in homicide-suicide cases is a recurrent feature in all studies on the subject despite geographic, temporal, and social characteristics” (p. 23).
• About the variety of homicidal-suicidal behavior, processes associated with it, and the value of investigating a small number of cases in-depth:

…it may well be more effective in increasing knowledge of this phenomenon to investigate closely a small number of cases. Interpretation of the processes leading to these offences is difficult, but impressions and tentative conclusions are of value, as the greater part of contemporary literature has a descriptive rather than an interpretative approach. To increase understanding of these extreme manifestations of human behavior, future analysis may be aided by studying a group of surviving offenders and/or victims. Such an arrangement would also be of value in the study of, for example, the victims' suicidal inclination and would probably teach us more about aggression and pain in less extreme circumstances. (p. 23)

• About how common the offenders appeared to be, and how similar they were to other patients who were not homicidal: “…..most of the offenders were law-abiding citizens with regular jobs. They did not impress us as being essentially different from patients we have encountered in clinical work” (p. 23).

This last statement brings up the question that was not addressed by the authors to what extent other patients might be harboring the same feelings and what it might take for them to act on these feelings
Explanatory Studies on Homicide-Suicide

Explanations based on the Prevalence of Homicide-Suicide

Coid’s Metastudy about the Prevalence of Homicide-suicide

Coid (1983) reviewed studies about the prevalence of homicide-suicide published between 1900 and 1979. In his metastudy, Coid reported that the findings of the various studies were within a narrow range. Because of this, he concluded that h-s rates were similar between countries and possibly stable over time. Coid quoted Gudjonsson & Petursson (1982) and Petursson & Gudjonsson (1981), who attributed this similarity to the epidemiology of psychiatric illness, which presumably would not differ substantially between countries or over time. On the other hand, rates for overall homicide tended to vary considerably among countries because of sociological differences.

Coid also reported that the results of studies into abnormal homicide, defined as homicide by those who were found to have been mentally ill or ‘Not Guilty by Reason of Insanity’ at the time of the homicide, moved in an even narrower range than the rates of homicide-suicide. Coid attributed this difference to “variations in recording practices and the volatility of the suicide rate of the general population” (p. 859). In connection with this remark, Coid mentioned that there might be a relationship between the drop in the English h-s rate between 1969 and 1979, and the drop of the overall English suicide rate during the same period. Coid did not comment on the fact that during this same period, the abnormal homicide rate in England and Wales had doubled according to some of the studies included in his metastudy. With respect to the h-s rate, Coid referred to
West (1965), who had found that half of the 78 perpetrators in his study were insane. Coid suggested that this could mean that half of a country's h-s perpetrators might be sane.

Coid's findings were not broken down by gender, age of the offender or the victim, type of h-s or any other variable. Due to this limitation of Coid's study, which was partially acknowledged by him, the appearance of similarities in the h-s rate between certain studies might obscure important differences between these studies. A good example of this can be found in Coid's observation of the similarity of the h-s rate in Denmark and Philadelphia in the 1950's, which was respectively 0.22 and 0.21 per 100,000 despite the fact that h-s cases as a percentage of all homicides was 36 for Denmark and 4 for Philadelphia. However, Coid did not mention that the great majority of offenders in the Philadelphia study were males committing spousal h-s, while mothers committing mfs were responsible for approximately half of the h-s rate in Denmark. In addition, Coid did not mention that rates of mfs in Denmark, which were among the highest in Europe, may have gone down after detoxification of coal gas in the mid 1960's and as a result, the overall rate of h-s as well, while there probably was no decrease of the h-s rate in Philadelphia since the rate of h-s and especially spousal h-s in the USA had increased (Milroy, 1995a)

Coid did not address the possibility that demographic factors may have influenced the overall homicide-suicide rate. For instance, countries with a large elderly population may have a higher overall h-s rate, because in many countries h-s tends to be more common among the elderly than among several other age groups. (Nock & Marzuk, 1999)
Milroy (1995a)

Milroy (1995a) replicated and updated Coid's research, and generally supported Coid's conclusions. He reported that the h-s rate had gone up in locations where the rate of overall homicide had also increased. However, the increase of the h-s rate was smaller than that of the homicide rate, which allowed Milroy to declare that Coid's conclusions were still valid. Milroy, nevertheless, admitted to be somewhat puzzled by the fact that the h-s rate of Dade County, Florida, which includes Miami, was eight times higher than the rate in the English Midlands. He wondered whether it would be realistic to attribute the entire difference to the greater availability of firearms in Miami. Milroy did not refer to a possible relationship between the overall suicide rate and the h-s rate in Miami as Coid had done for England and Wales.

Marzuk et al and Nock & Marzuk)

Marzuk et al. (1992) and Nock & Marzuk (1999) reported that Coid had found the h-s rates in different countries to be stable, while he had observed considerable variations in the suicide rate as well as the rate of overall homicide in the general population. However, the only reference that Coid had made in regards to suicide rates was that there appeared to be a relationship between the rates for h-s and general suicide in England and Wales because both had dropped between 1969 and 1979.

Marzuk et al. and Nock & Marzuk repeated Coid's observation of the similarity of the h-s rate in Denmark and Philadelphia in the 1950's, which was respectively 0.22 and 0.21 per 100,000 despite the fact that h-s cases as a percentage of all homicides was 36 for Denmark and 4 for
Philadelphia. Neither did Nock & Marzuk comment on what the appearance of similarity may have obscured or how things might have changed since the 1950's.

Marzuk et al. reported that the components of the h-s rate might differ among countries. While filicide-suicide accounted for 6 to 16% of h-s in the USA, it accounted for 40% of the h-s rate in England and Wales, and for 70% of the rate in Japan. They also implied that this phenomenon would sometimes occur while there was no significant difference in the over-all h-s rates of the countries. For England and Wales, they based their conclusions on a study by West (1965), despite several reports that the filicide-suicide rate in England and Wales, especially among mothers, had dropped significantly after the mid 1960's. Nock & Marzuk repeated the same findings in 1999, despite the fact that Milroy (1995a) had commented explicitly on the outdated nature of the information about England and Wales that was presented by Marzuk et al.

Comments on Coid, Milroy (1995a), Marzuk et al., and Nock & Marzuk

Virtually all studies on h-s quote Coid about the alleged similarity (between countries) and stability (over time) of the h-s rates. However, I have not located studies that mention the limitations of Coid’s study. It is particularly remarkable that there are no comments about the fact that given the alleged similarity of the epidemiology of psychiatric disorders the highest h-s rates in Coid’s study are 10 times higher than the lowest.

Coid’s remark about a possible connection between the suicide rate and the h-s rate in England and Wales, based on the simultaneous decline of both during the 1970s, has gone unnoticed in virtually all studies that quote Coid. Milroy (1995a) did not examine the possibility of a
relationship between rates of h-s and regular suicide despite the presence of several known risk factors for suicide in Miami and Dade County. Neither was this possibility raised by Marzuk et al. or Nock & Marzuk, while both these studies suggested that several types of h-s had more affinity with suicide than homicide.

Coid did not elaborate on why the range of rates for abnormal homicide might have been narrower than for h-s other than the comment on “recording practices and volatility of the suicide rate of the general population” (p. 859). Coid’s suggestion that the drop in the h-s rate in England and Wales may have been associated with a drop in the general suicide rate implies the possibility that the phenomenon of mental illness might differ for the perpetrators of abnormal homicide and perpetrators of homicide-suicide. In fact, such differences might explain why the range for rates of abnormal homicides generally is narrower than for h-s. Yet, neither Coid nor Milroy nor Marzuk et al. nor Nock & Marzuk addresses this possibility.

The possibility that the range of abnormal homicide rates is narrower than the range of h-s rates could be attributed to the fact that suicidal behavior may be more subject to rational thinking than abnormal homicide may play an important role in this regard. Behavior that is more subject to rational thinking may be more responsive to external factors. For example, the detoxification of domestic coal gas in England and Wales, which preceded a steep drop in the mfs rate, may have led potential mfs mothers to consider the logistics and consequences of using alternative methods.

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22 The population of Dade County, of which Miami is a part, had tripled in size during the period examined with most of the inflow coming from immigration of Cuban refugees and elderly Americans migrating to Florida. It is no secret that immigration, moving and old age are risk factors for suicide, and h-s tends to be higher among the elderly than among several other age categories.
As a result, many may have discarded their MFS plans altogether, while quite a few of mothers who substituted other methods for gas may have made MFS attempts that were not fatal.

At the same time, it must be acknowledged that the notion of comparing abnormal homicide and H-S rates and the range, within which they move, is rather uncertain and maybe even controversial, if indeed the rates for abnormal homicide doubled during the 1970s in England and Wales. Such a doubling of a phenomenon that allegedly moves in a narrow range is, to say the least, surprising.

The widespread belief that the overall rates of both homicide and suicide were not associated with the rates of H-S, which was only correct for homicide, may have dimmed awareness of the fact that theories about regular suicide could be utilized in finding explanations for H-S rates. In addition, the alleged presence of a narrow range of rates of H-S may have suggested that the forces responsible for the incidence of H-S are of such a universal nature that resisting them is useless. All of this may have discouraged closer examination of the H-S rates and the H-S phenomenon in general.

Discouragement of closer examination of H-S rates may also be associated with the observations by Marzuk et al. and Nock & Marzuk about similar rates between countries for overall H-S accompanied by variations in the rates of the components of H-S. Such observations suggest a certain degree of determinism about core phenomena. The observations by Marzuk et al. and Nock & Marzuk may be related to theories (Verkko, 1967) which hold that suicidal and homicidal urges
overlap to a large extent, and that differences in the homicide and suicide rates tend to balance each other out in ways that depend on external circumstances.  

Selected Samples of Fatal/Fatal cases using Psychological Autopsy studies

Graser (1992)

In South Africa, Graser (1992) conducted a psychological autopsy study on nine cases of homicide-suicide/familicide that were representative of 90 such cases during the 10-year period from 1979 to 1989. One of the objectives of his study was to approach this subject from the point of view of victimology, i.e. to discover how the victim might have behaved in ways that could have contributed to the murder.

Graser distinguished between murder-suicide, of which there were three cases in his sample, and extended suicide, of which there were six cases. The murder-suicides referred to cases of familicide, where the male killed or attempted to kill the spouse and all the children before committing suicide. The emphasis in these three murder-suicide cases appeared to have been on murder, where the males were triggered by something that made them act in an impulsive and unprepared manner. As a result, many of the intended victims survived. The extended suicide cases were clearly dominated by suicidal motives. The perpetrators had been experiencing serious

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23 However, elsewhere in this dissertation, several of the observations by Nock & Marzuk (1999), on which the suggestions for the alleged similarities between h-s rates are based, have been shown to be inaccurate, especially the outdated observation about female-perpetrated h-s in England and Wales. (Milroy, 1995a)

24 Fatal/fatal cases refer to cases where both the parent’s filicide attempt and his or her suicide attempt were fatal.
problems for a long period, and at some point, these problems became too overwhelming. Of the six extended suicides, two were committed by mothers who used the car exhaust to kill their children and themselves.

The role of process, triggers, prior communication and threats as well as earlier suicide attempts is described by Graser as follows (italics represent bold font in Graser’s study):

If the particular factor persists/deteriorates, it tends to assume progressively larger proportions in the perpetrator’s mind, until it reaches a point beyond his/her tolerance. Often a trigger event can be identified — such as an argument, rejection by a spouse, notification of criminal charges, loss of building contract, etc.

In the murder-suicide type of family murder, which occurs more spontaneously, the trigger event is usually more clearly perceivable. In the extended suicide category, on the other hand, it is usually a matter of a long-term malignant situation — an unhappy marriage, a long-term illness, financial problems, alcoholism, etc. — reaching proportions beyond the perpetrator’s tolerance.

Frequently, particularly in extended suicide cases, the proverbial “red light” can be seen flashing for days, or even weeks, prior to the tragedy. In the investigation under discussion, in seven of the nine cases, the perpetrator had previously made suicide threats — in some instances repeatedly. In fact, four of the perpetrators had actually attempted suicide. Three perpetrators had also threatened family murder.

In all but one of the cases where threats of suicide or family murder had been uttered, no preventive action was taken by those who heard the threats. In the one case, the family priest alerted the police but, in the absence of clear guidelines and facilities, he felt at a loss about taking drastic preventive measures. (p.370)

As to the nature and outcome of the attempts, the extended suicides were well prepared and lethal, as all the intended victims died. The extended suicide attempts were also intended to be painless since the victims were killed while they were sleeping. Many of the intended victims of the three attempts at murder-suicide survived because of the apparently impulsive nature of the act,
The reason some of the victims survived these murders and some of the children were not involved, lies in the spontaneous nature of the “murder-suicide” type of family murder. The act is not planned carefully and executed rationally; it occurs in an explosive way — which makes errors more likely. (p. 373)

With respect to the victimology aspects of the study, Graser remarked that, except in one or two cases, he had not found any behaviors by the victims that could have contributed to the killings. Even in these one or two cases, the actions by the victims were not of such a nature that their contribution would meet the criteria of victimology for having helped precipitate the act of h-s.

With respect to precipitating events, Graser reported that these triggers were not clear in cases of extended suicide because they were associated with a “long-term malignant” situation, which the offender at some point no longer could tolerate. Apparently, the triggers in the three cases of murder-suicide were more perceivable according to Graser, and in one or two of these three cases, the triggers may have included behaviors by one or more of the victims that helped precipitate the act. However, even in these one or two murder-suicide cases, there is not a significant presence of “victimology” symptoms, i.e. behaviors by the victim that triggered the offender.

Comment on Graser.

With respect to the precipitating effect of potential victimology symptoms, it appears that this may be a more relevant phenomenon in cases of simple homicide where the offender may not have had a preconceived plan to kill the victim, and where an impulse emanating from the victim precipitated the act of simple homicide. However, in h-s cases, the motivation to make a suicide
attempt appears to be dominant, and to have existed for some time, even to the extent of having an actual plan. The triggers needed to activate the implementation of an h-s plan appear, in some cases, to be associated with excessive fears. Various events might cause these fears to peak. Some of them might be related to the victim, such as the announcement that one will leave the relationship, while other triggering events might be related to financial problems or perceived social rejection.

On a more general level, this study by Graser appears to be the first psychological autopsy study, where the author had not only studied all available documents, but had also interviewed many of those who had known the perpetrators and their families. The interviewees’ remarks about the prior communication by the perpetrators of their intentions, and the lack of adequate reaction by family members makes one curious about the frequency of similar situations, and how often the reaction of family members may have prevented the potential perpetrator from carrying out his or her plans. It also makes one curious about how many mothers are having mfs ideation and plans, how many of them are expressing it, how family members and medical personnel react, and how many mothers are not expressing their ideation or are suffering after expressing it and not receiving an adequate response?

Although Graser reports that the victims cannot be said to have precipitated the murder-suicide event, the fact that concepts of victimology were guiding the research may have led him to involve the environment of the offenders/victims to a much larger degree than had been done in other studies on h-s. The observations by the families of the offenders' behaviors prior to their fatal
h-s attempts, as well as their account of their own contacts with the offenders gave a degree of depth to Graser's study not seen in many other studies.
Goldney (1977) described four cases of h-s in Australia, two by fathers who killed all the members of the family and themselves, and two by mothers who killed themselves, but not their spouse after having tried to kill all their children, half of whom survived. In his discussion, Goldney approached the cases primarily from a psychiatric point of view, and he made a number of observations:

- Goldney reiterated the important role of depression and the concomitant heightened sensitivity to rejection.

- Goldney noted that the husband of one of the mothers did not notice the abnormality in his wife’s behavior that had been noticed by others. He also commented that in the case of the second mother, the family was aware of the mother’s unusual behavior, but had not taken any steps to get help for her. Goldney further noted that during the hospitalization of this second mother for gastrointestinal problems, which had started after her first homicidal gestures, an opportunity had been missed to bring up her mental problems.

- Goldney makes the following observation about the notion of altruism and the concomitant phenomenon of extended suicide: “The concurrence of any altruistic thoughts with an act as manifestly hostile as murder is an indication of the degree of disturbed thinking possible in psychotic depression.” (p. 226).
• Goldney suggested that persons hospitalized for psychiatric problems, whose relationship with the staff was disturbed, tended to discharge themselves prematurely. They were also the ones who were at greatest risk of committing suicide after the discharge. Goldney (1977) remarks: “inability to form trusting relations with persons traditionally considered caregivers in society may be a sign of some importance” (p. 226)

• Goldney also noticed the immigration aspect and the relative isolation in which these families were living.

• Goldney remarked that in the case of the second mother, a newspaper on the kitchen table was opened on the page where the family murder committed by the first mother only a few days earlier was described. Goldney suggested that this might have played a role: “The reported events may have helped loosen ego control just enough to trigger the tragedy, though it is more parsimonious to consider that she became less in touch with reality due to her presumed mental illness.” (p. 227)

• Goldney remarked that the kind of retrospective discussion that he was engaged in by conducting this study often suggest a clarity that could not have been discerned at the time that events took place. He also reported that many of his ideas were somewhat speculative because little was known about this topic.
Comment on Goldney.

Now, with the aid of quite a few publications that reported on aspects that were only speculative for Goldney in 1977, it is possible to evaluate Goldney’s findings and conclusions from a broader perspective with respect to various types of h-s, especially extended suicide and the concomitant phenomenon of altruism. It is possible to see how Goldney’s understanding of murder followed by suicide was subject to the limitations of the knowledge at the time he published his study, i.e. 1977. By now, some of Goldney’s conclusions and the extent to which he generalized his findings may appear unrealistic.

With respect to the role of the family in the case of the two mothers, Goldney mentioned that the second mother’s family had not sought help for her despite obvious signs of dangerousness. Maybe Goldney did not consider the possibility that the family was unable to recognize that the mother’s earlier homicidal gestures might have been a precursor to a real homicide attempt. In addition, the potential shame and fear as a result of having the mother exposed as mentally ill might have kept the family from seeking help for the mother, or from pressuring her to get help.

In the case of the first mother, Goldney’s report that the husband did not notice the abnormality that had been noticed by others seems to suggest that Goldney may be associating the husband’s behavior with indifference. Indifference may indeed have been a factor. However, the possibility that the mother did not show this kind of abnormal behavior in the presence of the husband was not a consideration mentioned by Goldney. The fact that Goldney also assumed that the disagreement between the two spouses should have alerted the husband to the mother’s
abnormality does not take into account the possibility that disagreements may have been a way of life between these two people. Furthermore, the notion of the emotional numbing of potential perpetrators that in some instances accompanies chronic depression and, according to Baumeister (1990) may precede attempts at regular suicide may have played a role here. The additional notion that the emotional numbing by a potential offender referred to as a *deconstructed state* might extend itself to significant others, and in this particular case, to the husband, may shed some light on these events. This will be discussed later in more detail.

Goldney’s earlier quoted remark of, “The concurrence of any altruistic thoughts with an act as manifestly hostile as murder is an indication of the degree of disturbed thinking possible in psychotic depression.” (p. 226) brings up several issues.

The first issue is that Goldney implies that psychosis is a necessary condition for altruistic thoughts, with which I disagree, and which will be discussed later.

The second issue refers to the fact that Goldney associates psychotic depression with “an act as manifestly hostile as murder” (p.226). This suggests that the perpetrator is seen by Goldney as primarily committing murder, while according to several authors (Marzuk et al, 1992; Graser, 1992), some of these events are an extended suicide rather than a murder-suicide, where the suicidal person takes along others in the belief that this is the best option for them. This belief has been designated altruistic by some, while others (Harder, 1967; Marneros, 1997) pointed to the syntonic aspects of such an act for the mother who sees killing her child as the best solution for her own problem.
A third issue refers to the phenomenon that psychotic depression is primarily discussed by Goldney in the context of events that have taken place, where the alleged presence of psychosis serves an explanatory purpose and/or helps to explain the lack of a discernible motive. It makes one wonder how to recognize psychotic depression before a violent act, as well as how to identify who might be vulnerable to develop a psychotic depression.

Fourthly, it is not clear how Goldney’s rejection of the notion of altruism is related to the four cases in his study. Goldney also referred to the literature, when making his case against altruism and extended suicide. However, these four cases, and certainly the two mfs cases had only few of the characteristics that by now are usually associated with extended suicide and altruism: thorough preparation, relatively little effect from impulsivity, use of methods for filicide that are perceived as painless, and a lethal outcome for all the intended victims, including the offender.25

25 Nonetheless, Goldney’s study is sometimes regarded as providing support for the position that altruism and extended suicide are misguided concepts with the possible exception of situations characterized by a psychotic depression. The implicit assumption of those quoting Goldney appears to be that the cases in his study were typical of murder followed by suicide, and that Goldney had debunked the concepts of extended suicide and altruism. Apparently, he had done so by demonstrating why extended suicide and altruism did not apply to the four cases in his study, while other authors might have been prone to argue that these concepts would have applied. Nevertheless, Goldney continues to be quoted as before, even though extended suicide and altruism, as they are currently interpreted, would not be regarded as characterizing Goldney’s four cases.
The notion that disturbed relationships with hospital staff and an inability to form trusting relationships with them could be a risk factor for suicide, as well as for murder-suicide deserves further study for its value as a potential risk factor.

Goldney’s assessment that the newspaper story about another mother’s h-s “may have loosened ego control sufficiently to tip the balance” (p. 227) is interesting, and seems to have considerable face value. What might have happened here is that an act of homicide-suicide may have been unimaginable for the second mother. She probably thought about homicide-suicide considering her homicidal gestures in the weeks preceding the murders. However, the idea that she actually could do this may have been unimaginable for this mother. When she read about the other mother doing it, all of a sudden what had been unimaginable might not have appeared so unimaginable any longer.
Okumura & Kraus (1996) examined the charts of all 12 women, who had been committed to two mental hospitals in Germany between 1954 and 1992 after a nonfatal suicide attempt preceded by a fatal or nonfatal filicide attempt. Four were considered schizophrenic, three were described as suffering from a personality disorder, four were considered to have been suffering from endogenous depression at the time of the filicide, and one person had a so-called psychogenic reaction.

Psychiatric symptoms of the offenders. Three of the four schizophrenics were reported to have acted under the influence of delusions and/or hallucinatory commands, and thus could not be considered to have had a motive, according to Okumura & Kraus. The fourth schizophrenic was the only one who reportedly had a motive, which appeared to be of a retaliating nature and directed at the father of the child that was her victim. She was reported to have carried out the filicide attempt in a rather detached manner, and to have used the very violent method of slashing her child’s throat.

Of the three Personality-disordered women, (the specific personality disorder was not mentioned) two were reported to have been addicted to alcohol and/or drugs. All three women as well as the lone psychogenic reaction were said to have acted in reaction to events that happened around them. The mothers were reported to have been in a state of mind where they were aware of motives for their act, which Okumura & Kraus described as egocentric. (The two women that
were both personality-disordered and addicted showed behaviors that suggested to me a combination of DSM-IV Borderline and Anti-social personality disorders. The third personality-disordered mother appeared to suffer from Borderline Personality Disorder, as defined in DSM-IV. 

Of the four mothers who had been suffering from endogenous depression at the time of the filicide-suicide attempt, three were reported to have a personality of the “Typus Melancholicus”, of which the characteristics include: performance-oriented, orderly, very responsible, anxious and hypernomic, or overly inclined to follow rules.  

Okumura & Kraus also reported that at least three of the four endogenously depressed mothers were suffering from psychotic identification with the child that they had killed. The issue of psychotic identification receives much attention in their study in the context of their general discussion of extended suicide.  

The concept of extended suicide according to Okumura & Kraus. Okumura & Kraus point out that in some cases, a mother is so strongly identified with her child or children that one can speak of an extended self that includes, in the mother’s experience, mother and child. When such a mother attempts to kill herself, the children are automatically included because they are part of the extended self. The authors believe that the term extended suicide accurately describes these  

This concept suggests a combined dependent and obsessive-compulsive personality disorder, as defined in DSM-IV. Later, we will see how Meszaros and Danzinger (2000) diagnosed the five “Typus Melancholicus” mothers in their sample of nine women who had made a nonfatal mfs attempt, as suffering from the ICD-10 “anxious/avoidant” personality disorder, which gave them symptoms of all three personality disorders in cluster C of DSM-IV.

26 These characteristics suggest a combined dependent and obsessive-compulsive personality disorder, as defined in DSM-IV. Later, we will see how Meszaros and Danzinger (2000) diagnosed the five “Typus Melancholicus” mothers in their sample of nine women who had made a nonfatal mfs attempt, as suffering from the ICD-10 “anxious/avoidant” personality disorder, which gave them symptoms of all three personality disorders in cluster C of DSM-IV.
situations. Such mothers experience a sense of psychotic identification with their child or children, according to Okumura & Kraus.

While Okumura & Kraus consider mfs mothers who experience their child as part of the extended self as committing extended suicide because the child as part of the extended self is automatically included in the mother’s suicide, they consider mfs mothers without this sense of extended self as taking their children along rather than as committing extended suicide.

Okumura & Kraus report that the current practice of also applying the label extended suicide to the mfs attempts where the mother does not experience a sense of extended self is not correct, but since it has been adopted so widely, they also use it in their study.

The discussion around extended suicide by Okumura & Kraus also involves the question of whether to consider mfs as an act of altruism. When the act of mfs is truly extended suicide, there is, in the mother’s perception, no other person who is taken along. Therefore, the question of altruism is a moot point in such cases, according to Okumura & Kraus. When the mother does not experience the child as part of her extended self, and she believes that taking the child along in her suicide will save it from future suffering, then it can be said that her mfs represents an act of altruism.

*Extended suicide and Psychotic identification.* As to the psychotic identification in the context of extended suicide, Okumura & Kraus explain how the mother who experiences her child as part of her extended self has been over-identifying with her child for some time, if not from birth.
Such a mother, generally, has a history where she has not developed a genuine or authentic self. As a way of compensation for the lack of an authentic self, she has learned to identify herself with other persons, on whom she has become dependent, if not over-dependent, as well as with social roles that have taken on the role of a pseudo-self for this mother. Any problems or changes in her social roles, or in the relationship with others on whom she depends for a sense of identity, are difficult for this mother. When the changes or problems are too large, she is in danger of succumbing, loosing her self-esteem and with it the justification for her existence. It is easy for a mother who is going through this type of an existential crisis to believe that the child or children with whom she has an over-identification have also lost their justification for existence.

Okumura & Kraus speak of the mother’s over-identification with the child as something that has become a defining characteristic of her relationship with her child, and apparently has been present for a long time, while they speak of the mother’s psychotic identification with the child only in the context of the extended suicide by the mother.

*Comment on Okumura.*

It is not clear to me whether Okumura & Kraus are referring to psychotic identification as an especially severe form of over-identification, which is only seen in the context of extended suicide, or as merely another way of referring to over-identification that is occurring on an ongoing basis, maybe as a symptom of a personality disorder such as Borderline Personality Disorder. If the over-identifying mother indeed is experiencing a form of chronic, low-grade psychotic identification with her child on an ongoing basis, it is important for the clinician to be aware of this, and to identify under what circumstances the psychotic identification might lead to ideation about
extended suicide and behaviors in that direction. If the over-identifying mother were not experiencing a psychotic identification on an ongoing basis, it would be important to identify under what circumstances the over-identification could escalate into a psychotic identification.

In the context of the question when psychotic identification is present, it is interesting that Okumura & Kraus do not refer to any behaviors by the mothers prior to the act of extended suicide that suggest the presence of psychosis. Yet their description of the concept of over-identification at least implies the possibility that psychotic identification is present well before an actual mfs attempt is made. In other words, do Okumura & Kraus make a diagnosis of psychotic identification ex post facto, possibly because the seriousness of the act of mfs is such that they subscribe to the belief held by many clinicians that the mother must have been psychotic or mentally ill to make an mfs attempt? Alternatively, are they suggesting that such a diagnosis can be made beforehand, and might be a warning sign and a reason for a more in-depth evaluation of the mother?

The discussion on psychotic identification leaves two other aspects in need of further clarification. The first one refers to the age of the child. Several authors (Berman, 1996; Resnick, 1969; D'Orban, 1979) take the position that psychotic identification between mother and child, when it does happen, usually occurs during the child's first year, and associate it with the post-partum phase. The age of the children in Okura's study, with whom the mother might have had a psychotic identification varies from zero to nine. It is not clear whether Okumura & Kraus believe that psychotic identification, as it occurs during the post-partum phase, can also occur when the child is several years older than one. Possibly, they are defining psychotic identification in a way

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that is similar to the use of concepts such as merger and fusion that are sometimes said to be present in persons, especially women with Borderline Personality Disorder.

The other aspect concerns the motive. Okumura & Kraus emphasized that three of the four schizophrenics did not have a motive, or if they had one, it could not have played a role, presumably because the mothers were in the middle of a psychotic episode.\(^{27}\) The personality-disordered mothers' acts, on the other hand, were based on motives, and the motives were egocentric ones. Okumura & Kraus do not address the issue of motives for the endogenously depressed mothers. However, this may be related to the fact that Okumura & Kraus had pointed out that in true extended suicide there is no room for an altruistic motive because the concept of extended self precluded the possibility of experiencing the separate existence of another person, and consequently the opportunity to have an altruistic motive.

The extent to which a mother is thought to have been psychotic at the time of her mfs act, and especially the extent to which psychotic symptoms were foreseeable, if not detectable, prior to the mother's fatal or nonfatal mfs attempt, are of central importance in this dissertation because of the implications for the assessment of mfs ideation and behavior. After learning more about it from other vantage points, we will return to this issue.

\(^{27}\) Even a schizophrenic who is experiencing and acting on a command hallucination can be said to have a motive. Although such motives are not rational, it might be possible to discern certain patterns in the hallucinations and connect these with events in the schizophrenic's life.
Meszaros & Fischer-Danzinger (2000) studied nine women who had been hospitalized after a nonfatal, yet serious, suicide attempt following a fatal or nonfatal attempt at the lives of one or more of their children. The psychiatric examination was very thorough using interviews, psychological tests, meetings with family members, and all available medical records. The thoroughness of this examination made it possible to come up with diagnoses, based on ICD-10 that included the presence and nature of any premorbid personality disorders in addition to any psychiatric disorders that may have been present at the time of the act.

Based on their experiences with the women examined and in reference to the existing literature, Meszaros & Fischer-Danzinger identified certain risk factors for extended suicide. They reported that the following types of psychopathology and psychosocial stressors represent an increased risk for maternal filicide-suicide:

- severe depression with psychotic symptoms and/or delusion, paranoid type of schizophrenia, severe personality disorders, personality traits of the Typus melancholicus (hypernomic, orderly, anxious, overly responsible, obedient, and depressed) intoxication in multiple substance abusers, and the additional occurrence of acute stressful events, such as marital and/or financial problems. (p. 9)

28 In the study, the term “extended suicide” is used many times, including in the title. However, the definition that Meszaros & Danzinger provide of ‘extended suicide’ only applies to six or seven of the nine women. For this reason, the term ‘filicide-suicide’ is used by the authors when they want to refer to the mfs behaviors of all nine women.

29 Instead of acute stressful events, the authors used the word ‘overstrain’, which is their translation of the German word “uberspannen” or the Dutch “overspannen”. Use of this term dates back to the days of bow and arrow, where a bow could not always be in ‘ready position’. In current times, the term refers to a state of mind, where someone is no longer in control of himself or herself. It is often used for people, who go on disability because the stress at work has greatly weakened them. It is also often used to describe the state of mind of someone, who commits an act of violence varying from child abuse to filicide. English words that approach its meaning include
Meszaros & Fischer-Danzinger found that all nine women were severely depressed and that six of them had psychotic symptoms, while three did not. With respect to personality disorders, five were diagnosed (ICD-10) "anxious-avoidant" in addition to having a "Typus Melancholicus" type of personality, which was earlier defined as a combination of depression and anxiety, including hypernomy, the overconcern with the adherence to norms. In addition, one mother was diagnosed as paranoid, one as borderline, and one as borderline plus narcissistic, while only one of the nine mothers was diagnosed as not having a personality disorder. Seven had seen psychologists or psychiatrists before their act, and some of them even shortly before. Four had made previous suicide attempts. The five “Typus Melancholicus” mothers reportedly had altruistic and hypernomic motives for killing, as well as a psychotic identification with their victim(s), whereas egocentric motives were dominant in the four cases that did not fit the description of “Typus Melancholicus”.

With respect to diagnoses, Meszaros & Fischer-Danzinger observed that cases of extended suicide traditionally were associated with cyclothymia, but more recently also with other psychiatric disorders. In light of the association between cyclothymia and bipolar disorder, it is interesting to observe that most, if not all core symptoms of the Tyypus Melancholicus (anxiety, depression, hypernomy, fear of rejection, and low self-esteem) appear to play a central role in the recent conceptualizations of a bipolar spectrum. (Perugi & Akiskal, 2002) This will be further addressed in Chapter 7, The Vantage Point of Suicidology.

nervous breakdown or stressed out. Some states of PTSD may accurately describe what in this study has been translated into 'overstrain'
Meszaros & Fischer-Danzinger also stated that mfs attempts where the suicide and/or the filicide attempt were not fatal were clinically similar to the ones where both were fatal. They do not provide support for this from their clinical practice or from studies where both types had been examined and compared with each other or from other sources.

Comments on Meszaros

The study by Meszaros & Fischer-Danzinger has a number of characteristics that distinguish it from many other studies about mfs, i.e. the ICD-10 diagnoses of their nine patients contain diagnoses on what, in DSM-IV terminology, would be called both Axis I and Axis II. In addition, the information on the Typus Melancholicus provides the reader with more psychiatric information than commonly used in case descriptions of extended suicide. This enables the reader to get a better understanding of the mfs phenomenon and its variety. The data provided by Meszaros on the nine mothers will be analyzed to see if there might be an association between the diagnostic, demographic, and clinical picture of the nine mothers, and the nature and outcome of their attempts. Potential implications of such an association for the assessment of mfs ideation will also be discussed.

The alleged similarity between Fatal/fatal and fatal/nonfatal cases according to Meszaros.

Meszaros & Fischer-Danzinger had stated that, from a clinical point of view, there is little difference between cases with a fatal suicide attempt after a fatal or nonfatal filicide attempt and cases with a nonfatal outcome of the suicide attempt. This statement for which no support was provided brings up a number of questions that have also been raised as a result of similar statements in other
studies (Nock & Marzuk, 1999). In fact, it appears that there are significant differences between the
two types of cases. For instance, Bourget & Gagne (2002) reported that fatal/fatal attempts are
usually accompanied by a suicide note, while fatal/nonfatal ones are not, which suggests a degree
of impulsivity and lack of planning which caused the attempt to be something else than fatal/fatal.
The issue of the alleged similarity between fatal/fatal and fatal/nonfatal cases is of central
importance to this dissertation, and will be addressed further in Chapters 6, 7, and 8.

Typus Melancholicus, anxiety and help-seeing behavior. The characteristics of the Typus
Melancholicus suggest a key role for anxiety. The description of Typus Melancholicus contains
many features of (DSM-IV) dependent and obsessive-compulsive personality disorders. The fact
that all five Typus Melancholicus mothers in the Meszaros study had also been diagnosed with the
ICD-10 anxious/avoidant personality disorder further highlights the anxiety component. In fact, it
appears that these five mothers had a composite of the DSM-IV cluster C (anxiety) personality
disorders. In Chapter 7, The Vantage Point of Suicidology, clinical syndromes associated with
different diagnostic approaches and classification systems, such as Typus Melancholicus, Bipolar
Spectrum, Cyclothymia, Cluster C Personality Disorders, and Client Centered Obsessional
Disorder (McDermaid & Winkler, 1955), all of which have been associated with extended suicide
and mfs, will be compared and contrasted with each other.

The observations by Meszaros & Fischer-Danzinger that of the nine mothers, five were of
the Typus Melancholicus, and that seven had seen a mental health expert before their act, some of
them shortly before their act, may be interrelated. There are indications that will be further
addressed in Chapters 6, 7, and 8, that the characteristics of the Typus Melancholicus may be
typical of mothers of young children who are in ongoing psychotherapy. If further research confirms this, then it will be especially important for clinicians to learn about risk factors for the presence of mfs ideation among mothers who have personality features described by the Typus Melancholicus. Such risk factors might not be obvious, because people of this personality type often are high functioning. On the other hand, depressed and potentially suicidal mothers of young children (dpsmyc) who do not fit the description of Typus Melancholicus may have pre-attempt behaviors that could make it easier for psychotherapists to identify them as potentially dangerous.

Marneros (1997)

Marneros (1997) describes extended suicide as mainly driven by a fear of damaging the persons that one feels closest to. Marneros refers to the fear of damaging or hurting others as blaptophoby. He distinguishes between extended suicide cases associated with schizophrenia or hallucinatory commands, with which he does not concern himself in this study, and those that are not associated with schizophrenia or hallucinatory commands.

Marneros proposes that for a homicide-suicide to be considered an extended suicide, the following four characteristics must be present:

- The intention to commit suicide must be dominant.
- The perpetrator does not have a negative attitude towards the victim.
- The taking along in death happens without the knowledge or the consent of the victim.
- There is a hypernomic sense of responsibility that is associated with the exceptionally strong relationship between the perpetrator and the victim.
Marneros argues that the term *altruistic* in connection with extended suicide often is not correct because the motivation to include others in one’s suicide is primarily syntonic. The motivation is primarily syntonic because it helps the perpetrator deal with the perceived negative consequences of leaving their children behind without a parent, if he or she were to make a fatal attempt at regular suicide. Marneros argues that use of the term ‘altruistic’ is more justified when the perpetrator kills someone who is clearly suffering and who might welcome death, and subsequently commits suicide to avoid the consequences of being prosecuted for something that was believed to be the right thing to do. In these situations, suicide is a consequence of the murder, and therefore, not extended suicide.

Marneros provides descriptions of three cases of extended suicide where the perpetrators were rescued, two mothers and one husband killing, respectively, their children and his young wife. Both mothers were described in a manner that can best be summarized as perfectionistic.

Marneros describes the process preceding an attempt at extended suicide in such cases, for which he quotes Bien (1984, 1986). Initially, there is a suicidal period, during which the mothers are kept from making a suicide attempt only by the thought that this would be inhuman towards their children. This is followed by a *homsuicidal* period characterized by a great deal of ambivalence after which at some point, a decision to go ahead with the h-s is made and implemented very quickly, in great rage and not according to a plan. Marneros is not clear about what happens during the *homsuicidal* period.
The reader is left with the impression that extended suicide, even when not committed by schizophrenics, is associated with a lack of preparation, planning, and premeditation. According to Marneros, there is no real weighing of pro's and con's when the decision is made. Marneros does not clarify whether he bases these conclusions on contributions by Bien (1984, 1986) or on the experience of the perpetrators who became his patients after their fatal filicide and nonfatal suicide attempts.

**Comment on Marneros**

Marneros based his conclusions on the state of mind of the three offenders at the time of their extended suicide attempt, which he describes as impulsive and full of rage. Considering that all three of them survived their own suicide attempts, there is a possibility that they are only representative of those who attempt extended suicide in a comparable state of mind, i.e. rageful. Marneros does not address the conclusion presented in other studies that much maternal filicide-suicide is premeditated and well prepared or, according to Berman (1996) without rage.

The remarks about the suicidal feelings preceding the *homisicidal* stage could be very valuable from an assessment point of view. I have not yet located studies that provide information to what extent mfs mothers might be experiencing ideation about regular suicide prior to the mfs attempt. Further research needs to be done in regards to this question.
Explanations based on the Japanese View of Filicide-Suicide (oyako shinju)

Iga (1996)

Iga (1996) described the concept of parent-child suicide (oyako shinju) in terms of the cultural context. The case was that of a Japanese woman who had killed her child, and was rescued before she had been able to kill herself. Iga described how the woman, who had been living in the USA for 14 years with her Japanese husband, after having lived the first 20 years of her life in Japan, was unable to deal with her husband having an affair that might result in a divorce.

First Iga stated that the concept of oyako shinju was still very prevalent in Japan because a mother who is contemplating regular suicide knows that children left behind will experience discrimination and hardship in Japan's society because of the 'extended' stigma of being the child of a mother who committed regular suicide. In addition, there would be the emotional suffering of having lost their mother to suicide. A mother who commits suicide without taking her children along is viewed more negatively than the one who takes her children along. Iga also described the social circumstances that would make divorce a worse alternative for many women than continuing to endure a bad, and often abusive, relationship. Although individual psychopathology is usually a necessary condition for mfs in Japan, as well as in other countries, the social circumstances and the society's attitude towards suicide in general create fewer obstacles than elsewhere in attempting mfs.
Then Iga described why it is often hard for Japanese to adjust to Western society. The idea that one actually would be able to change those aspects of one’s life that cause hardship apparently has not been accepted, and certainly not internalized by many Japanese who live in countries where such ideas are the norm. This led to the increasing isolation in the case Iga described. The mother was not in touch with other Japanese or Americans. She felt too much shame in relationship to the Japanese, and was too unfamiliar with American culture to apply other standards to her own situation.

Comments on Iga. The fact that mfs is so much more prevalent in Japan than elsewhere suggests that the potential for such prevalence might be present elsewhere as well. The actual incidence of serious mfs attempts might depend on external circumstances, such as public ‘approval’ in Japan or availability, like the operational ‘advantages’ of coal gas in England and Wales prior to the mid 1960’s.

Iga’s description of how lack of adjustment to life in the USA, accompanied by a sense of despair due to not meeting the standards of the original culture, describes one particular pathway in which immigration may contribute to mfs. Considering that a disproportionate number of mfs cases are committed by immigrants or children of immigrants in most countries, of which data are available, Iga’s account may explain certain aspects of their situation.

In this context, where it appears to be a norm not to challenge existing norms or ideas, Iga also commented on the position of Japanese intellectuals, who see it as their duty to propagate government policies rather than examine the policies in an objective fashion. An example of this will be described in the review of Sakuta (1985) in this subsection.
Bryant (1999) quotes reports about the incidence of 200 to 400 cases of maternal filicide-suicide per year in Japan. Bryant draws attention to the way the traditional parent-child suicide in Japan (oyako shinju) is treated by the courts. Bryant focuses on the beliefs underlying the courts' treatment of oyako shinju:

- Suicide is culturally seen as a possible rational and honorable step.
- To commit suicide, one does not have to be mentally ill, although it is understood that the suicidal mother may be having emotional problems.
- Not taking one's children along would be worse than leaving them alone without a mother, because the society will not care well for them, and the children will be discriminated because of their mother's suicide.
- The concept of merger and fused identity of mother and child is not seen as pathological in Japan and may even have been encouraged. Shame appears to be the central theme.

Sakuta (1985)

Sakuta reports that there are 150 to 200 cases per year of filicide-suicide in Tokyo, after which he presents data of 27 cases where a parent made a fatal or nonfatal suicide attempt in conjunction with a fatal or nonfatal filicide attempt. The study looks like a population study, and, is therefore, almost by definition mainly descriptive. However, Sakuta does not disclose on what basis these cases were selected for his study. It appears that one of the selection criteria was whether the police had information about it. Sakuta does not address to what extent this sample was representative for the population of persons making attempts at filicide-suicide. The manner in which the findings were presented suggests that Sakuta believed that the findings were representative for the situation in Japan.
Comment on Sakuta. It is remarkable that Sakuta’s study is widely quoted as being informative and implicitly representative of the situation in Japan while the limitations are not mentioned. The fact that Sakuta did not address the issue of the selection process may be in accordance with a common intellectual attitude in Japan that Iga (1996) had mentioned.

Comment on the Japanese situation in general.

Historically, neonaticide and infanticide without subsequent parental suicide for economic reasons as well as regular suicide appear to have been more prominent in Japan than they may have been elsewhere (Briggs & Cutright, 1994). In other words, when parents did not see a future for a child in their family, there was less hesitation to kill the child than one might expect in Western Europe. In addition, when the parent or parents see less of a future for themselves, there is less hesitation to commit suicide. As a result, it may not be very surprising that extended suicide is regarded with more tolerance in Japan than elsewhere, and is more frequent than it is known to be in other countries.

Studies presenting typologies, theories or other explanations

Berman (1996)

Berman (1996) distinguished four “dyadic death types and their core psychological features” (p. 349). The dyadic death types are erotic aggressive, unrequited love, dependent-protective and symbiotic. Berman’s erotic aggressive type has many features that make it similar to spousal h-s of the murderous jealousy variety, as it would be designated by Nock & Marzuk (1999). Cases of extended suicide, where the motive is altruistic, such as many cases of mfs as well as spousal h-s due to declining health would be categorized as dependent-protective by Berman. The
categories of *unrequited love* and *symbiotic* are associated with suicide pacts. The core psychological features of the *dependent-protective* and *erotic-aggressive* are represented in Table 4.3

<table>
<thead>
<tr>
<th>Type</th>
<th>Erotic-aggressive</th>
<th>Dependent-protective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Features</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship Type</td>
<td>Intimate Adults</td>
<td>Elderly Peer or Parent-Child</td>
</tr>
<tr>
<td></td>
<td>Interchangeable Roles</td>
<td>Caretaker-Dependent Object</td>
</tr>
<tr>
<td></td>
<td>Chronic Love-Hate</td>
<td></td>
</tr>
<tr>
<td>Level of Dependency</td>
<td>One-sided Enmeshed</td>
<td>High Unilateral</td>
</tr>
<tr>
<td></td>
<td>One-sided Ambivalent</td>
<td></td>
</tr>
<tr>
<td>Rage</td>
<td>Intrarelationship hostility</td>
<td>None evident</td>
</tr>
<tr>
<td>Trigger</td>
<td>Victim precipitated. Threat to Separate</td>
<td>Threat to caretaker’s functional ability to protect</td>
</tr>
<tr>
<td>Goal</td>
<td>To preserve relationship</td>
<td>Mercy; To preserve relationship</td>
</tr>
<tr>
<td>Mutuality</td>
<td>Unconscious Collusion</td>
<td>Absent or cooperative decision</td>
</tr>
</tbody>
</table>

*Comment on Berman.* Berman’s views as put forth in Table 4.3 clearly show the differences between the core psychological features of the erotic-aggressive and dependent-protective types very clearly. It is particularly interesting that in the dependent-protective type, there is no evidence of rage. Many studies implicitly or explicitly assume that there has to be rage. In addition, the remark on the threat to the caretaker’s functional ability to protect in the dependent-protective type is interesting, as Berman implies that it is equally valid for the Elderly Peer and the Parent-Child situation. The manner in which Berman presents the differences between these two

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31 Table is partially copied from Table on page 348
categories highlights the importance of not presenting h-s in a manner that encourages one to recognize only one category, i.e. the erotic aggressive type.

Berman (1996) does not include information on a psychotic component in his table, although in the accompanying text, he does refer to it. This suggests that a psychotic component is not a necessary and certainly not a sufficient condition for h-s of the dependent-protective type.

It is particularly relevant what Berman (1996) writes about filicide-suicide.

More common in Japan than in the United States, Oyako-Shinju (parent-child suicide) is motivated primarily by mercy. The parent (usually the mother) assumes that the child will be happier to die with the parent than suffer in a harsh world without parental protection. The cultural view of the child having existence only as an extension of the mother's body and spirit makes the child's death almost a necessary and logical extension of the mother's suicide. Filicide-suicides most commonly involve infants as victims (infanticide), although occasionally older children are slain. Often, however, the dynamics involved with the homicides of older children are more complex and include retaliatory hostility toward the other parent. (p. 345)

This quote illustrates the lack of clarity that is characteristic of many studies on h-s and mfs. First, Berman's (1996) remark about the cultural view suggests that Berman describes the Japanese view of filicide-suicide. To what extent this view is valid outside of Japan, and especially in the USA is not clear in this study. Second, Berman does not define infant, infanticide, or older children. Considering that infanticide at the time of the publication of Berman's study generally was defined as the killing of a child younger than one year old, we are led to believe that Berman is reporting that filicide-suicides mainly involve parents, especially mothers, committing suicide after they have killed their child, who is younger than one year. This would be a remarkable conclusion by Berman considering that most research (Nock & Marzuk, 1999) indicates that the parent's
suicide is rare after the killing of a child younger than one year. Berman’s remark about older children and retaliatory motives is hard to interpret without having information about the age of the victims. In addition, retaliatory motives have been reported to represent only a small minority of filicide-suicide cases (Bourget & Gagne, 2002).

Daly & Wilson (1988)

Daly & Wilson (1988) have developed a theory of human filicide based on evolutionary psychology, which will be described later in this dissertation. They have applied their theory to familicide, which, according to them, is mainly perpetrated by the father. They introduce two terms, accusatory and despondent, to describe the behavior of these fathers. The men who were despondent intended to save their family from a bad future, while the accusatory tended to act more out of anger.

With respect to mfs, they argue that a mother who makes a serious mfs attempt is acting against the principles of evolutionary psychology (especially the drive to survive and procreate), and therefore, must be mentally ill. It is not clear whether the authors are defining mental illness as a psychiatric disorder or as insanity. For instance, Daly and Wilson’s work (1988) is quoted by Cooper & Eaves (1996), as “the insanity hypothesis developed by Daly and Wilson”.

Comment on Daly & Wilson. It can also be argued that the mother who does not consider herself fit enough to survive or to be a parent, and therefore, kills herself is acting in line with the principles of evolutionary psychology. She does not want to burden the species with the kind of
misfit that she considers herself to be. It remains to be seen whether this argument would support Daly and Wilson’s view that mfs mothers are mentally ill.

For purposes of assessment of mfs ideation, the ideas of Daly and Wilson may be of limited value because they do not specify behaviors or characteristics that a clinician could evaluate.

Theories about disturbances of the self that are used in suicidology

Starzomski & Nussbaum (2000)

Starzomski & Nussbaum (2000) argued that current explanations for domestic homicide-suicide, by which he meant spousal h-s, rely too much on socio-demographic features and psychopathology. He proposes to add the explanatory power of a number of theories that deal with disturbances of the self to the current explanatory framework for domestic h-s. Starzomski & Nussbaum describes how a number of self-oriented theories have been applied to help understand simple suicide, whereupon he applies these theories to spousal h-s. Starzomski & Nussbaum points out that it is important to understand why some people’s lives are vulnerable to such rapid disintegration that they become capable of making h-s attempts. Understanding this might enable the clinician to recognize a patient’s potential for such rapid disintegration, under what circumstances the patient is most vulnerable, and what the signs are of the disintegration actually occurring. In other words, Starzomski & Nussbaum believes that the application of the self-oriented theories with their emphasis on the impact of the interaction between a person and his or her
environment may help us understand why people with similar psychopathology react in different ways to certain external events.

The theories that are discussed by Starzomski & Nussbaum which have been applied to simple suicide include ‘Escape from Self’ (Baumeister, 1990), ‘Self-continuity, including so-called ‘warranting strategies’ (Chandler, 1994), and ‘Evolution of Self’ (Kegan, 1982) as well as several others. These theories will be discussed in more detail in the chapter on the applicability of suicidology. One of the other authors quoted by Starzomski & Nussbaum is Palermo.

*Palermo (1994)*

Palermo (1994) describes how the act of consortial/spousal h-s may have certain features that would justify considering it as extended suicide. The perpetrator first kills his partner because she is part of his (misperceived) extended self.

Terms used by Palermo to describe the slide towards h-s include “realistic emotional bankruptcy”, “perceived social pressures elevating a failed relationship into a generalized personal sense of failure and social shame”, and “feelings of inadequacy, ambivalence, and incompleteness claiming victory”. The word ‘psychosis’ is not used by Palermo. In other words, the mental processes that lead some men towards a path where they start having h-s feelings that they sometimes act on, may be unhealthy but they are not the product of a psychotic or otherwise organically damaged mind. These mental processes can become understandable in the context of the interaction between the h-s male and his environment.
Comment on Starzomski & Nussbaum and Palermo

Starzomski & Nussbaum's emphasis on rapid disintegration and the fact that the background and personality of some people makes them especially vulnerable to such disintegration represent concepts that may have much potential to be applied to cases of mfs behavior as well.

The weight that Palermo attaches to self-oriented and environmental factors relative to individual psychopathology echoes Starzomski & Nussbaum. Therefore, many of the findings of Palermo's study about spousal h-s probably can be applied to mfs for the same reasons that Starzomski & Nussbaum's findings about domestic/spousal h-s could be applied to mfs.
CHAPTER 5

MATERNAL FILICIDE-SUICIDE FROM THE PERSPECTIVE OF FILICIDE

Introductory Remarks

Filicide accompanied by a fatal or nonfatal suicide attempt by the filicidal parent accounts for 30 to 70% of all filicide. (Adelson, 1961; Adelson, 1991; Alder & Polk, 2001; Alder & Baker, 1997; Bourget & Gagne, 2002; D’Orban, 1979; Haapasalo & Petaejae, 1999; Somander & Rammer, 1991). The percentage is higher for intentional filicides, i.e. filicides other than fatal child abuse. The percentage is also higher when the children are older than 12 months.

In most cases, the suicide attempt is the primary drive for the filicide-suicide attempt. Many of such attempts are referred to as extended suicide. Understanding suicidal behavior can be considered key to understanding filicidal-suicidal behavior, and by extension, a good portion of all filicidal behavior.

The reviewed studies have been reexamined for their relevance to aspects of filicide-suicide. Special attention has been paid to the role of depressed and potentially suicidal mothers of young children (dpsmyc) who are in ongoing psychotherapy on an outpatient basis.
Overview of Chapter 5

The variety of the studies that are included in this chapter of the literature review is reflected in the sections in which the chapter is divided and their headings.

Studies published prior to 1980

These studies present a historical overview. Included are two hospital studies (McDermaid & Winkler, 1955; Tuteur & Glotzer, 1959), three population studies (Adelson, 1961; Myers, 1970; Rodenburg, 1971), and one psychiatric evaluation study of all cases of maternal filicide in a part of England and Wales (D’Orban, 1979). Also included are two studies that combine aspects of a hospital study with a theoretical contribution and a proposal for a classification system (Harder, 1967; Resnick, 1969), as well as two studies about parents with obsessions of infanticide (Chapman, 1958, Button & Reivich, 1972).

Population studies on child homicide and filicide in the USA

The review of population studies on child homicide and filicide in the USA includes several studies about underreporting as well as studies that label most forms of filicide, including filicide-suicide, as fatal child abuse.

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This review will be limited to studies published after 1950. To the extent that the studies from the second half of the last century refer to studies from the first half, attention will be paid to these early publications.
Population studies conducted outside of the USA

All studies reviewed here include all known cases where the parent made a fatal suicide attempt as well as all known cases where there was no suicide attempt or a nonfatal one. The findings and conclusions reached in such studies tend to differ from studies that only include parents who did not make a suicide attempt or a nonfatal one as well as from studies that only include parents who made both a fatal filicide and a fatal suicide attempt. There are indications that the predisposing and precipitating factors in filicide cases involving fatal suicide attempts by a parent may be different from cases where there is no or only a nonfatal attempt, although, of course, there is overlap.

Population studies limited to living persons

All studies in this section only include parents who made no suicide attempt or a nonfatal one. Some of these studies, especially the one by D’Orban (1979) that was mentioned earlier have extensive information on the offending parents. In several countries outside the USA, especially the Scandinavian countries the amount of information that is available on individuals, such as their medical records, including mental health data, is extensive compared with the USA and allows for a more comprehensive investigation than is possible in most parts of the USA.

Selected Samples: Hospital and Prison Studies

Authors of hospital and prison studies usually examine in some detail a small group of selected patients. Usually a psychiatric evaluation forms an important part of the study. Some of these hospital/prison studies contain samples that are designated unselected because they include
all the patients/inmates who share a similar background, such as suffering from or being charged with/having been convicted of filicide or attempted filicide.

**Selected Samples: Psychiatric Evaluation Studies**

This section includes two studies. The first one (*Lewis, Baranoski, Buchanan, & Benedek, 1998*) deals with the relationship between psychosis and weapon use by filicidal mothers. The second study (*Holden, Stephenson Burland, & Lemmen, 1996*) consists of a comparison of filicidal mothers who had been found NGRI with filicidal mothers who had been found Criminally Responsible (CR). In my review, the data of the NGRI group are re-analyzed.

**Selected Samples: A study based on Newspaper Accounts**

Included here is a study by Meyer & Oberman (2001) about maternal filicide in the USA that was based exclusively on information found in newspapers.

**Review and Background Studies**

Included are studies that are not primarily organized around the examination of patients, such as review studies (*Stroud, 1997; Stanton & Simpson, 2002*), and special studies about a specific aspect of filicide, such as the possibility of a relationship between the gender of the parent and the gender of the victim. (*Marleau & Laporte, 1999; Marleau et al., 1995a*)
Studies prior to 1980

McDermaid & Winkler (1955)

McDermaid & Winkler (1955) studied 12 mothers who had been hospitalized after killing or trying to kill one or more of their children. In their discussion of the results, they singled out six mothers. To explain the behavior of these six mothers they introduced the concept of child-centered obsessional depression (CCOD), of which the symptoms are depression, suicidal ideation, a perceived inability to care for the child, feelings of worthlessness, and obsessive fears about the child’s health and well-being, including thoughts that something could happen to the child, such as death.

This combination of symptoms can lead to compulsive efforts to protect the child against the perceived dangers. In addition, the desperate mother’s feelings of helplessness and hopelessness can lead her to do for her child what she believes needs to be done, including filicide or filicide-suicide. These mothers are described as psychoneurotics whose psychopathology generally does not include schizophrenia or psychosis, whose depression often is masked, and whose suicide attempts and suicidal preoccupation sometimes are not taken seriously by their environment, including clinicians.

A key feature of the CCOD is catathymic thinking, defined as a “transformation of the stream of thought as a result of certain conflicts of ideas that are charged with either a strong affect, usually a wish, a fear, or an ambivalent striving. . . . [The catathymic thinking can] give rise
to delusions of persecution or of reference” (p. 35), as a result of which violent acts may be carried out against others or self. McDermaid & Winkler also referred to Kretschmer (1934), who had pointed to the role that anxiety could play in the formation of catathymic thinking and the explosive behavior to which it can lead. In this context, McDermaid & Winkler quoted Kretschmer (1934) who had elaborated on the concept of raptus melancholicus, as a phenomenon where “anxiety and desperation surge up critically. This can lead to suicide and terrible acts of violence, especially in the murder of the patient’s own family members” (McDermaid & Winkler, 1955, p.36).

The etiology of catathymic thinking and the CCOD is associated with the (unconscious) mechanism of introjection where the original aggression against a parent or a parent surrogate is internalized and the “aggravation of this mechanism leads to depression and subsequent self-destructive tendencies”. (p. 36). In other words, “the depressive state weakens the ego functions, as a result of which suicidal tendencies become manifest, and the child that is considered as part of the person’s own body may become the victim of self-destruction” (p. 37). McDermaid & Winkler do not explicitly link CCOD to cases of filicide followed by suicide, although several of the cases described in the McDermaid & Winkler study involve nonfatal suicide attempts.

McDermaid & Winkler emphasize that the obsessional thoughts are symptomatic of a depressive state with suicidal ideas, and, therefore, different from the way obsessions usually are regarded from a clinical point of view. This point of view holds that persons with so-called harm obsessions will not act upon them, which is not necessarily the case with the type of obsessive thoughts that mothers with CCOD are experiencing.
McDermaid & Winkler link CCOD to studies in the 1930’s by Zilboorg (1932a, 1932b) and Bender (1934) that deal with the relationship among depression, suicidality, displacement of aggression from a parental figure onto one’s child, and the possibility of filicide-suicide.

Comment on McDermaid and Winkler

CCOD is referred to extensively in many later studies in order to explain filicidal and/or filicidal/suicidal behavior.

The fact that depression of the CCOD mother often is masked and that her suicidal behaviors may not be taken seriously by the environment suggest a person who may come across as exercising sufficient control over herself. This might lead the environment to minimize the seriousness of depressive symptoms or suicidal gestures.

The definition of catathymic thinking, which includes ambivalence and conflicting thoughts, in combination with McDermaid’s description of the symptoms of CCOD33 suggest elements of social anxiety, rejection sensitivity, and other aspects of anxiety such as PTSD. The suggested interaction of symptoms of depression and anxiety, and the spiking nature of some of the symptoms, reminds one of recent suggestions about the presence of a bipolar spectrum. This spectrum is believed to include various configurations of atypical depression, panic attacks, mania, social anxiety (Perugi & Akiskal, 2002), as well as many of the symptoms associated with

33 McDermaid and Winkler speak of depression, suicidal ideation, a perceived inability to care for the child, feelings of worthlessness, and obsessive fears about the child’s health and well-being, including thoughts that "something could happen to the child", such as death.
Borderline Personality Disorder. The possibility of an association between filicidal-suicidal behavior and a bipolar spectrum will be further addressed in Chapters 6, 7 and 8.

The remarks by McDermaid & Winkler about mothers as psychoneurotics whose psychopathology does not include schizophrenia or psychosis combined with their remarks about delusions of persecution or of reference as a potential result of catathymic thinking seem to suggest that someone who is not psychotic or schizophrenic can nevertheless suffer from delusions of persecution or reference. This conceptualization could aid in understanding what drives people who are not known to be suffering from a thought disorder to make attempts at filicide-suicide.

The recent conceptualization of a number of previously loosely connected symptoms being part of something like a bipolar spectrum seems to fit in the pattern of McDermaid & Winkler’s thinking. More specifically, feelings of panic or anxiety attacks that can occur without a diagnosis of schizophrenia sometimes escalate to the point where they give rise to thoughts that, in my opinion, may be hard to distinguish from delusions of persecution or reference. The reference to delusions, on the one hand, and the lack of a clear diagnosis of psychosis prior to an mfs attempt, on the other hand, is a theme that is present in many studies. Possibly, the definition of delusions plays a role here. Many of the case studies contain examples of thoughts that mothers had expressed prior to a subsequent mfs attempt. After the mfs attempt the thoughts were designated

34 When speaking of feelings of panic and anxiety as sometimes hard to distinguish from delusions, one is reminded of Kretschmer’s (1934) raptus melancholicus where “anxiety and desperation surge up critically and can lead to suicide and acts of violence against family members” (McDermaid & Winkler, 1955, p. 36)
delusions, especially altruistic delusions and delusions of rescue, while such thoughts prior to the act probably would have been regarded as mere cognitive distortions or maybe superstitions. The issue of delusions or delusion-like thoughts as symptoms of other psychiatric disorders, such as Borderline Personality Disorder or the aforementioned bipolar spectrum, will be further addressed in Chapters 6, 7, and 8.

**Tuteur & Glotzer (1959)**

Tuteur & Glotzer (1959) examined five mothers hospitalized after fatal attempts at filicide. Four of them had made a nonfatal suicide attempt, and two of these four had killed multiple children. Tuteur pointed to the following aspects that most of the cases, especially the four mfs cases had in common:

- “Suicide-murder may be interpreted as an attempt to remove the total-all, the actual and the extended self, so that nothing of the self remains” (p.450)
- Feelings of extreme inadequacy and inability to raise children
- Evidence of much anxiety, apprehension and a great deal of underlying conflict that had not been resolved
- “Coolness from one or both parents during childhood, when the concept of motherliness begins to develop in the female” (p.450)
- “A deep feeling of rejection by at least one important figure, creating a feeling of insecurity and non-acceptance of self to such a degree that life became unbearable and the total-all had to be removed.” (p.451)
- Difficulties with spouses
- Physical deficiency of one of their children, which may have contributed to own feelings of worthlessness and suicidal intent
- The likelihood of a diagnosis of schizophrenia, probably acute state at the time of the act
• “A faulty balance between logic and affectivity, at least during the act” (p.451), which indicates *schizophrenic thinking*

• Feelings of regret after the act

*Comment on Tuteur & Glotzer.*

Tuteur & Glotzer reported serious and long-term difficulties, including suicidal ideation, in the lives of the four mothers who had made a nonfatal suicide attempt in conjunction with their fatal filicide. Tuteur’s summary of the individual case histories indicates that some mothers had been thinking for some time about filicide-suicide. Tuteur reports that something happened that made it impossible for these mothers to maintain their repression of this ideation and of the urge to act on it. In this regards, he speaks of a faulty balance between affectivity and logic, which led to the schizophrenic thinking that was present at the time of the act. Tuteur also reports that the history of most of the five mothers included events that suggested a pattern that is typical for schizophrenia and may have culminated in the schizophrenic thinking that was present at the time of the act, and may have triggered the act.

*Adelson (1961)*

Adelson\(^35\) conducted the first population study in the USA when he examined child homicide during the 17-year period from 1944 to 1961 in Cayuga County, Ohio, which comprises Cleveland and surrounding areas. He found that of the 46 victims of child\(^36\) homicide, 36 had been

\(^35\) A follow-up study about the period 1970-1986 (Adelson, 1991) will be discussed later.

\(^36\) The age limit was not specified other than that the study involved preadolescent children, while neonaticides were not included.
killed by one of their parents. Five fathers and three mothers made a fatal suicide attempt and five
parents/mothers a nonfatal one. The 13 parents known to have made fatal or nonfatal suicide
attempts must have killed approximately 18 children. This would mean that 0.5 children per year
per million of the general population (presumably 2 million) were killed by a parent in conjunction
with a fatal or nonfatal suicide attempt by the parent.

The 13 parents known to have made a fatal or nonfatal suicide attempt were all white. Adelson reported that most of the suicidal parents had psychotic symptoms at the time of the act. The eight parents who were committed to a psychiatric institution included five mothers, three, four or all of whom may have made a nonfatal suicide attempt and two fathers, one or both of whom may have made a nonfatal suicide attempt. These seven parents were all white. The eighth person committed to psychiatric care was a black woman. There was no additional information on diagnoses other than that “frank psychosis in the assailant was the single most common factor in precipitating the fatal incident” (p. 1346). Adelson also remarked, “Seventeen persons were patently mentally ill when they unleashed the show of violence. Included in this were seven fathers who attempted to or succeeded in wiping out their entire families” (p. 1346)

37 Adelson’s remark that five “assailants” made a nonfatal suicide attempt is not specific about the assailants’ gender. There is a possibility that two fathers were among these five assailants, based on Adelson’s report that “seven fathers had attempted to or succeeded in ‘wiping out’ their entire family”, which had been nonfatal in two cases.

38 Adelson reported that 17 fathers and 11 mothers had killed 34 children. Nine of the fathers were reported to have killed one child in incidents of fatal child abuse and not to have made a suicide attempt, which leaves 25 children for 8 fathers and 11 mothers. Considering that multiple killings usually are associated with suicide attempts by the parents it is highly likely that the 13 parents known to have made a fatal or nonfatal suicide attempt were responsible for the homicides of 17 to 19 children, in other words “approximately” 18 children.
Harder (1967)

Harder (1967) studied the records of 24 hospitalized filicidal parents, 14 of whom were mothers, in order to better understand and conceptualize filicide, especially the notion of altruistic filicide. The 14 maternal cases included three neonaticides, three cases with a clear presence of postpartum psychosis, one clear delusional case, and seven cases where the mother had contemplated a suicide attempt in conjunction with the filicide. Five of these seven mothers carried out their plan and made a nonfatal suicide attempt, while the two others did not carry out their plan for suicide.

Harder refers to Gormsen (1962) when he suggests that mfs was more prevalent in Denmark than in most other countries. He also reported that close to 90% of maternal filicides were followed by a suicide attempt, and that 9 out of 10 of these attempts were fatal. The subjects for the study were selected based on availability. First, they were among the few mfs mothers, whose suicide attempt had been nonfatal. Secondly, it appears that the presence of a hospital record with enough information was a criterion. Some of the records used dated back to 1924.

Close reading of the seven cases where suicide had been contemplated shows that the mothers had acted in an impulsive rather than in the deliberate manner that is known to characterize mfs attempts where both the attempt at filicide and suicide is fatal.

Based on his examination of these records as well as on his understanding of the literature, Harder rejects the notion of altruistic filicide. He believes that hostility towards the child played a larger role than the women had suggested. He also argues that the motives of mothers
who claim to be altruistic, in fact, are syntonic. The argument that they should be saving their children from a bad future is countered by Harder with a reference to the concentration camps in World War II. Harder relates that maternal filicide in the concentration camps was rare, although the mothers had sufficient reason to believe that their own future as well as the future of their children was bleak.

Comment on Harder. Harder apparently assumes that clinically the cases studied by him are similar to cases where the suicide attempt was fatal. Harder’s “subjects” reportedly were hostile, while this is not an obvious characteristic of mfs (Berman, 1996) except for retaliating mothers, who kill a child to spite its father (Resnick, 1969; D’Orban, 1979), and then make a suicide attempt that often is nonfatal. It also has to be kept in mind that Harder’s information came from hospital charts, some of which dated back to the early 1920’s.

In his review of the literature, Harder (1967) does not refer to West (1965), whose landmark study included 78 cases of fatal suicide attempts after fatal homicide attempts, more than half of which were filicides. In fact, the English situation described by West was very similar to the one in Denmark. Prevalence of mfs in Denmark and England was among the highest in Europe at the time, and most mothers used coal gas that had not yet been detoxified, which probably accounted for the high rate of lethal outcomes. Harder’s comment on concentration did not take into account prior psychopathology.
Myers (1970) reported that 30 mothers and 10 fathers had killed respectively 35 and 14 preadolescent children in Detroit between 1940 and 1965.\textsuperscript{39} Five mothers and seven fathers had made a fatal suicide attempt and an additional seven mothers a nonfatal one. Two of the suicidal mothers had killed two children and one three. Several of the suicidal fathers also must have killed multiple children considering that there were 14 victims for all 10 fathers, but specific information is not provided. With a population of 2 million, a 25-year time span, 16 victims of mfs\textsuperscript{40} and between 7 and 11 of paternal filicide-suicide, we have a rate of approximately 0.5 child per million of the general population per year killed in conjunction with parental suicide.\textsuperscript{41}

\textsuperscript{39} Seventy-one perpetrators had killed 83 victims in what Myer called felonious homicides. Of these 71, 40 parents had killed 49 children.

\textsuperscript{40} Psychotic depression reportedly played a major role in the cases of the women who made an mfs attempt. Seventeen of the 31 mothers involved in filicide were Caucasian and 14 black. A racial breakdown for mfs is not provided.

\textsuperscript{41} This rate might be somewhat higher in light of the fact that perpetrators responsible for the death of an additional 51 children had not been prosecuted for a variety of reasons. Reasons included a lack of evidence or the death having been ruled an accident. Some of these 51 cases may have included parents who made a nonfatal suicide attempt in conjunction with a filicide.
Resnick (1969)

Resnick (1969) was able 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 generally been described as requiring the presence of psychotic symptoms at the time of the act (Sadoff, 1995; Tuteur & Glotzer, 1959). As a result, so I assume, filicide-suicide had been considered largely unresponsive to the traditional assessment methods used for simple suicide. Resnick’s study has already been reviewed in Chapter 1. A summary of the most important aspects will be presented at this point.

Resnick proposed six categories: altruism, battering, retaliation, neonaticide, unwanted children, and acute psychotic episode. Cases were assigned to a category based on the filicide motive. Cases where no motive could be found were assigned to the acute psychotic episode. In an updated form, this system is still being used.

Mothers making fatal or nonfatal suicide attempts after their filicide were usually assigned to the altruism category because they believed that their children would be better off dead in the event of their suicide.

In the USA, Resnick’s work had been preceded by Bender (1934), who described a process of filicidal and suicidal urges alternating and/or merging with each other, as well as by McDermad & Winkler (1955), who referred to the possibility of filicidal-suicidal ideation in an indirect manner.
The great majority of Resnick’s subjects were derived from hospital studies of the previous 200 years. Because hospital studies only deal with living persons, there were only four cases where the filicidal mother’s suicide attempt had been fatal. Three of the four fatal suicide attempts by a mother came from one population study conducted by Adelson (1961). Since Resnick included studies in 13 languages from all over the world in his review, it is not clear why he did not make use of West’s study (1965) that contained 31 mfs cases with a fatal suicide attempt in England between 1954 and 1961.

Resnick concluded that the psychodynamics of filicide-suicide were different from other forms of filicide, and that suicide rather than homicide was the dominant force in most cases and that preventing suicide would have prevented filicide. Resnick also appears to 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 is crucial for the clinician who is treating or evaluating these mothers.

Resnick regards as potentially dangerous in terms of possible acts of filicide or filicide-suicide those depressed mothers of young children who “have fears about harming their children and overconcern about their children’s health” (p.333) or who openly express filicidal or filicidal-suicidal ideation or plans. Resnick draws here on the study by McDermaid & Winkler (1955) that was discussed earlier.

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.

Although Resnick's study was not a population study, its findings sometimes have been quoted as if they came from a population study.

**Rodenburg (1971)**

Rodenburg (1971) studied filicide in Canada during the five-year period from 1964 through 1968. He found that 31 mothers each killed one child, and 10 mothers killed two or more, so that 41 mothers killed 54 children. Twelve mothers made a fatal suicide attempt and five a nonfatal one.

Rodenburg also studied paternal cases, and found that the relationship between the gender of the assailant and that of the victim, “fathers tending to kill boys and mothers girls” (p.43) was significant. Rodenburg also commented on the possibility of a relationship between the age and the sex of the victims,

A possible association between the age and the sex of the victim was also examined. The tendency for older children to be male, with a more equal sex division for younger victims, just failed to reach the 5 per cent level of significance. (p. 43)

The 41 mothers killed 30 girls and 24 boys, all under the age of 16. Closer examination (by me) of the data shows that in the age range of one through 5 years the mothers killed 16 girls and 8 boys, while there is no difference between boys and girls under the age of 1 and over 6. There
are no data to determine whether suicidal and nonsuicidal mothers differ with respect to the gender of the victim.

In terms of etiology, Rodenburg presented a review of the literature, and concluded, therefore, child murders performed by parents in a depressed state would thus suggest several etiological factors:

a. A certain type of personality structure
b. An inadequacy in handling aggression, which is considered to have originated from a disturbed relationship to the parental figures (i.e. internalization of the original aggression)
c. A possible relationship between a. and b
d. A disturbed relationship with the child, characterized by the inability to provide for a mature, giving relationship (p.47)

Comments on the possibility of a relationship between the gender of the mother and her victims

It is interesting that Rodenburg did not comment on the fact that for the mothers the ratio of killing girls to boys to girls in the 1-5 age range was 2 to 1, while it was 1 to 1 for the other ages.

Marleau & Laporte (1999) and Marleau et al. (1995) suggest the possibility that altruistic mfs mothers might be more inclined to believe that their daughters rather than their sons might have as miserable a life as they have had. This thought would put girls at greater risk in some situations than boys. Marleau did not differentiate between simple filicide and filicide-suicide. However, filicides motivated by the thought that her children will have as miserable a life as she remembers to have had may carry a higher risk of being followed by a fatal or nonfatal suicide attempt. Retaliating mothers, on the other hand, according to Marleau et al., might be more likely to
kill boys in order to spite the father, and make a nonfatal suicide attempt (possibly after an interval) or no attempt.

It is known (Nock & Marzuk, 1999) that mothers of children between the ages of one and six are more prone to make fatal or nonfatal suicide attempts in conjunction with filicide than mothers of children who are younger than one year. It is also known that, regardless of suicidal behavior, mothers are less likely to kill children over the age of six than under the age of six. Against this background, an elevated risk of mfs associated with gender would put mothers of daughters between the ages of one and six and the daughters at increased risk for mfs. In addition, there might be an elevated likelihood of mfs ideation in these situations. This question will need more research, and will be discussed further in Chapters 6, 7, and 8.

Comments on Rodenburg's remarks on etiology

The suggestions about etiology have a heavy emphasis on psychopathology. They also are based on assumptions about the presence of aggression and a disturbed relationship between the mother and the child. It is not clear to what extent there is support for these assumptions in the literature.
D’Orban (1979)

D’Orban (1979) studied 89 of the 104 women from the South East of England, including London, who during the six-year period from 1/1/1970 through 12/31/1975, had been charged with killing or trying to kill one or more of their children under the age of 16. All the women from this region who during this period had been charged with this crime were remanded in a special prison, Holloway, where D’Orban examined them. All information about the women’s medical and mental health history was available for the study.

D’Orban’s study is one of the first population studies where all subjects were psychiatrically examined. Previous studies involving psychiatric evaluations mostly consisted of case studies of selected patients in a hospital setting.

Using a combination of earlier systems of classification (Resnick, 1969; Scott, 1973) D’Orban established six categories: 
- battering, neonaticide (killing of infant during first 24 hours of life),
- mentally ill, retaliating, unwanted child (older than 24 hours) and mercy killing.

He compared the mothers in the various categories with each other on a number of independent variables (for instance, the presence of a psychiatric history or the age at which the first child was born) and dependent variables, such as filicide methods used.

The retaliating group is described as “aggression directed against the spouse displaced onto the child” (p. 561), while the mentally ill category is described by D’Orban as

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43 Of the 15 that were not included, four had children over 16, while there was not enough information on 11 of the mothers.
Cases suffering from psychotic illness, cases of acute reactive depression associated with a suicidal attempt and cases of personality disorder with depressive symptoms of sufficient severity to require admission to psychiatric hospital and who did not meet the criteria of the other categories. (p.561)

Of the 89 women included in the study, 24 were placed in the mentally ill category and 9 in the retaliating category. These two categories contained 17 of the 18 mothers, who had made a nonfatal suicide attempt in conjunction with the filicide, 14 of them simultaneous with or immediately after the filicide. In the cases of the other four mothers, there was an interval between the filicide and the suicide attempts, which "was motivated by remorse rather than forming part of a previously conceived murder-suicide plan" (p.566). Three of these four cases were in the retaliating group and one in the battering category. None of the 89 mothers in D'Orban's study killed or tried to kill their spouse in conjunction with their filicide.

D'Orban reports that the mentally ill and retaliating groups probably were underrepresented in his study when he quoted Gibson and Klein, who reported that during a previous six-year period, 1955-1960, there were 113 maternal killers, of whom 70 had committed suicide prior to trial.44 A similar ratio applied to D'Orban's 104 remanded mothers would have meant that there had been 169 fatal suicide attempts by mothers during the period covered by D'Orban's study. Yet, no information was provided on the number of mothers who had made a fatal attempt at both filicide and suicide had come down from 12 per year during the 1950's and early 1960's in England and Wales to 5 per year during the second part of the 1960's. He also did not mention that there were fewer recorded cases of battering in England and Wales from 1950 to 1960 than in the 1970's. By reporting specific numbers (70 vs. 43) without providing any qualifying comments, D'Orban could be seen to imply that a similar ratio applied to his study, which could have resulted in as many as (104 x 70/43=) 169 mothers with a fatal suicide attempt.

44 D'Orban quoted this information without adding that the number of cases, where a mother made a fatal attempt at both filicide and suicide had come down from 12 per year during the 1950's and early 1960's in England and Wales to 5 per year during the second part of the 1960's. He also did not mention that there were fewer recorded cases of battering in England and Wales from 1950 to 1960 than in the 1970's. By reporting specific numbers (70 vs. 43) without providing any qualifying comments, D'Orban could be seen to imply that a similar ratio applied to his study, which could have resulted in as many as (104 x 70/43=) 169 mothers with a fatal suicide attempt.
suicide attempt during D'Orban’s study or on any other details concerning their suicide.

Comparisons between the suicidal women who survived and those who did not survive, are, therefore, not possible.

The mentally ill mothers who made nonfatal suicide attempts were primarily bent on killing themselves and decided that it would not be fair to leave the children behind, according to D’Orban. In almost all cases, suicide was the primary motive.

In one, possibly two cases, the mother might have decided that the child’s future suffering could only be relieved by death, and then decided to commit suicide in the wake of that, i.e. as a reaction to her killing her own child the mother tried to kill herself. D'Orban suggests that these mothers' ideas about the future suffering of their child were delusional.

In other words, D’Orban appears to differentiate between two types of mfs mothers. Mothers of the first type, who represent the overwhelming majority, attempt mfs because they want to commit suicide and take the children along in order to protect them from a life without a mother. Mothers of the second type kill their children in order to protect them against future suffering, which is based on delusional ideas, and then kill themselves because they had to kill their child. To illustrate the delusional nature of such ideas, D’Orban remarks, “For example, a puerperal psychotic mother killed her two children ‘to save them from a violent world’ and another killed her child ‘to prevent him from becoming schizophrenic.’” (p. 565). It is worth noting that D’Orban did not speak of delusional ideas in the context of the suicidal behavior of the first group, i.e. the women who primarily wanted to kill themselves and decided to take their children along to save them from
a life without their mother. This suggests the possibility that the 10 mentally ill mothers diagnosed with reactive depression or a personality disorder might have been heavily represented among the 13 mothers making a nonfatal suicide attempt. In comparison, nonfatal suicide attempts among the 14 mothers diagnosed with psychosis would have occurred less frequently, relatively speaking.

D’Orban’s study also includes nonfatal filicide attempts by the charged mothers. For instance, the 24 “mentally ill” mothers had 41 victims, of whom 19 survived. In fact, eight of the 24 mentally ill mothers caused no fatalities at all. “Survival of the victim in these cases was quite fortuitous and usually occurred as a result of the mother attempting to poison or to gas herself and her children and being rescued in time.” (p.564)

The eight mothers without a fatal filicide attempt plus five other mothers, mainly from the retaliating group, whose children survived the filicide attempt, reportedly were not different from the ones whose filicide attempt was fatal. D’Orban does not define what he means when he writes that those with fatal filicide attempts were not different from those whose attempts were not fatal. Possibly, he is suggesting that the nonfatal outcome of the attempt was due to a coincidence and not due to lack of motivation or planning. However, this point needs further clarification.

Of the 24 mentally ill mothers, six were reported to have killed their only child,45 while 14 had killed or tried to kill multiple children. Of these 14, 11 mothers had two victims, two had three,

45 In all other cases, D’Orban spoke of killing or trying to kill. This suggests that these six mothers killed rather than killed or tried to kill their only child, which suggests the possibility of nonfatal filicide attempts.
and one had five. This adds up to 33 victims of mothers killing multiple children. By definition, the remaining four mothers only killed one child, while they had more than one child. They also must have been the “other” four mothers who were unlike the 20 mentally ill mothers who killed or tried to kill all their children.

In this regard, it is interesting that D’Orban mentioned that the average number of children of the 24 mentally ill mothers was 2.29. This would mean that the 24 mothers had 55 children, and that the four mothers who only killed or tried to kill one child while they had more than one child had 18 children among the four of them: the 14 children, who were not among the reported 41 victims, plus one victim for each of the four mothers. A problem with this line of reasoning is presented by the fact that the number of victims of the 24 mentally ill mothers appears to be 43 rather than the 41 reported by D’Orban. Six ‘only’ children, 33 victims of mothers killing or trying to kill multiple children, and 1 victim for each of the 4 mothers with more than 1 child, but only 1 victim adds up to 43 victims.

D’Orban reported that the birth order of the victims did not differ significantly among the various categories. Forty-one % of the victims in the mentally ill group were first-born.

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46 They did not kill multiple children, as 14 of the other mothers did, and they did not kill an only child as six of the mothers reportedly did.

47 This refers to D’Orban’s report that 20 of the 24 mentally ill mothers killed or tried to kill all their children.

48 Studies on maternal filicide suggesting that the birth order of victims is not random, and might help in understanding the phenomenon of maternal filicide generally refer to the 1979 study by D’Orban, who is quoted as having found that the first-born is at an especially high risk. A close examination of this study shows that D’Orban only reported that the birth order of the victims did...
**Diagnosis and prior psychiatric treatment**

Of the 24 mentally ill mothers, the following was the psychiatric diagnosis at the time of the offense: Personality disorder\(^{50}\), reactive depression 6, and psychotic illness 14, of which seven reportedly were associated with postpartum, while 4 were diagnosed with schizophrenia, 2 with paranoid psychosis, and 1 with depressive psychosis. Of these 24 mothers, thirteen made a nonfatal suicide attempt simultaneous with or immediately after the filicide, while another three mothers did not carry out their suicide plan.

As to the mentally ill group, at least 60% had received psychiatric treatment in the past, and close to 40% were receiving treatment at the time of the crime. As stated before, 16 out of the 24 had attempted or planned to attempt suicide simultaneously with the filicide attempt, while no such attempts were made in the other groups with the exception of one ‘simultaneous’ case in the retaliating group.

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\(^{49}\) D’Orban did not address the issue of multiple victims in this regard: there were 14 mothers with multiple victims in the mentally ill group, and only 5 mothers with multiple victims in all other groups combined. Therefore, the percentage of mothers in each group killing or trying to kill their firstborn is much higher in the mentally ill group than in the other groups. After all, 20 of the 24 mentally ill mothers were reported to have killed or tried to kill all their children. By definition, this includes the first-born. However, the birth order of the victim appears to be irrelevant when a mother is intent on killing all her children.

\(^{50}\) The author only specifies personality disorder for the entire sample (ICD, WHO, 1974: asthenic 13, antisocial 10, hysterical 10, explosive 6 and paranoid 1, for a total of 43 mothers whose main diagnosis was that of a personality disorder)
D’Orban reports that eight of the nine retaliating mothers had a personality disorder and one had a reactive depression. Almost all the retaliating women had made several suicide attempts in the past. It is interesting that only one out of the nine retaliating mothers attempted suicide simultaneously with the filicide attempt, and three made attempts after “an interval”, out of remorse. They also had the highest rate of psychiatric disorders of any of the six groups. Of these nine mothers, 89% reportedly had received psychiatric treatment. No information on previous suicidal behavior in the other groups, including the ‘mentally ill’ group is provided.

**Correlates**

D’Orban compared the mothers in the various categories with respect to the presence of approximately 20 independent variables. D’Orban did not provide information on the extent to which these variables are present in the general population. D’Orban found that the retaliating women had experienced the highest level of stress, followed by the battering women, and thirdly the mentally ill women. The sources of stress varied among the various categories. Mentally ill women reportedly had more psychiatric stress than the other groups, i.e. they were experiencing stress due to being depressed and/or psychotic. Financial stressors, which were relevant for the batterers, played less of a role for the mentally ill mothers, according to D’Orban.
Table 5.1: Potential correlates of Maternal Filicide: Mothers’ family of origin

<table>
<thead>
<tr>
<th>Variable</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of family of origin</td>
<td>3 children on average</td>
</tr>
<tr>
<td>Birth order of mother</td>
<td>No specific pattern</td>
</tr>
<tr>
<td>Criminal Hx family of origin</td>
<td>9% of all 89 mothers; little difference between the 6 groups here</td>
</tr>
<tr>
<td>Psychiatric Hx parents</td>
<td>25% of all 89 mothers; little difference between groups</td>
</tr>
<tr>
<td>Parental discord</td>
<td>9 out of 38 non-battering mothers, so about 24%</td>
</tr>
<tr>
<td>Severe Parental maltreatment</td>
<td>12% for non-battering mothers, 6 out of 53</td>
</tr>
<tr>
<td>Separation from parents, one or both, before age 15</td>
<td>20% of all mothers</td>
</tr>
</tbody>
</table>

Table 5.2: Potential correlates of Maternal Filicide: Mother’s own situation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal History</td>
<td>4 out of the 24 mentally ill. All offenses were non-violent, shoplifting, stealing, and solicitation. Most of the other groups had higher percentages.</td>
</tr>
<tr>
<td>Having an Illegitimate child</td>
<td>7 out of 53 non-battering mothers</td>
</tr>
<tr>
<td>Overseas born</td>
<td>7 out of 53 non-battering mothers</td>
</tr>
<tr>
<td>Marital discord</td>
<td>48% for the mentally ill; lower than other groups.</td>
</tr>
<tr>
<td>Housing problems-stress</td>
<td>Housing problems-stress: 8 out of 53. non-battering mothers.</td>
</tr>
<tr>
<td>Physical assault</td>
<td>5 out of 53 non-battering mothers, reported to have been physically assaulted by their husbands or boyfriends</td>
</tr>
<tr>
<td>Age of mother when she had first child and at time of act</td>
<td>21.9 vs. 23.3 for the general population. Age at time of act: 26.8 Other maternal killers were younger than this on both.</td>
</tr>
<tr>
<td>Marital status</td>
<td>71% married.</td>
</tr>
<tr>
<td>Victim ill or disabled</td>
<td>Only one child in mentally ill group had a chronic illness, while many mothers in other groups had sick children to deal with.</td>
</tr>
<tr>
<td>Social and Educational Status</td>
<td>Somewhat higher for the mentally ill than other categories</td>
</tr>
<tr>
<td>Financial difficulties</td>
<td>These were mentioned as occurring in only 5 non-battering mothers. No specifics were mentioned for the mentally ill group.</td>
</tr>
<tr>
<td>Psychiatric Treatment</td>
<td>10 out of 24 mentally ill mothers had psychiatric treatment at the time of the offense, while 54% were required to have out-or inpatient therapy at some point in their life.</td>
</tr>
<tr>
<td>Recent visit to (mental) health provider</td>
<td>50% of all maternal killers had been to see any type of helping/medical person (general practitioner, social worker, psychiatrist etc.) during the four weeks prior to the act. This figure was more or less similar for all categories, including the mentally ill.</td>
</tr>
</tbody>
</table>
Comments on Tables with Potential Correlates of Maternal Filicide

Many of the results are hard to interpret for the mentally ill group. For instance, D’Orban often would give information about the battering group that consists of 36 mothers and about the rest of the sample, the 53 non-battering mothers, without breaking it down for ‘retaliation’, ‘unwanted’, neonaticide and ‘mentally ill’. It is possible that a response such as “7 out of 53 mothers that were not in the battering group” primarily concerned women in the retaliating group which was reported to have the highest overall stress score of all groups. This may explain D’Orban’s comment that the mentally ill mothers’ current stressors were mainly psychiatric. However, it would have been very helpful to know more about how many mothers in the mentally ill group had certain family of origin issues. For instance, 18 of the 89 mothers reportedly had been separated from one or both of their parents before the age of 15: how many of these 18 mothers were in the mentally ill category?

The information about the 20 correlates presented in the two tables and in D’Orban’s other comments may not be detailed enough to make more specific comments about the mentally ill group, yet the information that is provided suggests a picture of women who are not overwhelmed by external stressors. They still appear to be in control of most aspects of their lives, but they are experiencing emotional and psychological problems for which many of them are getting help.

The information in these two tables is based on information that was present in D’Orban’s study. This information was scattered throughout the study, and not presented in tables.

In order to have a more complete picture of what risk factors or combinations of risk factors might explain the filicidal-(suicidal) behavior of the women in the mentally ill group, the current information simply is not sufficient.
Other Comments on D’Orban (1979)

D’Orban’s study is one of the most frequently quoted in the field of filicide. The findings with respect to mental illness and suicidal behavior also have been quoted widely. Yet, a closer analysis of the data on suicidal behavior and mental illness in D’Orban’s study and the way in which its findings have been interpreted by other authors demonstrates how much confusion there is in the literature with respect to mfs behavior:

Several studies, including Alder & Polk (2001) that quote D’Orban do not mention the limitation that mothers with a fatal suicide attempt were not included, and not one study commented on the implied ratio of 169 mothers with a fatal suicide attempt vs. the 104, who had been remanded to the psychiatric prison.

Some studies (Alder & Polk) report that the mentally ill in their own study only represent a minority of child killers, and they refer to the 24 mentally ill mothers in D’Orban’s sample of 89 in support of this position. However, these studies often do not take into account that ‘mentally ill’ is only a label for those mothers who reportedly did not have a specific motive or whose motive could not be ascertained. In fact, D’Orban reported that the nine retaliating mothers had the most serious psychopathology of all mothers considering the number of hospitalizations and prior suicide attempts. In addition, many of the 36 battering mothers also had diagnoses of depression and personality disorders.53

53 It also is known by now (Hawton, Roberts, & Goodwin, 1985; Hawton & Roberts, 1981; Roberts & Hawton, 1980) that many battering mothers have made suicide attempts and that 1/3 of suicide attempters are associated with child abuse.
There appears to be a tendency (Felthous & Hempel, 1995) to associate suicide attempts, which occur in conjunction with filicide attempts, with elevated levels of mental illness and especially psychosis. As a result, many studies that associate D’Orban’s category of mentally ill with insanity and psychosis because of the 13 mothers making nonfatal suicide attempts generally did not take into account the following:

- Ten of the 24 “mentally ill” mothers had a diagnosis of personality disorder or depression
- It probably was the 10 mothers with a depression or personality disorder, and not the 14 mentally ill mothers with psychosis, who made up the bulk of the 13 mentally ill mothers who made non fatal suicide attempts

Not one study quoting D’Orban discussed the possibility that there may have been more nonfatal suicide attempts during the period covered by D’Orban's study than during previous periods54 mirroring a similar trend in regular suicidal behavior among females in England and Wales.

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54 Brown (1979) reported that the number of regular nonfatal suicide attempts among women had increased, while the rate of fatal suicide had decreased. Brown attributed this to the detoxification of coal gas, the reduced availability of prescription drugs that had been used for fatal suicide attempts, and the extent, to which other methods had been substituted for coal gas and prescription drugs. Specifically, Brown reported that many women continued to use coal gas because they were not aware of the degree of detoxification at the time of their attempt. The fact that the detoxification occurred gradually over a period of 10 years may have played a role here. In addition, some women survived their suicide attempt when substituting other methods with which they were not sufficiently familiar. Considering that West reported that over 90% of maternal filicide-suicides, all of which were fatal, had been carried out with coal gas, it is to be expected that the process that occurred in regular suicide would occur in mfs as well. In fact, this expectation is further strengthened by D’Orban’s comment that the survival of many of the mothers and their children was quite ‘fortuitous’, e.g. because their attempt was interrupted before the gas or the poison had had the intended effect. It is not clear why D’Orban did not associate the detoxification of coal gas and its aftermath with the “fortuitous” survival of mothers and their children.
D’Orban does not connect the 24 mentally ill mothers’ filicidal and/or suicidal behavior to specific diagnoses (Personality\textsuperscript{55} disorder 4, reactive depression 6, and psychotic illness 14, of which 7 reportedly were associated with postpartum). A closer look at the data suggests a pattern where the six mentally ill mothers killing their only child probably overlap with the seven mentally ill mothers with postpartum psychosis, one of whom was reported to have killed two children. It also is likely that only few, maybe none, of these six mothers made a suicide attempt. This pattern can be deduced from the following information in the study:

- Six of the 24 mentally ill mothers killed their only child rather than killed or attempted to kill, which was the expression commonly used by D’Orban.

- Mentally ill mothers who killed a child younger than 6 months did not kill additional children, something that only battering mothers did. Children younger than six months are easier to kill, and attempts to do so are usually fatal.

- Nine of the 24 mentally ill mothers had killed a child younger than 6 months (neonaticides were not included).

- Seven of the 14 psychotic mothers reportedly had a postpartum psychosis.

- Therefore, it is virtually certain that the six mothers killing their only child were mothers of children younger than six months, who were suffering from postpartum psychosis.

- There are several indications that postpartum mothers who kill their child often kill their first child\textsuperscript{55}. This would mean that the six postpartum mothers killing their only child probably were younger than the other 18 mothers.

- There are some indications that postpartum mothers might make suicide attempts or might try to kill their children, but it is rare for them to do both, i.e. mfs. This could be related to the fact that most mothers making serious suicide attempts in conjunction with filicide are older than 27, while most postpartum mothers in D’Orban’s mentally ill group probably were considerably younger than that.

\textsuperscript{55} The author only specifies personality disorder for the entire sample (ICD, WHO, 1974: asthenic 13, antisocial 10, hysterical 10, explosive 6 and paranoid 1, for a total of 43 mothers whose main diagnosis was that of a personality disorder).

\textsuperscript{56} Further research will be done to what extent there is support in the literature for these indications.
If, indeed, none of these six mothers attempted suicide, then the 13 mentally ill mothers with nonfatal suicide attempts are concentrated among the 18 mothers who did not kill their only child. Of these 18 mothers, eight have a diagnosis of psychosis, six of a reactive depression and 4 of a personality disorder. This information is important because references to D’Orban’s study often equate the mentally ill label with psychosis and suicide attempts. This may not be correct and could easily be misinterpreted by clinicians consulting the literature. They might believe that a diagnosis, which does not include psychotic symptoms, could suggest less danger of filicide or filicide-suicide than is warranted.

Large family size as seen in the four mothers who had 18 children among the four of them might be a protection against attempts at mfs where a mother usually intends to kill all her children. When such a mother cannot kill all her children, she may kill none, and she will not kill herself either, because she would not leave her children behind without a mother. Therefore, cases where a mother killed or intended to kill only one child, while she had more than one child are often associated with psychosis. Suicide attempts can occur in conjunction with such filicide attempts, and there are indications that they often are nonfatal when they do occur due to the impulsivity associated with many cases of psychosis. There is a possibility, therefore, that these four mothers were among the seven mothers who had been diagnosed with psychosis that was not related to postpartum conditions.

Eight mothers, as already pointed out, ended up not killing a child. It is likely that most of these mothers made a nonfatal suicide attempt in addition to a nonfatal filicide attempt. D’Orban’s comment on the fortuitous nature of the survival of the children and the mother suggests this
possibility. Therefore, it seems possible that most of the 19 victims who survived the filicide attempt
were part of families where everyone survived rather than being part of a family, where, for
instance, the mother killed two children and made a nonfatal attempt at killing a third. This
possibility is also supported by the earlier mentioned possible increase of nonfatal suicide attempts
among mfs mothers mirroring an increase in nonfatal attempts at simple/regular suicide among
women (Brown, 1979).

If D’Orban’s data are treated the same way that data are treated in a Swedish study by
Somander & Rammer (1991)57 about child homicide that covered a similar period (1971-1980), we
see a great deal of similarity in the findings, while a comparison of the two studies’ findings as they
were presented shows considerable differences, as the following data illustrate:

- D’Orban’s 13 mothers not killing a child, 8 of who were in the mentally ill group, would not
  have been included in Somander’s study. Many of these mothers probably were among
  the 18 mothers that made a nonfatal suicide attempt as they may have belonged to the
  families that reportedly were rescued in their entirety.

- The postpartum mothers who had killed a child without making a suicide attempt, of whom
  there might be as many as six, would have been placed in Somander’s category of
  postnatal depression.

- The four mothers attempting suicide “after an interval /out of remorse” may not have been
  included in Somander’s study because of the interval, if they had not already been
  “disqualified” because of the nonfatal outcome of their filicide attempt.

- It is, therefore, possible that of the 18 mothers in D’Orban’s study, who had made a
  nonfatal suicide attempt, as few as 6 would have been included in Somander’s study as

57  Somander & Rammer (1991) only included cases where a child had been killed, while 13
mothers in D’Orban’s study only made nonfatal filicide attempts. In contrast to D’Orban, Somander
included both offenders who had made a fatal and those who had made a nonfatal suicide attempt.
All cases where a child’s homicide was accompanied by the offender’s suicide attempt referred to
parents, including two stepfathers.
having made a nonfatal suicide attempt after having killed one or more of their children. Six mothers in a population that is between one-third and one-fourth of the general population of England and Wales during a six-year period is very similar to the seven Swedish mothers who survived their suicide attempt after a fatal filicide attempt out of a population of 8-9 million during a 10-year period. It is also interesting that the number of 25 fatal/fatal mfs attempts mentioned by Gibson (1975) for the five-year period of 1967-1971 for all of England and Wales is similar to the six fatal/fatal mfs attempts in Sweden during the 10-year period of 1971-1980. This last remark has to be interpreted in the context that the population of England and Wales was about 7 to 8 times as large as that of Sweden at the time.

Two studies about Filicidal Ideation/Obsessions of Infanticide
(Chapman,1959; Button & Reivich, 1972)

I will first review two studies\(^{58}\) in which filicidal ideation is discussed, after which I will make comments on both of these two studies.

Chapman (1959)

Chapman studied 20 women with obsessions of infanticide and of impending insanity as a result of the obsessions about infanticide, and reported the following:

- Demographics
  - Most women were 25-35.
  - The 20 women were of all religions, and social and educational levels.

\(^{58}\) There are several other studies, (Anthony, 1959; Feinstein, 1964), almost all of them conducted before 1970, which are largely similar to these two studies in terms of definitions and assumptions about the nature of filicide.
All women had two or three children. Chapman reports to have never seen or heard of mothers with obsessions of infanticide that had only one or more than three children, and therefore believes that this phenomenon is limited to mothers with two or three children.

• Symptoms

  o The mothers were fantasizing about stabbing their children in the chest or decapitating them as the most frequently to be used method.

  o Of the 20, 12 were passive and non-assertive, had much repressed anger, and had problems disciplining their children.

  o Symptoms had started relatively recently for most of the mothers, from a few days to a few weeks or months, which indicated a better prognosis. Some had had symptoms for a long time before consulting someone, one even 14 years.

  o Quite a few had expressed a fear of long-term hospitalization because they believed that obsessions of infanticide had to indicate the presence of insanity.

• Other relevant information

  o None of the 20 showed other or previous symptoms of obsessional behavior.

  o None of them had suicidal thoughts.

  o The results of the Rorschach test indicated anxiety, phobias and obsessions, but no depression or schizophrenia.

  o Other observations were that some of the women came from cold, distant, hostile parents.

  o None of them was hospitalized, and the great majority responded well to outpatient treatment

A small group had experienced childhood sexual trauma and were much harder to treat, although Chapman's remark that most of the women responded favorably to psychotherapy appears to include the mothers in this small group.
Button & Reivich (1972)

Button & Reivich studied infanticidal obsessions in 42 patients (36 women, 6 men), who had reported to have filicidal obsessions as their main complaint or as an important part of their psychopathology. The 42 patients had been selected from 1317 consecutive admissions to the emergency room of a mental hospital. Suicidal thoughts had been experienced by 43% of the 42 patients. The authors did not elaborate on this.

Button & Reivich briefly mentioned that a number of patients who had been seen in the ER might have been missed because they might have been afraid or too embarrassed to report and admit to the filicidal obsession and/or because workers in the emergency room were unable to detect/elicit the obsessions. This aspect of the study was not further addressed or incorporated in the conclusions.

After observation and a psychological test battery, Button & Reivich concluded that the sample consisted of two groups. First, the depressive group, including patients with an obsessive-compulsive personality, who tended to become depressed when under pressure, and secondly, a more or less schizophrenic/psychotic group,

Presumably, then, breakdown of personality functioning in the obsessive group was manifested by depression and increased ruminativeness progressing to frank obsessionalism with failure to repress egodystonic infanticidal thoughts. Breakdown in the borderline personalities group [the second group] resulted in a more or less typical acute schizophrenic picture. Clinical diagnoses, psychological testing-MMPI profiles of 8-6 for the borderline schizophrenics and 2-8/2-8-7 for the obsessive compulsive depressives- and treatment results, in their consonance, support this view. (p. 239)
Comments on Chapman and Button & Reivich

Mfs and killing of multiple children are not mentioned as objects of ideation.

The methods that were most frequently mentioned as coming up in the mothers' fantasies were violent, e.g. stabbing in the chest, and decapitating. In this context, it is worth remembering that mothers who use weapons in actual filicide attempts usually have high rates of psychotic symptoms according to Lewis, Baranoski, Buchanan, & Benedek (1998), especially when the children are young enough for the mothers to kill them easily without weapons, as virtually all of the children in these three studies were.

All the patients apparently had volunteered this information. Whether the visits to the emergency room were on a voluntary basis is not reported by Button & Reivich.

All mothers in Chapman's study had immediately informed their husbands of their obsessions, but no one else.

It appears, therefore, that most of the patients/mothers who are being described in these two studies may have had typical harm obsessions, which usually are not acted on. This would mean that they differ from mothers with mfs ideation, who primarily want to commit suicide and take all their children along.
A caveat is necessary with respect to the mothers who reported to have experienced childhood sexual abuse. Chapman reported that they were more difficult to treat, although eventually they seemed to respond to treatment. They only represented a very small group, according to Chapman. There is a possibility that filicidal thoughts by the mothers in this small group may not have been associated with typical harm obsessions that usually are not acted on, and that when the filicidal thoughts subsided Chapman (possibly mistakenly) believed that they were cured. The group apparently was too small to justify studying them in depth.

A second caveat may be necessary with respect to the belief that harm obsessions are not acted on. The violent fantasies that many of the mothers had might make it worth to investigate to what extent such fantasies might be precursors of future psychopathology that might include psychotic symptoms and active filicidal behavior. It might be helpful to research to what extent psychotic women who have killed or tried to kill their children, especially those using weapons, may have had the kind of symptoms that Button & Reivich describe as a prodromal phenomenon.

A third and last caveat concerns the finding by Button & Reivich about two groups, an obsessive-compulsive-depressed one, and a borderline schizophrenic one. The authors report that most of the 42 patients were hospitalized and responded favorably to treatment. They do not differentiate clearly between the responses to treatment of these two groups. Particularly, it does not become clear whether and how these two groups might differ in potential dangerousness after the treatment. In this context, it is relevant to point out that Button & Reivich do not report for how long the patients had been followed after the completion of their treatment, if at all, and whether they would have been informed about any relapse or deterioration of symptoms.
Comments on studies prior to 1980

The role of psychotic symptoms

Most of these eight studies indicate that psychotic symptoms, including delusions, may have played a role in making an attempt at mfs, but they differ in the importance that they attribute to psychosis and they also differ in their view of the mechanisms through which psychosis may have played a role. This diversity of viewpoints is associated with various factors, such as the population that was studied, or the era during which the study was published. However, the review of more recent studies in this chapter will show that there continues to be a diversity of viewpoints with respect to the role of psychosis in acts of mfs.

Despite the diversity of viewpoints, one trend is unmistakable and concerns the increased recognition of convergence of factors, of comorbidity of mental disorders, and of the importance of external stressors, all of which could contribute to the presence, the strength, and the contents of psychotic symptoms and delusions. D'Orban's study included an analysis of 20 factors that may have played a role in this regard, and was in many ways a forerunner of this trend. The topic of psychosis will be addressed in more depth in Chapter 6, 7, and 8.
The role of fatal child abuse

In the studies published prior to D’Orban (1979) fatal child abuse, also referred to as *filicide associated with battering*, or *accidental death* appeared to claim fewer victims than other forms of filicide, and did not receive an unusual amount of attention.

D’Orban (1979), who wrote about maternal filicide in England and Wales, argued that fatal child abuse was extensive, yet different from other forms of filicide, most notably those that he labeled ‘mentally ill’, where maternal suicide attempts and killing of multiple children occurred, which were virtually absent in the battering/fatal child abuse category. In addition, the psychopathology associated with fatal child abuse was shown to be different from the ‘mentally ill’ as well as stressors and certain demographic features.

Nevertheless, in the USA, attention given to (fatal) child abuse 59 started to increase in the late 1970’s, which may or may not be associated with an increase in the prevalence of child abuse, and came to dominate filicide studies to the extent that all filicides, including those related to suicide, were referred to as fatal child abuse. As a corollary, the distinction between fatal and nonfatal suicide attempts was no longer mentioned because it may no longer have been

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59 It could be noteworthy that interest in filicide and child abuse increased at the same time that interest in domestic violence increased. The increase in interest for domestic violence may be partially attributed to the feminist movement, which not only raised awareness of spousal abuse, but also of the long-term consequences of various types of child abuse which made the child victim vulnerable as an adult. From an interest in the long-term consequences for adults abused as children to active efforts to learn more about current child abuse seems like only a small step.
considered relevant. Therefore, it was not clear what type of suicidal behavior was denoted by a particular number of suicide related filicides.

In the same vein, reporting of multiple killings, usually primarily if not exclusively associated with filicide-suicide, was discontinued in several studies (Silverman & Kennedy, 1988) along with discontinuation of reporting of the number of offenders in cases with multiple offenders.\textsuperscript{60} It is possible, even likely that several studies where the number of victims was identical to that of offenders, adopted this policy without mentioning its use.

It would not be until the early 1990’s that the trend of \textit{everything is fatal child abuse}, started to reverse itself. This happened first in countries where fatal child abuse had decreased so much that filicide in conjunction with suicide, which had remained remarkably stable compared to the prevalence of fatal child abuse, again became the form of filicide that would claim most victims among preadolescent children.(Somander & Rammer, 1991).

\textit{The role of filicidal-suicidal ideation}

The description of certain behaviors of mothers in several of the reviewed studies clearly indicates the presence of mfs ideation prior to the act. In addition, reference was made to the fact that clinicians should be especially alert for the danger of mfs when dealing with mothers of young children, who were overconcerned about their children’s well-being, depressed and suicidal.

\textsuperscript{60} Approximately 2/3 of victims of filicide-suicide were part of multiple killings or attempts to kill, while the corresponding figure for multiple offenders rarely was higher than 1/10
The focus in these warnings appeared to be on preventing possible incidents of mfs, and seemed to be based on the premise that mfs behavior is rare. The idea that there might be degrees of mfs ideation, most of which remain outside of the area of the clinicians' concern, but which might be precursors of more serious ideation, as well as a source of suffering in their own right, did not seem to have caught on. Nor will it do so in studies published after 1980.

In the context of filicidal-suicidal ideation, attention was also given to obsessions of infanticide, which appeared to be so-called harm obsessions. Usually these obsessions are not acted on and they tend to respond well to treatment, as they did in the studies that were reviewed.

However, a small group of mothers appeared to be somewhat different from the majority. Many of them had experienced sexual abuse in their childhood, and they responded more slowly to treatment. I believe that there is a possibility that the obsessions of some of these mothers in this small group might not have been the relatively harmless harm obsessions seen in most mothers.

There is also the possibility that for some mothers these obsessions of infanticide, even when they are only harm obsessions at the time she sees a doctor, may be prodromal symptoms of future filicidal or filicidal-suicidal ideation and behaviors. To what extent this is, in fact, the case is something that deserves further study.
Population studies about child homicide and filicide in the USA

All studies reviewed in this section are based on police or coroner records only. Studies in the USA involving psychiatric evaluation will be reviewed later in this chapter in the section “Selected Samples: Psychiatric Evaluation Studies”.

Two Studies in Cleveland, Ohio (Adelson 1961, 1991)

Adelson (1961)

The review of this study can be found in this chapter in the section, Studies prior to 1980.

Adelson (1991)

In a repeat study covering the years 1970-1986, Adelson (1991) reported the following:

- There were 21 incidents of filicide-suicide involving 21 children, 8 mothers, and 13 fathers. This represents a rate of 0.6 children per million of the general population.

- With respect to the offenders’ suicide in conjunction with pedicide, Adelson reported 23 cases during the second period, and specifically mentioned that there was one case, where an adult, the father of a friend of a victim, “killed two children in one incident”. This language implies that the other 21 cases did not involve multiple children.

- Of 194 children who died as a result of homicide, 75 were Caucasian and 119 African American (population was 50% African American). In addition, out of these 194, 90 were the result of filicide.

- With respect to filicide-suicide, there was no information on nonfatal suicide attempts, the race of the parents or on fathers attempting familicide.

- In comparing the findings of the second period with the first period, Adelson referred to eight pedicides in the first one, which he contrasted with the 21 pedicides in the second one. However, Adelson (1961) reported in his first study that eight filicidal parents had made a fatal suicide attempt, while another five filicidal parents had made a nonfatal suicide attempt. In addition, Adelson (1961) reported on several parents, who had killed multiple children.
Based on the information provided in this first study, it appeared that between 17 and 19 children had died as a result of filicide-suicide. The apparent contradiction between the 1961 study of the first period and the 1991 version with respect to filicidal-suicidal behavior is not explained by Adelson (1991).  

**Two studies in the Miami area**

*Copeland (1985)*

Copeland (1985) found that half of the 130 child homicides in Dade Country, Florida (including Miami) between 1956 and 1982 that were examined by him were not associated with ongoing child abuse. This was particularly true for children that were three or older. The issue of parental suicide was not addressed by Copeland.

*Crittenden & Craig (1990)*

Crittenden & Craig (1990) who used essentially the same information confirmed Copeland's findings. However, Crittenden & Craig also reported that 69 offenders had not been criminally prosecuted for various reasons, and that for 17 of these 69 offenders the reason happened to be suicide, which was not further addressed by Crittenden & Craig.  

This would amount to a rate of 0.5 to 0.8 children per million of the general population per year killed in

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61 Possibly Adelson has adopted the practice (Silverman & Kennedy, 1988) of reporting only one victim and one offender in cases of multiple offenders and/or victims. In addition, he may have adopted a practice of only reporting attempts as filicide-suicide where both the filicide and suicide are fatal, as Silverman & Kennedy did. However, Adelson does not address this issue.

62 The fact that half of the child homicide cases were perpetrated by African Americans, who are known to have a low suicide rate, makes it more likely that the filicide-suicide cases may have taken place mainly among Caucasians.
conjunction with a fatal or nonfatal suicide attempt of one of their parents assuming that most of the
17 suicidal offenders were parents.63

Two Studies in California

Chew (1999)

Chew (1999) reported that out of 1498 homicides64 of children under 15 in California between
1981 and 1990, 279 were associated with the offender’s suicide.65 This amounts to a rate of 0.95
child per million of general population (estimated at 29 million during this period) per year being
killed in conjunction with the suicide of the offender, who usually is a parent.66

63  As fatal and nonfatal suicide attempts by offenders of child homicide usually involve
parents and often consist of multiple killings, it is likely that the number of children killed in
conjunction with fatal or nonfatal suicide attempts by one of their parents is higher than 17. If the
findings of other studies are a guide in this respect, the figure is likely to be close to 30. With a time
span of 28 years, during which population of Dade County grew from 500,000 to 1,750,000, the
rate of children killed in conjunction with parental suicide per year per million of the general
population is somewhere between 0.6 and 0.8 depending on the speed of the population growth.

64  Approximately 40% of the 1498 children were killed by a relative. There was no information
on what kind of relative.

65  Of these 279 children, 95 were younger than one year. In this age bracket, they
represented 25% of the victims, which is three times more than in most studies. No explanation is
suggested for this unusually high percentage.

66  The figure of 279 included many victims of multiple killings, which usually are associated
with filicide-suicide.
Sorenson & Peterson (1994) examined race and ethnicity patterns of child homicide in Los Angeles City between 1980 through 1989. They found 246 cases of child homicide. Yet, they never referred to suicide of the perpetrator as a potentially contributing factor.

Two Studies in the Detroit area

The study by Myers (1970) has been reviewed in the section, Studies prior to 1980, in this chapter.

Goetting (1988, 1990) reported that during a five-year period from 1982 through 1986 in Detroit 36 parents had killed 33 children under the age of six. There were no cases of filicide-suicide, and only one incident involving multiple killings. Of the offenders, 94% were African American, as was 63% of population in the area studied. Much of the killing consisted of fatal child abuse, although there were also quite a number of cases where the parents knew that their treatment of the child could or would result in death.

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I consider the examination of the data as one study, which led to several publications by Goetting.
Other population studies on Child Homicide in a particular part of the country (Abel, 1986; Kaplun & Reich, 1976) either do not mention the possibility of parental suicidal behavior as a possible factor or mention that there were no incidents, as Goetting (1988, 1990) did for Detroit. Issues that have affected population studies on child homicide are mislabeling and underreporting.

Mislabeling

Most studies addressing child homicide on a national level only speak of fatal child abuse and peer related child homicides (Christoffel, 1990; Christoffel et al., 1983; Christoffel & Liu, 1983; Jason, 1983; Unnithan, 1996). In fact, there has been a debate, especially in the USA during much of the 1980’s and early 1990’s whether all child homicide was related to child abuse (Christoffel, 1984, 1990; Christoffel, Anzinger, & Amari, 1983; Christoffel & Liu, 1983; Jason, 1983). Jason (1983), in a study “The Child Homicide Spectrum” that refers to all cases of child homicide in the USA in one year expresses this opinion very clearly:

There are two broad categories of child homicide: The first predominates until the victim age of 3 years, is intrafamilial, and is associated with bodily force and poorly defined precipitating events. It might be described as fatal child abuse. The second type predominates after the victim age of 12, is extrafamilial…Homicides that occur in children between 3 and 12 years of age are a mixture of these two types. (p.578)

In this view, even child homicide by a parent who makes a fatal or nonfatal suicide attempt is regarded as fatal child abuse, where there is no attention for the suicidal behavior of the parent as a possibly contributing factor. For instance, Margolin (1990) writes, “Four other deaths from
physical abuse were associated with a parent's own suicide" (p.313). Subsequently, one of these deaths, a clear case of mfs, was described by Margolin, "A mother drowned her son and herself" (p.314). In referring to this drowning incident, Margolin inadvertently made it clear that most likely this parental suicide happened in conjunction with the filicide, or as one act consisting of two parts, and did not happen out of remorse as a reaction to the filicide.

Studies (Copeland, 1985; Unnithan, 1994) conducted to examine the extent to which all child homicide indeed was due to fatal child abuse showed that there were no signs of previous injuries in about half of the victims of child homicide. It was concluded that in most of these cases child abuse might not have played a major role. It is also worth noting that these same studies did not refer to the possibility of parental suicidal behavior in conjunction with filicides, even though there were indications that suicidal behavior might have played a role in 30 to 50% of the cases in the USA.

Underreporting

There is widespread agreement that the official data on child homicide and filicide understate the reality. (Alder & Polk, 2001; Alder & Baker, 1997; Brenner, Overpeck, Trumble, DerSimonian, & Berendes, 1999; Ewigman, Kivlahan, & Land, 1993; McClain, Sacks, Froehlke, & Ewigman, 1993; Meyer & Oberman, 2001; Nock & Marzuk, 1999; Overpeck et al., 2002; Overpeck et al., 1999) This can happen in a variety of ways. Several studies (Emery, 1986, 1993; Newlands & Emery, 1991) refer to the possibility that a certain percentage of “crib deaths”/SIDS/”cot death are the result of infanticide due to a postpartum depression or other reasons. Studies differ in the percentage that they consider suspect in this regard. It varies from 3 to 20%. Other studies
(Ewigman et al., 1993) refer to the possibility that children, whose death was reported to be an accident, in fact might have been cases of child homicide.

Ewigman et al. (1993). These authors reported that half of the 297 deaths of children under the age of five in Missouri between 1983 and 1986, which had not been ruled a homicide at the time of death, upon re-examination were shown to have been due to fatal maltreatment. This would amount to an average of 38 cases per year during this four-year period. Ewigman et al. also reported that agencies did not exchange information that could have helped determine the cause of death, or maybe even prevent it.

Some of the study's information relating to the parents that is not elaborated on by the authors suggests that considerable numbers of parents did not have a profile containing risk factors typical of fatal child abuse: married 51.8%; Caucasian 73.7%; not enrolled in American Families with Dependent Children, AFDC 54.2%; adequate prenatal care 48.2%.

Comments on underreporting. The data about the profile in Ewigman's study that make it atypical for fatal child abuse (married, Caucasian, prenatal care, not on AFDC ) may be interpreted as support for Ewigman's finding that half of the 297 cases upon re-examination were still considered an accident and not due to fatal child abuse. However, these same data also contain some elements that are typical of parents, and especially mothers who are involved in mfs behavior.
Ewigman et al. do not address the possibility that some of the cases of underreporting that were investigated by them may have been associated with parental suicidal behavior, although some of the incidents suggest that possibility, especially when methods were used that also are common among mothers making mfs attempts. For instance, they report a case where drowning would be listed as an accident (“the mother had lost sight of the child for 5-10 minutes”), but where the mother was not questioned, even though there had been previous reports of child abuse for this mother. In a case like this, but without a report of prior child abuse, a mother might have intended to make an attempt at mfs, but decided not to go ahead with the suicide after the child had been killed. If this mother reported the child’s death as an accident, she most likely would not be questioned considering that even a mother with a previous report of child abuse was not questioned after her child died as a result of an alleged accident. In this context, it should be pointed out that mfs mothers reportedly are rarely involved in child abuse. Examples of suicide attempts that were planned after the filicide, but not carried out are reported in various studies. (D’Orban, 1979; Haapasalo & Petaejae, 1999)

A related, yet somewhat different scenario refers to the possibility of an aborted attempt at mfs. In such a scenario, a mother might have planned to make an mfs attempt, but decided to abort the attempt before her child had died only to find that the child already had died or no longer
could be saved. In both instances, a mother might be able to present the child’s death as an accident.

Scenarios where the child’s death was reported to be natural, while it was not, and may have been part of a planned mfs attempt, may have unfolded somewhat like the drowning scenario just described. In this regard, it is important to be aware of the fact that some studies report how easy it is for someone to kill an infant without any trace of violence showing up, and thereby making it hard to prove intent. It should be pointed out that suspicious child homicides that were registered as natural deaths were not part of Ewigman’s research effort.

The findings of Ewigman et al. and the various other scenarios could increase an estimate of the actual occurrence of filicide and possibly of filicide-suicide, including mfs attempts and mfs ideation.

68 After finding that their child has died, some mothers might rethink the abortion of the mfs attempt and make a fatal or nonfatal suicide attempt. Others might not do this for various reasons:

- The mother might have other children that she is unwilling and/or unable to kill at this point, and which she does not want to leave behind without a mother.
- The mother was not very serious about the mfs attempt in the first place, and had not made sufficient preparations for a suicide attempt.
- The death of her child overwhelms the mother and paralyzes her ability to make decisions and to implement them.

69 With a population of approximately 5 million at the time, each child death in Missouri involving parental suicidal behavior, would increase the rate for such behavior with 0.2 per million of general population per year.
Population studies outside the USA with both fatal and nonfatal parental suicidal behavior

Silverman and Kennedy (1988)


Among the maternal child killers, a distinction was made between infanticide mothers and noninfanticide mothers. Infanticide is a legal concept in Canada, and refers to mothers who killed their child due to mental weakness following delivery. Non-infanticide refers to all other cases of maternal filicide.

In cases, where there were multiple offenders or multiple victims, the authors only included one offender or one victim, for which they used the most intimate connection.

The following of their findings are the most relevant for this dissertation:

• With respect to the 45 infanticide mothers:
  o No mother made a fatal suicide attempt. There was no information about nonfatal suicide attempts.
  o Methods most often used by the infanticide mothers were suffocation (27%), beating and strangulation (each 12.5%), drowning (10.8%) and stabbing (5%).
• With respect to the ‘non-infanticide’ mothers:
  
  o Age distribution of victims\textsuperscript{70}
    
    \begin{itemize}
      \item 31.7% of the reported victims were under 1 year of age.
      \item 42.2% had an age of 1,2,3,4 or 5.
      \item 15.2% were 6,7,8,9, or 10 years old.
      \item 8.9% were 11 through 15 years old.
      \item 4% were 16 or older.
    \end{itemize}
  
  o Age distribution of the mothers
    
    \begin{itemize}
      \item 32% were between 18 and 25 years old.
      \item 59.2% were between 26 and 45.
    \end{itemize}
  
  o Methods used:
    
    \begin{itemize}
      \item Beating 22.4%
      \item stabbing, 9.4%
      \item strangulation 12.9%
      \item drowning 14.7%
      \item suffocation 16.1%
      \item Shooting 9.4%
      \item arson 2.2%
      \item Other 12.5%
    \end{itemize}
  
  o Suicidal behavior:
    
    \begin{itemize}
      \item 18.7 % of the noninfanticide mothers made a fatal suicide attempt.
      \item There is no information on:
        \begin{itemize}
          \item Nonfatal suicide attempts by the mothers
          \item The number of mothers involved in multiple killing, which is common among filicidal-suicidal mothers
        \end{itemize}
    \end{itemize}

\textsuperscript{70} Presumably, these figures reflect the policy of reporting only one victim, even when there are multiple victims. The authors do not report what child is considered for the age distribution of victims in case there are multiple victims or what the age distribution would have been if multiple victims had been taken into account.
The number of children known to have died in multiple killing incidents due to the policy of only reporting one victim in cases of multiple victims

- Marital Status
  - 67% were married.
  - 3.9% had a common law marriage.
  - 8.8% were divorced or separated.
  - 2.2% were widow.
  - 10.6% were single.

With respect to all filicidal mothers, the authors report or remark the following:

- Maternal filicide as a percentage of female perpetrated homicide has remained stable over the 23-year period, between 10 and 12%.

- Females perpetrated 79 manslaughter cases other than infanticide or non-infanticide between 1961 and 1983. Reportedly, children were among the victims. No further information is provided. In addition, much infanticide and filicide is not reported, according to the authors. The extent, to which the official, national statistics may be underreporting, is not known.

- Of the non-infanticide mothers, 67% reportedly was mentally ill and of the infanticide mothers 36%, while only 6% of women killing their spouse had been declared 'mentally ill'. The authors express their doubt about the degree of mental illness, and cite other studies that express similar doubts, including studies by Strauss (1980 a, b) who believes that psychological reasons play a role in only 10% of child abuse.
The authors suggest, “Non-infanticide is child abuse gone awry” (p. 124) referring to the means that were often used, such as beating. They come to this conclusion after comparing infanticide and non-infanticide. Infanticide mothers are reported to ‘suffocate’ and reportedly are not child abusers, while the non-infanticide mothers “beat their victims to death” (p. 124). In this context, the authors do not distinguish between childhood homicide where there were signs of previous abuse, and childhood homicide where such signs were not present. In addition, they ignore the fact that drowning, suffocation and strangulation, the methods that are most often used in mfs, had been used by 43% of the non-infanticide mothers.

The authors did not provide an explanation for the apparent sharp drop of non-infanticide after about 1979/1980.

Comments on Silverman and Kennedy

The authors assume that the great majority of non-infanticide mothers are child abusers. They did not take into account the possibility that the designation of ‘likely child abuser’ may not have applied to the following mothers:

- Mothers who made a fatal or nonfatal suicide attempt in conjunction with the filicide.
- Mothers who killed more than one child, which is not accounted for in their data, and which tends to be associated with a suicide attempt by the mother.
- Mothers who used means other than beating or stabbing, especially drowning or suffocating that often are used by suicidal mothers.

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If the rate of 18.7 % for fatal suicide attempts were accompanied by a comparable prevalence of non-fatal suicide attempts, as is the case in many studies, we would have close to 40% of the mothers making a suicide attempt, fatal or non-fatal. Even when the prevalence of nonfatal suicide attempts by mothers is only half that of the fatal ones, we are still left with 30% of filicidal mothers making a suicide attempt. Considering that many suicidal mothers kill or try to kill more than one child, it is likely that 40 to 60% of all children killed by their mother were killed in an event that involved a fatal or nonfatal suicide attempt by the mother.

The 18.7 % of non-infanticide mothers making a fatal suicide attempt is likely to be concentrated among the 68.3% of the mothers, whose children are older than 12 months. Many studies (Barraclough & Harris, 2002; Nock & Marzuk, 1999) have found that the killing of children younger than one year old is followed by a fatal suicide attempt in less than 5% of the cases.

Child abuse often is the main cause of filicide among mothers who did not make a suicide attempt and has a low prevalence among mothers, who make a fatal or nonfatal suicide attempt (Alder & Baker, 1997) Therefore, it is likely that mothers committing filicide followed by a suicide attempt will present with a different clinical picture than mothers who have not made a suicide attempt and who have killed their child in the context of fatal child abuse. However, clinicians may discount the filicidal risk of mothers who are not abusing their children or considered at risk of doing so, when they do not take into account the possibility of suicide preceded by filicide. Silverman and Kennedy’s study, which defines maternal filicide as child abuse gone awry while it
ignores the possibility of suicidal mothers having a different clinical picture could easily contribute to clinicians incorrectly assessing the danger of maternal filicide.

In countries, where there have been effective policies to reduce child abuse, such as in Sweden (Somander & Rammer, 1991), the prevalence of fatal child abuse appears to have decreased considerably, while maternal filicide followed by a fatal or non-fatal suicide attempt remained stable or decreased only marginally. If no differentiation is made between these types of maternal filicide, policies for reducing child abuse and fatal child abuse may not be credited with the full measure of their effectiveness.

The fact that the percentage of maternal filicide as a percentage of female-perpetrated homicide is reported to have remained relatively stable could be interpreted to imply that maternal filicide is primarily similar to female homicide, and that any ‘ups and downs’ of total female homicide data automatically imply similar ups and downs for maternal filicide.71 It must be noted that many studies view mfs as primarily suicide (Alder & Baker, 1997; Alder & Polk, 2001; Bourget & Gagne, 2002; D'Orban, 1979; Nock & Marzuk, 1999; Resnick, 1969)

71 In several countries, where child homicide rates are stable, overall homicide rates have increased (Somander et al., 1991). Whether this also applies to overall female homicide, is not something on which I can find data at this point.
Somander & Rammer (1991), who examined child homicide in Sweden, where all such cases are centrally registered, report the following for the period of 1971-1980, for the entire sample:

- Of 96 children under the age of 15 who were killed, 2 were killed by unknown perpetrators. The other 94 were killed by 77 perpetrators. Of these 77 perpetrators, 65 were parents.

- Of the 79 victims of filicide, 58 were killed in 43 h-s incidents, 5 in fatal child abuse, 2 in neonaticide, two as a result of a postnatal depression, and 12 as a result of a variety of causes referred to as the category of other intrafamilial.

- Neonaticide and fatal child abuse were absent during the second five-year period (1976-1980). Somander & Rammer attribute this to liberal abortion laws and an extensive government campaign against child abuse. As a result, the proportion of h-s in intrafamilial homicide increased during the second five-year period, even though there were fewer h-s incidents.

- Of all 77 perpetrators, 18% were foreign citizens, compared to 5% of general population, although only six of the 77 known perpetrators were from outside Scandinavia/Finland. Of the 14 foreigners, three were males involved in fatal child abuse. No additional information on the other 11 foreigners was provided.

- Of the 77 perpetrators, 26 (35%) had a prior history of inpatient psychiatric care, and 9 (12%) of prior outpatient treatment.

- Of the 18 surviving female perpetrators, all of whom were psychiatrically examined, 17 were found to be mentally ill: 11 were diagnosed with psychosis and 6 as “mentally abnormal equivalent to insanity”. Of 29 surviving males, 12 were found to be psychotic, 8 were “suffering from other mental abnormality equivalent to insanity”, and 9 were not found to be mentally ill, although seven of these nine males were regarded as “mentally abnormal not equivalent to insanity” (p. 49).

- Of the 12 children killed by parents in the “other intrafamilial category”, 8 were killed out of altruistic motives. The authors do not report whether any of the perpetrators of these eight child homicides had planned to make a suicide attempt in conjunction with the filicide that was not carried out.
With respect to the homicide-suicide group, Somander & Rammer report the following:

- There were 43 incidents resulting in the death of 58 children
- Of the 30 fathers, incl. 2 stepfathers, 6, including one stepfather, survived their suicide attempt, while 7 of the 13 mothers involved survived theirs.
- Of the 43 incidents, 18 were reported to have involved two, three, or four children. This would mean that with the 25 incidents not involving multiple victims accounting for 25 of the 58 victims, there would be 33 children left for the 18 incidents involving two, three, or four victims. The authors do not provide an explanation for the fact that these data appear contradictory.
- A firearm was used by 11 parents, almost all of whom were male
- The mothers only killed children, while several of the fathers also killed their spouse.
- Somander & Rammer report,

  Both female and male perpetrators had altruistic motives, i.e. the well-being of the child was a primary concern. . . . For various reasons not related to children, the perpetrator considered suicide. . . . Explicit indications of problems for h-s parents were the following.  
  
  - Partner relation 14
  - Custody of children 4
  - Economics 4
  - Desire to save child from a cruel world 1
  - No clearly expressed motive
  - Due to mental illness 7
  - Other 4. (p.49)

- With respect to employment status Somander & Rammer report, “Out of the total male perpetrators with high professions (9/53), 8 were found in the homicide-suicide cases. The highest proportion of lower- and medium-salaried employees (5/13) were found among females in this group” (p.49). In other words, of the 13 mfs mothers, there were at least five with the kind of employment that suggests that they middle class as well as high functioning in regards to work.

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72 Apparent contradictions with respect to the role of the children in the filicidal-suicidal attempts of the parents will be discussed under Comments.
• Of the 43 parents, 3 had a criminal record, 7 were regularly abusing alcohol or drugs, while 12 were intoxicated during the act, which is described as a low number by the authors.

• Of surviving perpetrators, both of h-s and other forms of filicide, five of the six males were found guilty of murder and four of the six females of manslaughter. All females except one were committed to institutionalized psychiatric care.

Demographic information is not sufficiently detailed to determine whether there might be a relationship between for instance the age and gender of the offenders, and those of their victims.

The authors believe that the findings of their study confirm those of the study by Resnick (1969). In that study Resnick found that intrafamilial homicide is different from other child homicide because of the presence of an explicit, altruistic motive. Somander & Rammer report that the only solution for whatever problem the parent had was suicide,

... and to spare their children the effects of that problem [it was necessary] to take them with the... Males took their spouses as well in some cases. Males' problems were mostly an inability to maintain the partner-relation associated with separation. The main female problem consisted of “experiencing helplessness and a feeling of being unable ‘to bear the burden any longer’, which usually referred to their inability to endure her partner’s harassments, abuse, or lack of enterprise. (p. 53)

Somander & Rammer conclude with this statement:

Our study implies that child homicide often is the final result of interpersonal conflicts, psychological stress, or unhappiness, in combination with mental disorder. The high rate of previous psychiatric care among perpetrators indicates that when a parent is discharged from this kind of care, special precaution should be taken. In the first place, the medical personnel must pay regard to the welfare of the children. Of importance is the need for children not to be considered a means to cure the adult. Further efforts must be made to provide treatment and service to families under psychological stress, especially when there are conflicts in the partner relation. (p. 54)
Comments on Somander & Rammer

The study by Somander & Rammer (1991) is regarded as one of the best epidemiological studies. (Stroud & Pritchard, 2001) The fact that Sweden has a central registration system for murders, suicides, and other relevant data, probably contributes to the quality of this study. Nevertheless, there are certain aspects that deserve some scrutiny.

Filicide-suicide motives not related to children

The authors' remark that the motives for filicide-suicide were not related to the children suggests that the initial suicidal wish was not related to the children. It would be surprising if this finding applied to many of the mfs mothers in the study or even some of the fathers. Several studies (Alder & Polk, 2001; Graser, 1992; Okumura & Kraus, 1996) relate how mothers sometimes can be driven to mfs because they believe that their children will have as miserable a life as they think that they have had. In that context, they may be blaming themselves for their own inability to provide their children with what they need emotionally as well as the fact that the children may have “inherited” the mother's inability to be happy. These thoughts apparently are more frequent among mothers than among fathers. It appears unlikely that Swedish mothers would be an exception in this regard.

The parents' motives for filicide-suicide reported by the authors include partner relations, custody of children, and economics. A possible explanation for the absence of motives related to the children could be that 30 of the 43 parents were fathers whose motives are more likely to fall into a category, such as partner relation. Another reason could be that mothers were
overrepresented among the 11 parents, whose motive was listed as “not clearly expressed, but the circumstances mostly [7 of the 11 cases] indicated mental illness” (p.49).

The question of bias

Somander & Rammer remarked that during the five-year period from 1976-1980 there were no cases of fatal child abuse or neonaticide in Sweden thanks to the wide availability of abortion and a national program aimed at preventing child abuse. The possibility of underreporting was not addressed by them.

Somander & Rammer remarked that all 18 surviving female offenders of filicide had been psychiatrically examined and that 11 had been found to be psychotic and another 6 “mentally abnormal equivalent to insanity” (p. 49). This means that there is chance of 94% that a mother who kills a child without killing herself will be found to have been insane at the time of the act, and a chance of 61% of having been psychotic. Somander & Rammer do not discuss the possibility that those who diagnosed these mothers may have considered filicide such a heinous and unimaginable act that the offending mother simply had to have been insane, if not psychotic.

Somander & Rammer also commented that if other countries would also psychiatrically examine their filicide offenders, they too would find that their filicidal mothers are as mentally ill as the mothers are in the Swedish study. The authors appear convinced of the quality of the Swedish approach. However, this raises the possibility that they may not have been as critical in the interpretation of data as one would expect in a study like this.

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Contrast between mental illness and high functioning

There seems to be a contradiction in the analysis of the findings. On the one hand, the authors point out how high functioning the h-s parents were, and how reasons other than mental illness played a major role. On the other hand, they conclude that mental illness or mental abnormality played such a major role that all surviving offenders had to be “committed to institutional psychiatric care” (p. 50). The fact that 17 of the 18 surviving female offenders were found to have been psychotic or “equivalent to insane” at the time of the act reinforces the impression of mental illness. This point will be discussed in more detail in Chapters 6, 7, and 8.

Wilczynski & Morris (1993)

Wilczynski & Morris (1993) examined police and coroner records about child homicide in England and Wales from 1982 through 1989. They report the following:

- A parent was suspected in the death of 494 children due to homicide. This figure probably represents an underestimate of the extent of filicide, according to the authors.
- In 20 cases, there was not sufficient information, so that only 474 cases were examined.
- These 474 homicides were believed to have been perpetrated by 395 parents. The difference between 395 and 474 is not explained, although it is probably due to multiple victims.
- Of the 395 parents, 44% were mothers
- Of the mothers, 23% made a fatal suicide attempt, while 24% of the fathers did so.
These data, therefore, indicate that 41 mothers, or, an average of five per year, made a fatal suicide attempt after having killed one or more of their children.

**Comment on Wilczynski & Morris (1993)**

Wilczynski & Morris do not comment on nonfatal suicide attempts in conjunction with filicide in this study. However, in a different publication Wilczynski (1997b) reported that the prevalence of nonfatal suicide attempts by mothers was comparable to that of fatal attempts.

**D’Orban (1990)**

D’Orban (1990) compared data on female homicide in England and Wales during 1980-1987 with two earlier periods, 1957-1962, and 1967-1971. The data on mfs were not as clearly presented as they were in the study by Wilczynski and Morris. The study shows that suicide after a homicide by either gender increased from 20 in 1980 to 58 in 1987. D’Orban does not specify what the percentages are for male and female perpetrators.

**Comment on D’Orban (1990)**

This study shows intriguing differences between the various periods, but does not provide sufficient data to draw conclusions. Nor does it provide explanations for the differences. The data in the study by Wilczynski & Morris (1993) showed an average of five fatal suicide attempts in conjunction with maternal filicide during the 1980’s. Therefore, the increase in suicides after homicides is probably not due to an increase in suicide after maternal filicide.
Fornes, Druilhe, & Lecomte (1995)

Fornes et al. (1995) reported that during a four-year period from 1990 through 1993 in Paris and suburbs the following happened:

- 28 fathers and 18 mothers had killed one or more of their children
- Four fathers and eight mothers had made a fatal suicide attempt in conjunction with the filicide. There is no information about nonfatal suicide attempts.
- Methods used for filicide and suicide were the same: drowning (3), poisoning (4) and guns (4)
- There were 13 incidents where the parents killed two children and one where they killed three.
- The average age of those killed in the multiple killings was 6.5, while the average age of all 81 victims of child homicide was 5.5.
- All children lived in “very low income areas” (p. 203).
- There was no difference between Paris and the suburbs.

No information is provided to what extent parents involved in multiple killings made a fatal or nonfatal suicide attempt, although information is provided that suggests a relationship. There were 14 incidents involving multiple killings, and 12 parents who made a fatal suicide attempt.

Comments on Fornes

- We may speculate, based on other studies, that most, if not all, incidents of multiple killing were associated with parental suicide.
• We also may speculate that there are parents in this sample, who made a nonfatal suicide attempt, especially because methods for filicide such as drowning and poisoning were frequently used.

• If the filicide of the 29 victims of the 14 incidents of multiple killings is associated with parental suicide during these four years, then Paris and suburbs with a population of 10.7 million have a rate of 0.6 child per million of the general population killed in conjunction with parental suicide. This is in the middle of a range of 0.4 to 0.9 for most studies.

• The report that all children lived in very low income areas is somewhat surprising. The prevalence of filicide-suicide appears to be within a normal range. The prevalence of filicide-suicide of mothers was also in a normal range, but on the high side. In many studies women involved in fatal suicide attempts after a fatal filicide attempt are, on average, not to be found in the lowest social classes. To what extent cases of filicide and filicide-suicide among people in higher income areas possibly were underreported remains an open question.

• The fact that children lived in “very low income areas” (p. 203) does not automatically mean that the parents were of a low social class. There is also the possibility that parents who identified with the middle class resented having to live in a low-income area, and may have blamed themselves for it. This may have been a contributing factor to suicidal behavior.73

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73 There is also a suicide theory that claims that under certain conditions minorities have a higher suicide rate. One of these conditions could be living in a low-income area due to failed efforts at upward social mobility or as a result of downward social mobility.
Alder & Baker (1997) reported that between 1978 and 1991 in Victoria, Australia (population 4 million) 32 mothers had killed one or more of their children. Of these 32 mothers, 10 had committed neonaticide, 7 of them had fatally abused their child, 11 of them had made fatal or nonfatal attempts at suicide in conjunction with filicide, while 4 were distinct cases that could not be categorized.

Of the 11 mothers involved in filicide-suicide, 8 had made a fatal suicide attempt after the filicide and 3 a nonfatal one. Of these 11 mothers, 7 killed multiple children, and 10 of them killed all their children, which means that some of these 10 mothers killed their only child. Additional information on the mfs mothers that was provided by the authors consists of the following:

- The mfs mothers were altruistic, i.e. mfs was seen as in the best interest of the child.
- They had difficult lives, including, in some cases, physical violence by their male partner.
- They had to deal with their problems by themselves. They were described as withdrawn.
- They were described as good mothers, who had a close relationship with their children. In fact, they were caring mothers, who saw death as the “only option to ensure the children’s happiness” (p. 27).
- Eight were divorced or separated, while three were in bad marriages.
- Several had made previous attempts at regular/simple suicide, and seven of them had received psychiatric treatment.
- Generally, there were no major motives of a financial nature. However, threatened or real separation from a husband or intimate partner and/or events associated with a separation, such as custody issues reportedly played a major role.
Alder & Baker emphasize that their findings differ from those of most other studies on maternal filicide, such as prison or hospital studies because their study included cases where the mother had made a fatal suicide attempt.

Alder & Baker argue that many of the mothers making fatal or nonfatal mfs attempts do not fit the characterization of female homicidal behavior as "highly emotional outbursts entailing a loss of control" (p. 15). Alder & Baker add,

In contrast, the mfs mothers had things carefully planned, showed devotion to the children, i.e. causing their children little pain and 'ordering events after their death... At some point, the mothers took control in the only way perceived available to them. (p. 28)

Alder & Baker summarized their findings with these words:

Overall, these were women most often over 30 years of age with two or more young children, who felt that they could no longer cope with the difficult circumstances in which they found themselves and killed themselves and their children whom they believed would be better off dead: 'I wanted them to be at peace.' Those women planned a desperate act, having decided that it was the only option left for them to bring peace and happiness to themselves and their children. (p. 28)

In a follow-up study, Alder & Polk (2001) described all cases of child homicide in Victoria between 1985 and 1995, including extrafamilial and paternal filicide. Their data on maternal filicide overlap to a certain extent with the previous study by Alder & Baker. Alder & Polk described each case in some detail, including motives, methods, previous attempts, psychiatric treatment, and prior communication. These were their findings:
Of the 28 mothers who had killed one or more of their children, there were 10 cases of neonaticide, 7 of fatal child abuse, 6 of filicide-suicide, and 3 of extreme psychiatric disturbance. Two distinct cases could not be categorized.

Of the six filicide-suicide cases, five mothers made a fatal suicide attempt and one a nonfatal one in conjunction with the filicide. Two of the three mothers in the category of extreme psychiatric disturbance also made a nonfatal suicide attempt.

Motives that were present among the filicide-suicide mothers included fear that the father would assault or molest the child, cultural conflicts associated with immigration, isolation and domestic violence. Separation, threatened or real, from the spouse often was the trigger. There was one case of the six, where retaliation might have played a major role. In other cases, it became clear that the mother’s fears about the well-being of her child contributed to her own unhappiness. In several cases, one of the children had a disability or chronic illness.

There was no evidence of previous systematic abuse of the children.

Four of the six mothers had made prior suicide attempts and four of them had received prior psychiatric treatment.

The mothers had written suicide notes and/or communicated their intentions to others prior to their act.

The authors emphasize, as they did in the first study, that while these events were emotional, they also were rational. The mothers did not show evidence of loss of control, as is often suggested in studies on maternal filicide.

As to the extreme psychiatric disturbance, two of the three mothers made a nonfatal suicide attempt. They only killed one of their children, while the mfs mothers generally killed or attempted to kill all their children. The three mothers in this category were reported to have delusions that involved “higher forces or other beings” (p.59). They also were older than the mothers in the filicide-suicide category were.

The distinct cases included a mother with mental retardation.
Comments on both studies (Alder & Polk, 2001; Alder & Baker, 1997)

The authors of both studies emphasize that the fact that their study included cases of mothers with fatal suicide attempts caused their findings to be different from other studies about maternal filicide, which, according to the authors, often are based on samples of patients in hospitals or inmates in prison.

If only mothers who had made a nonfatal suicide attempt or no suicide attempt had been included, Alder & Baker almost certainly would not have remarked, “Representations of female homicide as predominantly emotional outbursts entailing a loss of control are not supported by the data” (p.15). The distinction that was made by Alder & Polk between filicide-suicide and extreme psychiatric disturbance very nicely illustrates this phenomenon.

If only filicidal mothers with nonfatal suicide attempts had been included in the study, there would have been two mothers from the extreme psychiatric disturbance category and one from the filicide-suicide category, referred to as Joan Gunsten, who killed one child, and made nonfatal attempts at the life of her other two children and her own life. The manner in which Joan made her attempts suggests that she had not planned or prepared for these actions, while the other five mothers in the filicide-suicide group clearly had planned and prepared. Joan had spoken with a social worker who was aware of Joan’s suicidal and filicidal-suicidal plans only a few days earlier in a manner that had reassured the social worker. The other two filicidal mothers with a nonfatal suicide attempt were in the extreme psychiatric disturbance category. One of them had made a filicide attempt in the past, and both were known to have made prior suicide attempts, and to have been suffering from psychotic episodes and/or command hallucinations. The manner in which they
carried out their filicide and suicide attempts clearly shows the influence of a thought disorder, and strongly suggests that they may not have had a plan to make an mfs attempt. If they had a plan, then it was not accompanied by good preparations and/or it was implemented so impulsively that it was unlikely to be lethal, at least for the suicide part.

It is also worth noting how the mothers in the filicide-suicide group were described as good mothers, somewhat withdrawn and without some of the stressors commonly associated with child abuse, such as financial and housing problems. They also were divorced, separated, or in bad marriages. Events associated with their intimate and interpersonal relationships played a major, and sometimes a triggering role.

Finally, the fact that most of the filicide-suicide mothers, as well as the extreme psychiatric disturbance mothers, were immigrants or children of immigrants was mentioned by the authors as potentially significant. Two additional comments need to be made in this regard. First, the Australian province of Victoria had grown from 1.5 million to 4 million between 1965 and 1990, and much of the growth was accounted for by immigrants. In addition, the percentage of Australia’s population that is immigrant or a child of immigrants could be anywhere between 30 and 60%. Therefore, the fact that immigrants or their children are prominently represented in these two studies is to be expected. Secondly, immigration and being a child of immigrants are known risk factors for regular suicide, and they figure prominently in many of the filicide studies (Alder & Polk, 2001; D’Orban, 1979; Meyer & Oberman, 2001) as well. The issue of immigration as a contributing factor will be addressed further in Chapters 6, 7, and 8.
Vanamo, Kauppi, Karkola, Merikanto, & Rasanen (2001)

Vanamo et al. (2001) studied intra-familial child homicide as part of a national study to learn more about child abuse in Finland. They reported the following details about the 292 cases of child homicide and undetermined death between 1970 and 1994 in Finland:74

- There were 56 cases of neonaticide, 34 cases where the killer was a family member other than the parent or no family member, as well as 57 cases of undetermined death, 20 of which were children under the age of two who had no injuries. Therefore, 145 children who were not newborns were killed by a parent.

- Of the 145 children killed by a parent, 75 children died in conjunction with a fatal suicide attempt by a parent. Of these parents, 20 were mothers, 2 of whom killed two children, while the other 18 killed only one child. Information about children on whose life an attempt was made, but who survived is not provided by Vanamo et al.

- The 75 victims of filicide-suicide were unevenly distributed over the 25-year period of 1970 through 1994: 25 from '70 to '74, 11 from '75 to '79, 10 from '80 to '84, 8 from '85 to '89, and 20 from '90 to '94. The authors mention that the economic conditions during the first and last five-year periods were difficult in Finland, and imply that this may have contributed to the prevalence being higher in these two periods. The figures for filicide not followed by a nonfatal suicide attempt also show considerable fluctuation, but do not follow the same pattern as filicides followed by fatal suicide attempts.

- Parents were also responsible for the death of 70 children, whose filicide was not followed by a fatal suicide attempt. Of these children, 43 were killed by a mother. No information is provided about how many mothers were involved in these 43 deaths other than that 15 of the 70 filicides committed by either parent occurred in incidents where more than one person was killed. The additional victim(s) could be a spouse and/or one or more children.

74 The authors report that they only studied in detail the cases of 70 children whose death was not a neonaticide, and was not followed by the suicide of one of the parents. In fact, the information presented about these 70 children did not contain many details.
Comments on Vanamo et al.

A study by Haapasalo & Petaejae (1999) about maternal filicide between 1970 and 1996 by mothers who did not make a fatal suicide attempt contains information that may supplement the information provided by Vanamo et al. Haapasalo & Petaejae reported the following:

- Of 48 filicidal mothers, 15 had committed neonaticide and 33 mothers had killed or tried to kill one or more of their children after they were more than one day old.
- These 33 mothers had 39 victims, of whom only six survived.
- Of the 33 mothers, 13 had made a nonfatal suicide attempt in conjunction with the filicide attempt and another eight had planned to make a suicide attempt that they did not carry out.

Haapasalo & Petaejae did not provide any information on cases of maternal filicide where the mother had made a fatal suicide attempt.

Both studies used national records. The main difference is that Vanamo et al. studied the period from 1970 to 1994, and Haapasalo & Petaejae the one from 1970 to 1996. Vanamo et al. did not provide information on nonfatal suicide attempts that may have happened in conjunction with the filicide, while Haapasalo & Petaejae only reported on mothers who did not make a suicide attempt or a nonfatal one. This means that when I add the 20 mfs mothers with a fatal suicide attempt between 1970 and 1994 reported on by Vanamo et al. to the 13 mfs mothers with a nonfatal suicide attempt between 1970 and 1996 reported on by Haapasalo & Petaejae, there is no overlap.

There may be some minor discrepancies in the methods used by Haapasalo & Petaejae and Vanamo et al. to include cases in their respective studies. In addition, there are no data on fatal suicide attempts in 1995 and 1996. Yet, I do consider it acceptable to add the numbers of these two studies in order to make a global estimate of the number of filicide victims, whose filicide occurred in conjunction with the parent's, and especially the mother's fatal or nonfatal suicide attempt.
As to rates, Vanamo’s account of 75 victims of filicide followed by a fatal suicide attempt by either parent amounts to 0.6 child per year per million of the general population (estimated at 5 million) between 1970 and 1994. When victims of an unknown number of fathers\textsuperscript{77} and 13 mothers\textsuperscript{78} making nonfatal suicide attempts in conjunction with the filicide, are added the rate will probably rise to approximately 0.8.\textsuperscript{79}

The combined data of both the Vanamo and the Haapasalo studies mean that in Finland, between 1970 and 1996, 53 mothers killed or tried to kill one or more of their children that were older than 24 hours. Of these 53 mothers, 20 made a fatal suicide attempt, 13 made a nonfatal suicide attempt and another 8 had planned a suicide attempt in conjunction with the filicide which they did not carry out\textsuperscript{80}.

The number of 33 mothers making fatal or nonfatal suicide attempts in conjunction with filicide during a 26-year period in a country with a general population of 5 million amounts to a rate of one mother per 4 million of general population per year.

\begin{footnote}{77} As to the unknown number of fathers, it has to be kept in mind that fathers’ suicide attempts in conjunction with filicide generally are fatal, so their number might be small.\end{footnote}

\begin{footnote}{78} The 33 mothers, who made no suicide attempt or a nonfatal one and who killed or tried to kill one or more of their children older than 24 hours, had 39 victims, of whom 6 survived. Therefore, 33 children were killed. The exact number of victims of the 13 mothers making nonfatal suicide attempts is not known.\end{footnote}

\begin{footnote}{79} The estimated figure of 0.8 does not include an estimate of filicide among the 57 children dying in cases of undetermined death, 20 of which were under the age of two and did not show injuries.\end{footnote}

\begin{footnote}{80} Including the victims of these eight mothers in the rate of children per million of the general population per year whose filicide occurred in the context of parental suicidal behavior would make it necessary to increase my estimates of this rate.\end{footnote}
Even though these data do not include information on any fatal suicide attempts following filicides in 1995 and 1996, the fact that 41 of the 53 known cases of maternal filicide were associated with suicide is significant. It is particularly significant in light of the fact that this study was conducted to learn more about child abuse in Finland. According to several studies, mfs usually is not accompanied by child battering (Alder & Baker, 1997; Alder & Polk, 2001).

The focus on child abuse in the study by Vanamo et al was strong. In fact, all 19 studies listed in Vanamo's reference section showed an emphasis on (fatal) child abuse. This may also explain why Vanamo et al. (2001) did not refer at all to the study by Haapasalo & Petaejae (1999).

81 There are some discrepancies in the data. Haapasalo & Petaejae speaks of 33 children older than 1 day killed between 1970 and 1996 by mothers who did not make a suicide attempt or who survived one, while Vanamo et al. speak of 43 children older than one day killed between 1970 and 1994 by mothers, of who we only know that they did not make a fatal suicide attempt.
Bourget & Gagne (2002)

Bourget & Gagne (2002) examined the data of all 27 mothers who had killed 34 children during the eight-year period from 1991 through 1998 in the province of Quebec. Of the 27 mothers, 11 had made a fatal suicide attempt and four a non-fatal attempt after their act of filicide. The authors applied a revised classification system for filicide to the current sample. The following information refers to all 27 mothers and is not broken down for the various categories (mentally ill, fatal abuse, retaliating, mercy, and other)

- A psychiatric motive was determined to have been present in 85% of the cases.
- Domestic violence was found in the lives of 6 of the 27 women, and it may have been present to a greater or lesser extent in the lives of 15 of the other 21 mothers. Indications of a possible presence of domestic violence were not found in the six cases of mothers who killed multiple children and made a fatal suicide attempt.
- The age range of the mothers was 19-49, while the average was 32.25.
- The age distribution of the children was 8 children under the age of one, 17 from one through five years, 7 from six through ten years, and 2 older than ten years.

About the 15 mothers making suicide attempts after their filicide (11 of them fatal and 4 nonfatal) the following information is provided:

- Six mothers killed multiple children and made a fatal suicide attempt.
  - One of these six mothers killed three children using carbon monoxide
  - Five mothers killed two children: Two of them used carbon monoxide, two used a firearm, and the fifth stabbed.
  - The suicide attempt was fatal in all six cases and took place immediately after the filicide.
Five of the six mothers had left suicide notes. The stabbing mother had not left a suicide note.

All six had received psychiatric treatment.

Three of these six mothers had told a doctor or mental health clinician about “their problem”. The authors did not indicate whether ‘problem’ referred to a stressor that may have triggered the mfs act, to having ideation about making an mfs attempt, or to something else.

Only one of the six mothers was reported to have been suffering from psychosis prior to committing her act of mfs. This mother had been sexually abused for a long time by her father and a brother, and had been having serious and chronic symptoms of mental illness, such as a long-time plan to hang herself. She also was three months postpartum.

Five mothers made a fatal suicide attempt after killing one child.

Of these five, four had left suicide notes.

Psychiatric treatment for depression had been received by four of the five mothers.

Three of the five had contacted ‘others’ about their ‘problems’.

Four mothers made a non-fatal suicide attempt after their filicide.

None of them had left a suicide note or told others about their “problems”.

Three of them had received psychiatric treatment.

The age of one of these four mothers was mentioned in a case description. It was 43 at the time of the offense.
Revised Classification system

The authors applied a revised classification system for filicide to the current sample. This system represents a revision of a system that Bourget & Bradford (1990) had proposed earlier, and includes

- Categories for mentally ill, fatal abuse, retaliating, mercy, and other
- Specifiers for association with suicide, association with substance abuse and predictability
- A requirement to make a note of the presence or absence of intent and mental illness

In other words, a mother involved in filicide could be placed in the category fatal abuse and be considered mentally ill at the same time. Only when the mental illness is so dominant that the category of mentally ill better accounts for the patient’s behavior than the category of fatal abuse, should the patient be assigned to mentally ill. The revised system includes a new specifier *predictable*, which is to be applied to cases, where it was known that the mother was severely mentally ill, and had communicated filicidal intentions. The authors also suggest future revisions to adjust to new knowledge, for instance about serotonergic and genetic factors.

Comments on Bourget & Gagne (2002)

The 15 mothers making suicide attempts in conjunction with a filicide attempt represent a rate of one mother per four million of the general population per year for Quebec (population estimated at 8 million). This is within the range of other geographic units, although on the high side. In
addition, 22 children were killed in conjunction with fatal or nonfatal suicide attempts by mothers, or 0.35 children per million of general population per year. This figure only refers to children killed as a result of maternal filicide-suicide.\textsuperscript{82}

The authors do not mention what the psychiatric treatment received by 13 of the 15 mothers who had made fatal or nonfatal suicide attempts had consisted of. It makes quite a difference whether the treatment consists of once weekly psychotherapy on an outpatient basis or whether one has been hospitalized for some months.

The authors do not mention, whether any of the 12 mothers, who did not make a suicide attempt, may have planned to do so as part of an mfs plan, but were unable or unwilling to carry it out after the filicide attempt had been completed. Some of the methods for filicide used by these 12, such as drowning and strangulation, suggest that some of the nine mothers, who reportedly did not kill as a result of fatal child abuse, might have been contemplating a suicide attempt. Other studies found some cases of filicide in which the suicide plan was not carried out. (D' Orban, 1979; Haapasalo & Petaejae, 1999)

The fact that none of the four mothers making nonfatal suicide attempts had left a suicide note, while nine out of the 11 mothers making a fatal suicide attempt had done so, is potentially very significant. The absence of a suicide note and the nonlethal outcome of the suicide attempt suggest the possibility of impulsivity and lack of premeditation and preparation. At the same time,

\textsuperscript{82} If the paternal component were similar, the rate would be 0.7, which is in the range of most countries.
the presence of a note and the lethal outcome of the suicide attempts suggest that these 11 women, at least nine of them, had carefully planned their act, and therefore probably engaged in previous ideation and preparatory behaviors. The only mother killing multiple children, who had not left a suicide note, stabbed her children, which according to Lewis et al. (1998) often is associated with acting under the influence of psychosis.

In the context of the relationship between mfs and psychosis, it should be pointed out that the authors considered 23 of the 27 mothers to have acted with psychotic intent. This included all those who attempted suicide. Considering that only a few mothers had been diagnosed with psychosis and only one mother was reported to have made the mfs attempt under the influence of psychosis, it is important to learn more what exactly is meant by psychotic intent. In this context, it is also important to point to the fact that many of the mfs attempts accompanied by a fatal suicide attempt showed a considerable degree of premeditation, and little of the impulsivity that often is associated with psychosis.

Many of these cases are designated predictable in the context of the revised classification system because clinicians knew how serious the mental illness of some of the mothers was. In Chapter 6, 7, and 8, the interrelated issues of intent, predictability, the relationship between psychosis and mfs, the role of “delusions of salvation”, and the relationship between a diagnosis of psychosis and ‘being in an acute psychotic episode’ will be addressed. The remarks and observations made in this study by Bourget & Gagne will be further discussed in that context.
Population Studies with only Living Subjects

One of the most important studies (D’Orban, 1979) has already been reviewed earlier in this chapter.

Scott (1973)

Scott (1973) proposed a classification system that was not based on motives, since he considered that as too subjective. Instead, he introduces the notion of the origin of the impulse to kill one’s child. When a parent kills because of displaced anger, the stimulus is said to have originated outside of the victim. However, when the parent kills because the child made him or her lose his or her temper, the stimulus is said to have come from the child. In addition, there was a category of gross mental pathology, where the notion of the origin of the stimulus to kill was irrelevant.

In re-analyzing a sample of 39 mothers who had killed one or more children between 1957 and 1962, Scott assigned 32 of them to the category of gross mental pathology. Of these 32, 13 had made a nonfatal suicide attempt.

Comment on Scott

During the period of 1957-1962 in England and Wales, recorded cases of fatal battering, which usually are not associated with mental illness or gross mental pathology, were much less numerous than in the 1970's (D’Orban, 1979), while on average 12 mothers per year made a fatal suicide attempt. In the 1970's this number had dropped from 12 to five. (Gibson, 1975; Wilczynski
& Morris, 1993) Therefore, the mothers who made a nonfatal suicide attempt in the 1957-1962 period are likely to have not planned it well, which suggests that they may have been psychotic. Scott’s assessment of gross mental pathology for 32 of these 39 mothers therefore may have been correct. However, it is unfortunate that Scott did not address the fact that many mothers had made fatal suicide attempts, and might have had a different type of psychopathology than the 39 mothers in his sample, especially the 13 who made a nonfatal suicide attempt.

Scott’s proposals for a new system of classification of child homicide have not widely been accepted.

**Cheung (1986)**

Cheung (1986) studied maternal filicide in Hong Kong between 1971 and 1985, and reported to have used D’Orban’s (1979) classification system. As in D’Orban’s study, all women charged with filicide or attempted filicide were psychiatrically evaluated.

Cheung reported that “marked similarities and little differences were noted when our findings are compared with those of Western researchers” (p.185). The author points to similarities in the age of the victims, the age of the mothers, methods used, and the distribution of the mothers across the various categories in the applied classification system.

Before comparing suicidal behavior in Cheung’s study with D’Orban’s findings, I want to address three aspects of the study as a whole (Table 5.3). First, there is the number of offending
mothers, 35 for Cheung, and 89 for D’Orban. This may be similar to or in the same range as
D’Orban’s findings if we allow for the difference in the number of years and the size of the general
population. Yet, the numbers are definitely not comparable for the years 1971 through 1975,
which are among the six years researched by D’Orban. During these five years, Cheung reported
that four mothers were involved in maternal filicide, while d’Orban spoke of 89 for six years. This
means that the numbers in D’Orban’s study were four to five times higher than in Cheung’s study,
allowing for the difference in populations and the number of years. The results during Cheung’s
third five-year period, 1981-1985, were similar to D’Orban’s results from 1970-1975. No
explanation for the rise from four cases during the first 5-year period to 20 cases in the third five-
year period was provided.

Secondly, the mothers in Cheung’s sample “scored” much better than the ones in D’Orban’s
sample on most of D’Orban’s 20 correlates of filicide, especially in regards to family of origin
issues. The possibility that cultural differences might be responsible for how much information
about one’s family one is willing to divulge, is not discussed except that Cheung reported that all
mothers but one were Chinese.

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83 D’Orban’s 89 mothers during six years from a general population consisting of 15-20
million are compared with Cheung’s 35 mothers during a 15-year period from a general population
of 4 million.
Table 5.3 Comparison between the findings of D’Orban (1979) and Cheung (1986)

### Table 5.3a: Overall information

<table>
<thead>
<tr>
<th>item</th>
<th>Cheung</th>
<th>D’Orban</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>location</td>
<td>Hong Kong</td>
<td>South East of England, incl. London</td>
<td>Both predominantly urban</td>
</tr>
<tr>
<td>Size of population</td>
<td>4 million</td>
<td>15-20 million</td>
<td></td>
</tr>
<tr>
<td>Time period covered</td>
<td>1971-1985 (15 years)</td>
<td>1/1/1970-12/31/1975 (six years)</td>
<td></td>
</tr>
<tr>
<td>Nonfatal suicide attempts</td>
<td>10</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Fatal suicide attempts</td>
<td>Not included</td>
<td>Not included</td>
<td></td>
</tr>
<tr>
<td>Age limit of child</td>
<td>12</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>

### Table 5.3b # of cases per five-year period

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<tr>
<th>item</th>
<th>Cheung</th>
<th>D’Orban</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td># of mothers-total</td>
<td>35</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td># of mothers during 1971-1975</td>
<td>4</td>
<td>5/6 x 89 = 75</td>
<td>England a factor five higher</td>
</tr>
<tr>
<td>1976-1980</td>
<td>11</td>
<td>No information</td>
<td></td>
</tr>
<tr>
<td>1981-1985</td>
<td>20</td>
<td>No information</td>
<td></td>
</tr>
</tbody>
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### Table 5.3c Types of maternal filicide

<table>
<thead>
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<th>Item</th>
<th>Cheung</th>
<th>D’Orban</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td># of mothers-total</td>
<td>35</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td># battering</td>
<td>11</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td># mentally ill</td>
<td>14</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td># neonaticide</td>
<td>6</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td># retaliatory</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td># unwanted</td>
<td>1</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td># mercy killing</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
A third aspect concerns the number of offending mothers in the 15-19 age bracket which is reported to represent 11% of all filicidal mothers, while this age bracket represents only 0.39% of the general female population of Hong Kong according to Census data quoted by Cheung. (See Table 5.4) It seems impossible that an age bracket comprising the five years from age 15 through 19 would only represent 0.39% of all women in Hong Kong.84

Table 5.4: Age distribution of offenders compared with census data.
Copied from Cheung (1986), p.186

<table>
<thead>
<tr>
<th>Age</th>
<th>No.</th>
<th>Filicide %</th>
<th>Census %</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>4</td>
<td>11.4</td>
<td>0.39</td>
</tr>
<tr>
<td>20-24</td>
<td>5</td>
<td>14.3</td>
<td>4.71</td>
</tr>
<tr>
<td>25-29</td>
<td>17</td>
<td>48.6</td>
<td>11.65</td>
</tr>
<tr>
<td>30-34</td>
<td>5</td>
<td>14.3</td>
<td>13.61</td>
</tr>
<tr>
<td>35-39</td>
<td>3</td>
<td>8.5</td>
<td>8.45</td>
</tr>
<tr>
<td>40-44</td>
<td>1</td>
<td>2.9</td>
<td>9.48</td>
</tr>
<tr>
<td>Over 44</td>
<td>0</td>
<td>0.0</td>
<td>51.71</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Comments on Cheung

As most suicidal behaviors occur among mothers in the mentally ill groups, Cheung's and D'Orban’s findings for the respective mentally ill groups will be compared (Table 5.5).

84 The possibility that the 0.39% figure did not refer to the percentage of the general female population that is in the 15-19 year age bracket, but instead to another entity, such as the percentage of mothers in the general population that is 15 to 19 years old cannot be completely ruled out, but appears to be rather unlikely. In this context, Cheung speaks of, "The age of the subjects is shown in Table IIa. The commonest age group was 25-29 years. As compared with the general population (Hong Kong Census, 1981), there were more mothers in the younger age group." (p. 186).
Table 5.5 Comparison of findings of Cheung (1986) and D'Orban (1979) with respect to category of the mentally ill

Table 5.5a General Information

<table>
<thead>
<tr>
<th>Item</th>
<th>Cheung</th>
<th>D'Orban</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior psychiatric treatment</td>
<td>70% (10 out of 14)</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Prior suicide attempts</td>
<td>8</td>
<td>No information</td>
<td></td>
</tr>
<tr>
<td>Nonfatal suicide attempts</td>
<td>8</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Average size of family/average number of children X number of mothers in mentally ill category</td>
<td>2.8 x14=39</td>
<td>2.29 x 24=55</td>
<td></td>
</tr>
</tbody>
</table>

Table 5.5b Age of victims

<table>
<thead>
<tr>
<th>Item</th>
<th>Cheung</th>
<th>Cheung adjusted: 1.5 x number in column to the left: adjusted for 15 vs. 6 years, and 4 vs. 16 million population.</th>
<th>D'Orban</th>
</tr>
</thead>
<tbody>
<tr>
<td># Mentally ill mothers</td>
<td>14</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td># of children</td>
<td>2.8 x14=39</td>
<td>2.29 x 24=55</td>
<td></td>
</tr>
<tr>
<td># victims 0-6 months</td>
<td>7</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td># victims 6-24 months</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td># victims 24-36 months</td>
<td>3</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>3-7 years</td>
<td>4</td>
<td>6</td>
<td>7 (age 3 and 4)</td>
</tr>
<tr>
<td>8-11 years</td>
<td>1</td>
<td>2</td>
<td>6 (age 5 and over)</td>
</tr>
<tr>
<td># victims of mentally ill mothers- total</td>
<td>16</td>
<td>26</td>
<td>41</td>
</tr>
</tbody>
</table>
The similarities between the mentally ill categories in Cheung’s and in D’Orban’s studies consisted of the fact that 10 of Cheung’s 14 mothers had received prior psychiatric treatment, and that the overall numbers seemed quite similar. However, there are also differences between the findings of the two studies.

Only one (two in the adjusted format) of Cheung’s 16 child victims was in the age bracket of 6-24 months, while 10 of D’Orban’s 41 victims were.

Only two mothers were reported to have killed or attempted to kill (actually Cheung spoke of only “attempted to kill” rather than “killed or attempted to kill” for these two mothers) more than one child. Each of these two mothers had two victims. In D’Orban’s study, 14 of the 18 mothers who had more than one child killed or tried to kill more than one child, while six killed an only child.

The 24 mothers in d’Orban’s group had 41 victims, of whom 19 survived. In fact, eight mothers ended up not killing any children. Cheung does not report on victims who survived except in a general and indirect way by speaking of “killing or trying to kill”.

In light of the fact that the mothers in the mentally ill group, on average, had 2.8 children, it appears that most of the mothers killed or tried to kill only one of their children, while they had more than one child. In D’Orban’s study, only four of 18 mothers with more than one child did so.
Unlike D’Orban (1979), Cheung did not speak of extended suicide or motives of altruism that tend to be used in describing mothers who kill or try to kill all their children. Mothers who kill only one child while they have more, and in addition make a nonfatal suicide attempt, as many in Cheung’s study appear to have done, often do not plan their act in advance and also may act in an impulsive and not very deliberate manner. Nevertheless, the intent at the moment of the attempt may have been high and the nature of the attempt may have been serious. Yet, the impulsivity may be responsible for the nonfatal outcomes. Mothers who are engaged in these types of mfs behaviors often have high rates of psychotic symptoms. (Graser, 1992; Lewis, 1998)

These data suggest the possibility that most of Cheung’s 14 mentally ill mothers were suffering from high rates of psychotic symptoms. This may apply to the mothers of the seven children under the age of six months, who may have been suffering from post-partum symptoms. It may also apply to many of the other mothers because they only killed one child, while they had more children, and made a nonfatal suicide attempt. In most studies that include both mothers with fatal suicide attempts and mothers with nonfatal or no suicide attempts, the number of mothers making fatal suicide attempts in conjunction with filicide attempts (that usually are fatal and involve all children) is, at least as high as the number of mothers making nonfatal suicide attempts. 85 Therefore, it is possible that the number of Hong Kong mothers making fatal suicide attempts, about whom Cheung is not reporting, is at least as high as the number (10) of mothers making nonfatal attempts. However, it is likely that in Hong Kong during the period covered by Cheung’s

85 We now know that the number of fatal suicides during the period and in the area covered by D’Orban’s study may have been somewhere between 10 and 12 (it was approximately 30 for all of England and Wales), and thus similar to the 13 nonfatal suicide attempts in the mentally ill group.
study the number of fatal suicide attempts is higher than the number of nonfatal attempts, because so many of the nonfatal attempts may be associated with psychosis and impulsivity. This suggests the possibility that mothers who are more associated with altruism and extended suicide, and who may plan and prepare better, generally have been making fatal suicide attempts.

Cheung had mentioned that most of the mentally ill mothers were known to psychiatric institutions before they made the mfs attempt. This information has to be evaluated against the background of the hesitant attitude many Chinese may have towards psychiatric treatment, which may not have been widely available anyway. In other words, the mothers in Cheung’s study may only be representative for that part of the population of Hong Kong that could be considered as within the potential reach of psychiatry. In this context we have to be aware of the fact that in cultures where receiving psychiatric treatment is stigmatized, which it may have been in Hong Kong at the time, those receiving psychiatric treatment anyway may have very obvious and serious symptoms.

An additional possibility is that the type of mother seen in D’Orban’s study, who tends to be involved in extended suicide and to kill or to attempt to kill all her children in a manner that is perceived as painless by her, may be less prevalent in Hong Kong. Reasons for this could consist of lack of opportunity considering that mfs events usually occur in the home. Living in small quarters, often with extended family, may provide formidable obstacles to a mother who is not known to be psychotic, but so desperate that she wants to make an attempt at mfs. A second frequently used method in many studies consists of car exhaust, for which one needs a car, and a
garage or an isolated outdoor location. All of these may have been scarce in Hong Kong in those years.

There is no information about the prevalence of mfs with fatal suicide attempts. The only information with respect to mfs mothers who made a fatal suicide attempt consists of Cheung’s remark that the mentally ill might have been underrepresented in the study because mothers who made fatal suicide attempts probably had symptoms on the basis of which they would have been assigned to the mentally ill category.

In fact, there is no information about female suicide rates in Hong Kong in general. Suicide rates may have been high because there may have been many refugees from mainland China. Many of these refugees may have been traumatized during the Cultural Revolution there during which as many as 20 million people reportedly were killed. Fear because of the handover from Hong Kong to China in 1999, about which there was no agreement until 1984, may also have played a major role in the rise of the number of filicides between 1971 and 1985. These factors also may have had an impact on rates of regular/simple suicide. Such factors were not present in England during the period that was covered by D’Orban’s study.
Haapasalo & Petäjä (1999) studied the following aspects of maternal filicides in Finland between 1970 and 1996 that were not followed by a fatal suicide attempt: circumstances and stress factors in the mother’s life at the time of the act, psychological problems prior to the act, as well as the mothers’ childhood experiences. Based on the contents of mental state examinations, which are extraordinarily thorough in Finland, they provided the following information about the 33 mothers who had killed children older than 24 hours and younger than 12 years.

86. The MSE reports were individually analyzed using an assessment form specifically designed for this study. The form comprised the following sections: (a) Background (personal information, demographic data, current indictment, criminal history), (b) Homicidal act (circumstances, triggers, expressed motives, suicide attempts, alcohol and drugs), (c) Family situation (financial matters and living conditions, marital relationship, children), (d) Mother’s health (health problems, treatments, prior diagnoses, alcohol and drug abuse history), (e) Pregnancy, birth, infancy, and early development of the child victim(s), (f) Mother’s family-of-origin (financial and living conditions, relationships with parents, siblings), (g) Problems in the family-of-origin (parental substance abuse, criminality and mental health problems, physical, psychological and sexual abuse, neglect), and (h) Mental state examination conclusions.

87. In addition to comprehensive psychological testing and observation of the mothers during their pre-trial hospitalization, school records, medical files and many other documents are used. In addition, extensive questionnaires are sent to relatives, friends, and others who know the mother well about all aspects of the mothers’ lives, including their childhood.

88. They also wanted to examine to what extent these aspects differed between mothers who had committed neonaticide and those who had killed or attempted to kill children older than 24 hours. This review will only address the findings concerning the mothers who had killed “older” children.
• Attempt-related: outcome, methods, target (multiple, age, gender)
  o Of 48 filicidal mothers, 15 had committed neonaticide and 33 had killed or attempted to kill 39 children older than one day, six of whom survived. Of these 33 mothers, 6 killed or tried to kill two children, and 1 killed or tried to kill three children.
  
  o Methods used for filicide attempts (n=39) were: drowning: 13, drugging and drowning: 4, strangulation: 6, suffocation: 5, physical abuse: 4, stabbing/slashing: 3, and miscellaneous: 4.
  
  o The gender and age distribution of the 39 children was: 18 girls, 20 boys, 1 missing; fourteen under 12 months, eleven from 12 through 36 months, nine from 4 through 6 years, three from 7 through 10 years, and 2 were missing

• Demographic Information (n=33):
  o The mothers’ age was on average 30 years, with a standard deviation of six years
  
  o Seventy-seven % had completed their basic formal education and an additional 17% had a high school education. Occupational status ranged from skilled or semiskilled workers (71%) to managers and professionals (13%).
  
  o employed: 9, unemployed: 1, homemaker/maternity leave: 17, other: 3, missing: 3.
  
  
  o lived with spouse and children: 26, with children: 5, other: 2.

• Categories (n=33)
  o filicide-suicide: 13
  o impulsive aggression: 6
  o psychotic episode: 5
  o postnatal depression: 5
  o fatal child abuse: 4

• Suicidal Behavior (n=21)
  o 13 mothers made a nonfatal suicide attempt
  o 8 mothers contemplated making a suicide attempt, but did not carry it out after they had made their fatal or nonfatal filicide attempt
• Stressors: The five most pressing stressors were: 89 (n=33)
  o marital problems: 22 mothers
  o fatigue: 19
  o child-related stress: 18
  o pregnancy and childbirth: 16
  o financial difficulties: 14

• Psychological problems
  o 85% reportedly had some problem
  o 50% received some kind of professional help.

• Degree of legal responsibility
  o 63% were regarded as not legally responsible for their act due to insanity
  o 29% were not fully responsible and were thus given a reduced sentence

• Specific psychological problems prior to act
  o anxiety and fear (fear of death, fear of harming the child, overconcern for the child's health, phobias, nervousness, and tension): 15 mothers
  o behavioral problems (substance abuse, aggressive behavior, restlessness, suicide threats, and passivity): 12 mothers
  o depression and mood disorders: 27 mothers
  o obsessional thoughts (mainly concerning harming the child): 3 mothers
  o psychotic symptoms (hallucinations, delusions, distorted thinking, and disorientation): 10 mothers
  o Somatization and eating disorders: 9 mothers

89 Other stressors, with less prevalence than the five listed in the text include: Conflicts with extended family, Infertility treatment prior to pregnancy, Lack of social relationships, Miscarriage, Miscellaneous, Mother's physical illness, Partner's alcohol abuse, Partner absent from home for long periods of time, Physical and/or psychological child abuse, Poor housing conditions, Separation from spouse/partner, Work-related stress
Mother's own experience of child abuse under age 16

- Neglect: 15%
- Physical abuse: 27%
- Psychological abuse: 49%
- Sexual abuse: 9%

Problems in the family-of-origin:

Although childhood maltreatment was found... the majority of the mothers did not appear to have lived in multiproblem childhood family environments. For 56% of the mothers, no financial difficulties, parental alcoholism, parental mental health problems, or parental criminality were reported. (p. 230)

Qualitative portraits

Haapasalo & Petaejae also report that the contents of the reports of the Mental State Examinations, and especially the description of some of the personality features, could only be conveyed by the method of a qualitative portrait. Subsequently, Haapasalo & Petaejae paint a qualitative portrait of the 33 mothers:

The 33 non-neonaticide mothers were slightly older, mostly married and had stayed at home to take care of their children. Before the homicidal act quite unexpectedly occurred, most of these mothers were reported to have been 'perfect' mothers who took good, even meticulous, care of their children and were controlled and restrained in their relations with other people. In their jobs, most had been good workers, well liked and conscientious. Most of the children they killed/attempted to kill were under 4 years of age. One of the most common methods of killing or trying to kill the child was drowning in the bathtub. The mothers' current life stress was related to their family life, including marital problems. They also suffered from psychological problems prior to the incident, especially depression and mood disorder symptoms. They had usually spoken about their problems to someone: a spouse, friends, or family members. The non-neonaticide cases were classified into five qualitatively different subgroups: Joint homicide-suicide (n=13), Impulsive aggressiveness...
Following up on their observation that there were “five qualitatively different subgroups”, Haapasalo & Petaejae paint qualitative portraits for each of the subgroups except for the joint homicide-suicide subgroup. Comparison of these four portraits with the general portrait that has just been quoted suggests that the general portrait was more a description of the joint homicide-suicide subgroup than of the group of 33 mothers as a whole.

- Impulsive-aggressive mothers (n=6):

  “Marital and other problems were present in the cases of impulsive acts, and the accumulation of stress factors had led to a sudden displacement of pent-up aggressive feelings” (p. 233). Haapasalo & Petaejae described one incident of mfs with the motive of retaliation.

- Psychotic episode (n=5):

  Three of the psychotic mothers thought that they would be saving the child from the influence of a bad mother, from suffering in a bad world or from an ill fate and gloomy future by killing him/her; one thought that her child was not hers but a changeling, and one could not give any reason for what she did. (p. 233)

- Post-partum depression (n=5):

  The mothers who suffered from postpartum depression had had no significant problems earlier. They seemed to be happy while expecting the child and then suddenly became depressed and killed or tried to kill the child. (p. 233)

- Fatal abuse (n=4):

  “The abusive mothers had personality disorders and had abused their child even before the fatal incident” (p. 233).
Potential explanations suggested by Haapasalo & Petaejae

Haapasalo & Petaejae describe some potential explanations for the maternal filicidal behavior without linking the explanations to the five subgroups among the non-neonaticide mothers: joint homicide-suicide/filicide-suicide, impulsive-aggressive, psychotic episode, postnatal depression, and fatal child abuse. The explanations will be quoted verbatim for the most part. Comments will follow in the section Comments on Haapasalo & Petaejae.

Mental illness. Haapasalo & Petaejae suggest that the high degree of suicidality (13 nonfatal attempts and 8 mothers having planned suicide without carrying it out) indicates a high degree of mental illness. They believe that this is confirmed by the finding that 73% of the 33 non-neonaticide mothers were found to have been mentally ill. Possible reasons for the high incidence of mental illness, according to Haapsalo et al. “could be that there may have been many cases of delusional psychosis and severe depression, or that the threshold for diagnosing mental illness in a mother who has killed a child older than 24 hours may be low” (p. 234).

Another reason for the high percentage of diagnoses of mental illness might consist of the fact that these mothers have been quite “forthcoming about their psychological problems” (p. 234) before they killed one or more of their children.

Perfectionism. Haapasalo & Petaejae suggest that the fact the mothers were known to be meticulous in the care of their children indicates that they may have . . . tried to excel in motherhood . . . and may have been suppressing their negative feelings and impulses in the process. When the stress in the lives of these mothers increased, they no longer were able to inhibit negative feelings. When these negative
feelings surfaced, they may have triggered psychotic breakdowns, as well as feelings of depression and aggressive behaviors . . . [which] may have led to the act. (p. 235)

**Negative childhood experiences**

Abuse and insecure parent-child attachments in childhood could have had repercussions on the mothers' self-esteem and, later, on their self-confidence as a spouse and mother. Consequently, psychotic delusions and depressive thoughts may center on distorted thinking of oneself as a bad mother who is not capable of taking care of her children. (p.235)

**Attachment perspective**

It appears that an attachment relationship between caregiver and child develops during the child's first few years. Any disturbance in the development of attachment may lead more easily to extreme behaviors at that point than later when the relationship has already been established and various strategies to cope with the relationship have emerged. (p.234)

Finally, Haapasalo & Petaejae recommend that asking direct questions regarding a mother's life conditions and stressors as well as addressing difficult topics, such as family violence and child abuse, may help to identify at-risk mothers.
Comment on Haapasalo & Petaejae

This study contains much relevant information, which probably is quite accurate considering the thoroughness of the Finnish Mental State Examinations. It is unfortunate that there was no information about

- mothers who had made a fatal suicide attempt after their filicide
- the nature of the nonfatal suicide attempts
- differences among the five subgroups of the 33 non-neonaticidal mothers with respect to the various variables

The number of mothers experiencing specific psychological problems prior to their act suggests certain interrelations between the five subgroups and specific psychological problems. For instance, 5 of the 10 mothers who experienced psychotic problems prior to their act probably are accounted for by the five mothers in the subgroup psychotic episode. Quite possibly, the subgroup postnatal depression was heavily represented here as well. If this indeed were so, then this would indicate that many of the 13 joint homicide-suicide mothers did not experience psychotic symptoms prior to their act. Since the presence of psychotic symptoms prior to the act of mfs is a central theme of this dissertation, this particular finding by Haapasalo & Petaejae is of special importance.

As to the other psychological problems, the 15 mothers experiencing anxiety and fears may well have been heavily represented in the subgroup joint homicide-suicide considering the contents of the fears, such as fear of death, fear of harming the child, overconcern for the child's health, phobias, nervousness, and tension. Behavioral problems may have been prevalent among mothers in the impulsive-aggressive subgroup and those in the fatal child abuse subgroup. Considering that
27 mothers were found to be depressed, one wonders whether depression might be seen as a necessary condition for mfs.

Several comments on the attachment perspective and the position of Haapasalo & Petaejae may be appropriate considering the importance that Haapasalo & Petaejae attribute to the filicidal mother's childhood experiences. About the attachment perspective Haapasalo & Petaejae remarked, as pointed out earlier,

> It appears that an attachment relationship between caregiver and child develops during the child's first few years. Any disturbance in the development of attachment may lead more easily to extreme behaviors at that point than later when the relationship has already been established and various strategies to cope with the relationship have emerged. (p. 234)

- The statement just quoted refers to an attachment relationship between mother and child and, specifically, how the relationship is experienced by the mother. It deserves notice that this differs from the way attachment is usually presented, i.e. the development of the child’s attachment to the mother (or patterns of attachment among adults).

- It is not completely clear from the statement whether Haapasalo & Petaejae is referring to the relationship between the filicidal mother and her own mother/parent or between the filicidal mother and her own child. Haapasalo & Petaejae refer to extreme behaviors in the early phase of the development of the attachment process. Considering that filicide is an extreme behavior, and that Haapasalo’s study deals with women who have killed or tried to kill a child, it appears that Haapasalo & Petaejae is referring to the mother’s relationship with her own young child/children.

- It is not clear whether there actually is a disturbance in the attachment relationship between mother and child. Nor is it clear how the various subgroups of non-neonaticide mothers would be affected by the presence of such a disturbance, if there were one. With respect to the filicide-suicide subgroup, for example, it appears that the fact that the mother considers herself a bad mother, may cause her to contemplate (extended) suicide based on a belief that she will always be a bad mother, and that, therefore, her child will be increasingly unhappy. When such a belief by the mother is congruent with Haapasalo’s definition of a disturbance in the attachment relationship, Haapasalo’s statement makes sense.
There is also the possibility of the mother re-experiencing the disturbed attachment relationship she may have had with her own mother in her childhood. The re-experience may have been triggered by her child reaching the age at which the mother was experiencing these problems. The memories from her own childhood may have been so overwhelming that they clouded her consciousness, as a result of which she may have started to believe that her child was experiencing the same attachment problems with her. This could easily lead to guilt, hopelessness, and depression exacerbated by state-dependent memories. Meanwhile, in reality such problems may not have existed or may have been relatively minor.

The remark made by Haapasalo & Petaejae, “psychotic delusions and depressive thoughts may center on distorted thinking of oneself as a bad mother”, illustrates the definitional issues surrounding psychotic activity. Are Haapasalo & Petaejae referring to ‘mere’ cognitive distortions or to delusions, and in what manner and to what extent do the concepts of cognitive distortion and delusions differ from each other?

Considering that Haapasalo & Petaejae reported that 85% of the mothers had experienced psychological problems and about half of the mothers had received some type of professional help, it is likely that a process (possibly including suicidal, filicidal or filicidal-suicidal ideation) preceded the filicide act, and especially the mfs acts.

To what extent filicidal-suicidal ideation was present, and, if present, to what extent it was known to clinicians is not discussed by Haapasalo & Petaejae. However, the authors had mentioned that some of the mothers were known to be suicidal. They also had remarked that the psychological problem of anxiety and fears, which reportedly was affecting 15 mothers prior to their filicide attempt, could include fear of harming the child. Both the suicidality and the fears of harming the child suggest the possibility of a filicidal-suicidal process prior to the act of filicide or mfs.
As to risk factors, this study contains much information that could be helpful in formulating risk factors for filicide and mfs, including information about potential stressors, psychological problems, and childhood abuse. Unfortunately, any links between this information and the five non-neonaticide subgroups can only be speculated about, as I have done in this review.

Finally, the authors’ exhortation to address difficult topics, especially family violence and child abuse, as a preventive measure, is somewhat surprising because only four of the 33 mothers who killed a child were in the subgroup of fatal child abuse, while family violence did not figure large in this study except maybe for the six mothers in the impulsive-aggressive subgroup. It would have made more sense if the exhortation about addressing difficult topics also had included mfs ideation, and maybe even some mfs behaviors, such as aborted attempts.

**General Comments on Population Studies**

It may be useful to list the most noteworthy findings in regards to population studies at this point

*Prevalence*

The narrow range, within which prevalence figures are located, might have been expected given the research findings of Coid (1983) about the similarity between countries and stability over time. Yet it is striking to see that the great majority of studies show a figure between 0.4 and 0.8 children per million of general population per year killed by a parent in conjunction with that
parent’s fatal or nonfatal suicide attempt. The stability and similarity of this rate is a phenomenon that does not appear to be related to the total number of filicides or homicides in a country.

The percentage of all filicides that is associated with a parent’s suicidal behavior is also remarkable. Of the 79 child deaths due to filicide in Sweden, 58 (approximately 70%) occurred in the context of filicide-suicide. In Quebec, 22 of the 34 child deaths due to maternal filicide occurred in the context of fatal or nonfatal suicide attempts by the mother. In addition to these 22 child deaths, there may have been additional cases where the mother had planned to make a suicide attempt after the filicide, which she did not carry out.

Data in the USA are less complete than in many other countries. Yet, it appears that 30 to 50% of child deaths are related to parental suicidal behavior. The major differences between the USA and other developed countries in regards to filicide are

- incomplete data in the USA
- higher filicide rate in USA
- filicide in USA claims fewer victims than other forms of child homicide
- fatal child abuse in USA claims more victims than filicide-suicide
- There are some indications that in the USA there may be more males killing children, spouse, and self. Access to guns appears to play a role.
- Studies conducted in the USA which include a large percentage of African Americans show relatively high filicide rates and relatively low filicide-suicide rates. Because many studies in the USA have been conducted in urban areas with a high percentage of blacks, the impression has taken hold that filicide-suicide rates are lower in the USA than elsewhere. The results of the study by Chew (1999) about an entire state, California, suggest the possibility that rates there might be similar to those in other developed countries, and maybe even higher.
Fatal vs. Nonfatal Suicide Attempts

The three studies (Alder & Baker, 1997, Alder & Polk, 2001; Bourget & Gagne, 2002) included in this review that contained information on mothers who had made a fatal suicide attempt in conjunction with the filicide of their child as well as on those who had made a nonfatal attempt show differences between these two groups that could be significant. They certainly run counter to the observation of many researchers that, clinically, cases with fatal suicide attempts are similar to those with a nonfatal attempt. (Okumura & Kraus, 1996; Nock & Marzuk, 1999) A re-analysis of the cases descriptions of maternal filicide in Alder & Polk (2001) clearly demonstrated the difference between mothers whose suicide attempt was fatal and those whose suicide attempt was not fatal.

The mothers, whose suicide attempt was fatal, generally had left suicide notes, used methods for both the suicide and the filicide that were lethal and, certainly for the filicide, perceived as painless. They also tended to kill multiple, if not all their children. Their attempt appeared to be premeditated, and well planned in case of the fatal suicide mothers. They had been high functioning. While they often had a history of long-term psychiatric problems, these problems generally did not include symptoms of a thought disorder. There are no indications that they reported command hallucinations, for example.

The nonfatal suicide mothers tended to make attempts at filicide and suicide that were serious. However, due to impulsivity and lack of adequate planning, their attempts were more often nonfatal for both the filicide and the suicide. Because the attempts were serious, they could cause severe injuries. Two of the three mothers in the study by Alder & Polk (2001) were known to have
been suffering for several years from delusions and hallucinations. They were functioning very poorly. Alder & Polk designated their condition *extreme psychiatric disturbance*, while they referred to the fatal suicide mothers as *filicide-suicide*. The only mother in the filicide-suicide category who made a nonfatal suicide attempt also made nonfatal attempt at the life of two of her children, while she did kill the youngest child. That attempt had not been well prepared.

The example in Alder & Polk (2001) illustrates that it is important to pay attention to whether fatal suicide mothers are included, when one is evaluating studies on maternal filicide. When fatal suicide mothers are not included in a study, it is important to have at least a global idea of the numbers involved, and how a study’s findings might have been different if they had been included. For instance, both Cheung (1986) and D’Orban (1979) report that in their studies, which had an identical approach and only included living subjects, those filicide categories that are most associated with suicide, i.e. the *mentally ill* category, are probably underrepresented. D’Orban presented this information in a way that suggested that the number of fatal suicide mothers might have been 15 times higher than that of nonfatal suicide mothers. Cheung did not suggest any numbers for fatal suicide mothers. However, a detailed re-examination of the data in both the Cheung and the D’Orban study suggests that the extent to which fatal suicide mothers were underrepresented was more serious in Cheung’s study than in D’Orban’s. Harder (1967) based his conclusions of the motives of mothers who made an mfs attempt exclusively on the 10%, whose attempt was nonfatal. Yet, he suggested that his conclusions about certain aspects of mfs, such as the motive of altruism, which he rejected, were valid for all mfs mothers regardless of the outcome of their suicide attempt.
Psychopathology/Motivation

Studies differ with respect to the explanations they propose for maternal filicide, including mfs. They also differ with respect to the variety of motives that could play a role. It might be appropriate to make use of the concept of a continuum to describe this. On one end of the continuum, we see studies, especially older ones (McDermaid & Winkler, 1955; Tuteur & Glotzer, 1959), which discuss the etiology of maternal filicide, and especially mfs, only from the vantage point of mental illness. They usually referred to the presence of symptoms of psychosis or delusion as a major factor. Some of these studies differentiated between various types of maternal filicide, and suggested explanations that are still regarded as containing a good deal of validity, such as the concept of Child Centered Obsessional Depression (CCOD), which was coined by McDermaid & Winkler. Generally, these older studies did not address the impact of environmental factors.

It appears that the pendulum swung to the other end of the spectrum, where Silverman & Kennedy (1988) regarded all maternal filicide, incl. mfs that was not directly related to postpartum conditions as “child abuse gone awry” (p.124). They also referred to Straus (1980 a, b), who believes that only 10% of all child abuse is accounted for by psychological or psychosocial factors. Presumably, environmental factors played a major, if not a dominant role in the explanatory framework in these studies.

Many recent studies suggest that the great majority of mothers who made a fatal or nonfatal mfs attempt fall in one of three categories.
• Filicide-suicide, where the mother’s main motive was suicide, often referred to as extended suicide, or altruistic suicide, and associated with depression, anxiety and unfavorable environmental factors

• Retaliation, where the mother’s main motive was to spite the father of her children, and associated with highly volatile behavior, hospitalizations, suicide attempts and personality disorder

• Extreme psychiatric disturbance, associated with a history of schizophrenia, suicide and/or filicide attempts, and command hallucinations, referred to as acute psychotic episode by Resnick (1969).

The description of the psychopathology of mothers in the categories of retaliation and extreme psychiatric disturbance indicates that prior to the mfs attempt there were clear signs of a thought disorder and/or nonfatal attempts at simple/regular suicide.

With respect to the psychopathology of the filicide-suicide mothers, the literature suggests that suicidal motives generally are the driving force behind mfs rather than homicide. There also is a general recognition of the convergence of and interactions between mental illness, personality features and various stressors, especially interpersonal ones. A psychiatric disorder is regarded as a necessary, but not sufficient condition for mfs to occur. Lindqvist & Gustafsson (1995), whose study of 12 subjects included 10 cases of spousal h-s and only two of filicide-suicide of which one was mfs remarked that it is not possible to clearly pinpoint specific psychiatric disorders in h-s cases, while such a disorder appears to be a necessary condition,

The explanatory value of any particular psychiatric disturbance, including alcohol abuse, is therefore low, since the panorama of psychiatric disorder was so diffuse in both the present study and the literature as a whole. However, these fatal acts would not have occurred without the presence of severe mental disturbance. (p. 23)
From a point of view of psychopathology and motivation, it is also noteworthy that between 50 and 80% of mothers who made a fatal or nonfatal suicide attempt had been receiving psychiatric treatment at some point in their life, most of them recently or even around the time of the act. Okumura & Kraus (1996) as well as Meszaros & Fisher-Danzinger (2000) used the concept of *Typus Melancholicus* to refer to mothers that generally would be regarded as belonging in the category of filicide-suicide, of which the characteristics include performance-oriented, orderly, very responsible, anxious and hypernomic (overly inclined to follow rules) according to Okumura & Kraus (1996).

Other recent studies (Alder & Polk, 2001) while implicitly or explicitly recognizing the presence of a psychiatric disorder as a necessary condition, give much attention to the impact of environmental stressors. Some studies (Meyer & Oberman, 2001) refer to conflicting aspects of the role of a mother in modern society as a contributing factor.

Finally, many studies seem to reflect the problems their authors might have had with coming up with explanations for mfs behavior. Terms such as mental illness, delusional, psychotic, and insane often are used as if they are interchangeable. As a result, some studies that reported psychotic or delusional symptoms after a mother had made an attempt at mfs, in fact, described thoughts and beliefs held by the mother that most likely would not have been considered delusional or psychotic prior to the act.
Sadoff (1995) presented four cases of maternal filicide, illustrating neonaticide, infanticide, early filicide, and late filicide. Early filicide is the killing of one or more of one’s children when they are between the ages of 1 and approximately 12. In the case that is presented by Sadoff to illustrate early filicide, an overwhelmed mother kills her four children and was about to make a serious suicide attempt when outside intervention prevented that.

Sadoff reports that mothers involved in early filicide do not wish their children to have the same terrible experiences in life that they have had. Their desperate situation leads to depression and suicidal impulses, and eventually to a perception of mfs as the only solution left to them. Sadoff refers to Resnick (1969), who had called this type of filicide “altruistic”. In addition, Resnick reported to have learned from the mothers’ hospital charts some of which may have been 200 years old that many of the mothers had symptoms suggesting a diagnosis of psychosis. Sadoff illustrates these remarks about early filicide with a brief description of a case,

In one case, there was a boyfriend who was menacing and threatening and the mother of his five children attempted to kill them before she killed herself. Her delusional thinking was that if she had died and left the children, the father would rape the girls and torture the boys. She said she could not tolerate that in her thinking, so she attempted to kill them before dying herself. (p. 603)
Sadoff also provides a somewhat detailed description of another case of early filicide where the mother makes a nonfatal suicide attempt. Sadoff comments, among other things, on this mother’s lack of motivation to ask for help,

Theresa, as others, had been overwhelmed by the responsibilities and had little or no support system or availability of help. Furthermore, they [mothers such as Theresa who made an attempt at mfs] did not have the motivation or desire to ask for help and hoped to be able to handle the situation by themselves. (p. 603)

As to assessment and prevention, Sadoff describes “the paranoid condition” of the early and late filicide mothers as “a recognizable situation” (p.605). He suggests that this condition may be effectively treated and the mother removed from the stress of caring for her young children. “Signs and symptoms are present, but often ignored” (p. 605). Sadoff reserves an important role for the family doctor, who can observe the entire family, and, for instance, might notice that the mother is isolated.

Comment on Sadoff. The manner in which Sadoff discusses the role of psychosis in early filicide cases is typical for many studies about maternal filicide. Sadoff simply states that there was psychosis. He refers to Resnick who had also said so. Sadoff’s only justification consists of a remark about the presence of extreme fears (daughters being raped by their father) which did not seem realistic to Sadoff who subsequently labeled the fears delusions which he equated with psychosis

However, there are many cases of mfs in the literature where the fears of mfs mothers seem more realistic than the example Sadoff used. Even in Sadoff’s example, there might be a
realistic kernel considering what is known about mothers with a childhood history of sexual abuse. This point will be further addressed in Chapters 6, 7, and 8.

Sadoff's comments about Theresa, the mother in the description of the case of early filicide, and her lack of motivation to ask for help give the impression that MFs mothers will not ask for help. Many studies (Alder & Polk, 2001; D'Orban, 1979; Meszaros & Fisher-Danzinger, 2000) published before and after Sadoff, have pointed out that many of these mothers, in fact, had looked for psychiatric help and were receiving it.

As to assessment and prevention, Sadoff's description of the "mother's paranoid condition as a recognizable situation" (p.605) is based on the twin assumptions that paranoia is the main problem and that paranoia is treatable, if the family physician takes the trouble to get the whole picture. First, Sadoff makes quite a leap, when he moves from a description of fears that may be excessive, but also may have some basis in reality, to a diagnosis of paranoia. Secondly, Sadoff may not have taken into account the lack of time available to family physicians to get the whole picture as well as other obstacles, such as an incomplete understanding of the phenomena involved and feelings of countertransference.

Sadoff's general answer to the question of "How could a mother kill her children?" is intriguing. I will first quote his answer after which I will comment.

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91 For instance, this mother might have been sexually abused by her own father, who may have physically abused her brothers, which might make it more likely that she would perceive something similar with respect to the father of her children.
It is often difficult to understand how a mother could do such a thing unless one understands the extreme conditions under which such killings occur. Whether it is the panic of the adolescent in neonaticidal cases, the illness of the postpartum psychotic mother who kills her infant child, or the desperate situation, which leads to major depression and suicidal impulses in the mother who kills her young children. There is little in the literature or in the experience of this forensic psychiatrist to indicate that mothers kill their children in a cold-hearted, calculating manner. Mostly, the killings are done in a stage of fear, panic, depression psychosis, or in dissociative states. (p.605)

This answer speaks of a mother’s reaction to extreme conditions. These conditions may or may not have been extreme in nature, but were experienced as extreme by the filicidal mothers, including the depressed and suicidal mothers, who kill their young children and themselves.

Sadoff’s remarks about mothers not killing “in a cold-hearted, calculating manner”, and in what state of mind the mothers kill, “Mostly, the killings are done in a stage of fear, panic, depression psychosis, or in dissociative states” (p.605), are particularly intriguing.

The remarks about the mothers’ reaction to extreme conditions suggest that there might be an understandable and maybe even rational aspect to the acts of these filicidal women, including the mfs mothers. In addition, Sadoff’s remarks about fear and panic as possible components of the mothers’ state of mind are not directly suggestive of psychosis.

In addition, Sadoff’s remarks that these mothers generally do not act in a cold-hearted, calculating manner seem to suggest a lack of evil intentions and efforts to use filicide methods perceived as painless. However, there is not enough information to determine to what extent Sadoff’s views are similar to views suggested in several other recent studies (Graser, 1992; Alder
& Baker, 1997) that depict mfs mothers and their actions as deliberate, well prepared and not out of control.

Husain & Daniel (1984)

Husain & Daniel (1984) compared mothers who had killed one or more children with mothers referred for psychiatric evaluation after abusing their children. Two of the eight filicidal mothers had abused their children. All of the filicidal mothers had a major psychiatric disorder, which consisted of paranoid/hallucinatory symptoms for five of them. Two of the eight mothers killed two children, in both cases twins. The authors never discuss the possibility of mfs. It is possible that this did not play a role because five of the eight filicidal mothers were black, who are known for an extremely low suicide rate and who are, in comparison with Caucasian women, rarely involved in mfs. The methods used (4 children beaten to death, 2 stabbed, 2 drowned, 1 thrown from a height and 1 suffocated with a pillow) are not typically associated with mfs except for drowning and suffocating. It would be interesting to know whether the typical mfs methods were used by the Caucasian mothers, which could make mfs more likely.
Crimmins, Langley, Brownstein, & Spunt (1997)

Crimmins et al. (1997) psychiatrically examined 42 imprisoned women convicted of murdering children. None of them was reported to have attempted suicide at the time of the child murder. In about two-thirds of the cases, the victims were killed in the course of child abuse due to excessive force or in the course of an accident or illness, which often were associated with neglect. It appears that the great majority happened in a rage-like state with little preparation and premeditation.

Seventeen of the 42 women had made nonfatal suicide attempts prior to the filicide. Fourteen of these 17 had made more than one attempt. Seven had made the first attempt before the age of 13, and an additional 7 had made an attempt before the age of 19. Methods used consisted of overdose of drugs, wrist cutting, and other methods, such as poison and hanging. Crimmins et al. do not comment on the seriousness of the attempts or the intent to die.

Motherless mother. The central point here is the motherless mother. Due to a lack of love and nurturance coming from their own mothers, these women developed low self-esteem, which may have been made worse by the physical and sexual abuse that many endured in their childhood. Feeling bad about themselves, and without an example of good mothering, they had trouble “mothering” their children. They certainly thought of themselves as bad mothers, How you feel about yourself is largely influenced by how others conveyed how they felt about you during your youngest years. During early childhood, a mother is usually the person upon whom you can rely for security, warmth, and feelings of comfort. An absence of nurturance by a primary caretaker will interfere with the ability to develop positive feelings about yourself or the ability to build positive social experiences, unless alternative social and emotional supports are in place. Without having a “secure base” from which to
operate, one is unable to develop positive or healthy attachments with others (Bowlby, 1988). In situations where the mother may be emotionally unavailable to the child (e.g. mental illness, neglect) and other supports are absent, the child grows up with an impoverished emotional repertoire from which to gauge interpersonal relationships and an adequate sense of self-worth. When the child grows up and becomes a mother, she is then unable to give her own child a sense of warmth or security, for as a “motherless mother” she cannot give what she has not been given (Edelman, 1994; Zulueta, 1993). (p.54)

The phrase ‘unless alternative social and emotional supports are in place’ suggests that these supports were not in place for the women examined by Crimmins et al.

Crimmins et al. speaks of “the circumstance under which it happened”, which was child abuse in 68% of the cases, and neglect in 21%. It looks like at least 89% of the cases were not premeditated. The other 11% apparently happened outside of the circumstance of child abuse, i.e. was not associated with child maltreatment.

Comments on Crimmins et al. It may be worth noting that despite the many previous suicide attempts, no one attempted suicide simultaneously with or directly after the filicide.

The concept of the motherless mother, the absence of alternative supports, the childhood sexual and/or physical abuse, the abuse during adulthood, especially from male partners, the chaotic and difficult life circumstances and the previous suicide attempts are all risk factors for maternal fatal child abuse. Some of these factors, especially motherless mothering and childhood sexual and/or physical abuse, also may play a prominent role in mfs. This will be further discussed in Chapters 6, 7, and 8.
McKee & Shea (1998)

McKee & Shea (1998) studied 20 mothers charged with filicide, who were referred for psychiatric pretrial evaluation. They conclude,

The consistency of characteristics across countries suggests that women who kill their children are nonaddicted, married, low-income, mentally ill, new or recent mothers under 30, who acting alone and without weapons, kill only one of their children, likely of preschool age. (p.679)

A careful examination of the data provided by McKee & Shea shows the following:

- Of the 20 mothers, 11 were black, and nine were Caucasian.

- Three mothers attempted suicide in conjunction with the filicide.

- Three mothers killing multiple children killed nine children.

- Nine mothers, including the three mothers killing multiples killed all their children.

- Of 14 families with more than one child, 11 had at least one surviving sibling.

- Five of the mothers were reported to have attempted suicide. It appears that this only referred to suicide attempts prior to the filicide, and, therefore, was not related to the three attempts made in conjunction with the filicide attempt, although the information provided on this is not completely clear.92

- No breakdown of these data by race was provided.

Comments on McKee & Shea (1998). Based on what has been learned in other studies, it is possible that the three mothers killing multiple children are the three mothers who made nonfatal suicide attempts. This could mean that 35% of the victims (9 out of 26) were killed in conjunction

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92 In this context, it may be useful to point to the observations by Hawton et al (1981, 1985), who had found that mothers who had made nonfatal suicide attempts were at high risk for child abuse, and that mothers involved in child abuse were at high risk for suicide attempts.
with suicidal behavior of the mother. This percentage is bound to rise, when victims of mothers making fatal suicide attempts are also taken into account.

Even though there is no racial breakdown of the data, the possibility should be taken into account, based on previous studies, that the three suicidal mothers were Caucasian, as black women rarely are involved in mfs,\textsuperscript{93} especially when there are multiple victims.\textsuperscript{94} If this situation also were to apply here, it would mean that 1 out of 3, or 33.3\% of the Caucasian mothers in the study made a (nonfatal) suicide attempt. It also would mean that 9 out of the 15 victims of Caucasian mothers (60\%) are killed in conjunction with maternal suicidal behavior. These percentages would rise with the inclusion of Caucasian mothers who made a fatal suicide attempt after filicide.

These hypothesized configurations of the racial breakdown of mothers involved in filicide and filicide-suicide fit a pattern, where Caucasian mothers have been found to be more prone than black mothers to make attempts at mfs, and to target multiple children in these attempts. From a point of view of risk assessment, a racial breakdown of these data seems advisable and important, therefore.

\textsuperscript{93} The findings for the 11 black mothers might have been similar to the findings of studies, such as conducted by Goetting (1988) in Detroit, where 90\% of the mothers were black. None of the approximately 90 parents in Goetting’s study made a suicide attempt in conjunction with the filicide.

\textsuperscript{94} There are indications that suicidal motives play an even larger role in cases of mfs that involve multiple killings. Therefore, the very low suicide rate among black women makes it especially unlikely that they would be involved in mfs cases involving multiple killings.
The international comparisons, which McKee & Shea are referring to, are meaningless and potentially misleading because the studies are based on survivors only, and data about fatal suicide attempts by filicidal mothers are not provided. In addition, it is hard to understand how McKee & Shea can report that there were no attempts at filicide-suicide in D’Orban’s study. They compared the 24 mothers whom D’Orban (1979) had assigned to the mentally ill group with those mothers in their own study who had been assigned to the “Pathological” category, as defined by the classification system proposed by Bourget & Bradford (1990). While McKee & Shea reported that 3 of the mothers in this “Pathological” category made a nonfatal suicide attempt, they reported a figure of zero for the “mentally ill” category in the study by D’Orban (1979), while D’Orban had reported that of the 24 mothers in the mentally ill category, 13 had made a nonfatal suicide attempt.

Other studies indicate that during the six-year period covered by the study of D’Orban, (1979), 30 mothers (five per year, on average) in all of England and Wales made a fatal suicide attempt after having killed one or more of their children. Since D’Orban’s study covered an area with one-fourth to one-third of the population of England and Wales, this might mean that there may have been 10 to 12 fatal suicide attempts by mothers in the area and during the six-year period covered by D’Orban’s study. This would amount to two-thirds of the number nonfatal attempts. There is no information about the number of fatal mfs attempts in the area and period covered by the study of McKee & Shea.
McKee, Shea, Mogy, & Holden (2001)

McKee et al. (2001) administered the MMPI-2 to all 73 women undergoing a psychiatric evaluation after having been charged with murder of a child (30 of the 73), their partner (19 of 73) or an unrelated adult (24 of 73). The 30 women charged with the murder of one or more children, who filled out the MMPI-2 questionnaire, had a 6-8 profile, which suggests “persons who may manifest psychotic behavior, delusions, hallucinations, and disordered thinking characteristic of severe mental illness”. (p. 372). The authors did not speak of suicidal behavior in this regard.

Studies in Canada

Bourget & Bradford (1990)

Bourget & Bradford (1990) examined nine mothers and four fathers who had killed one or more of their children. Five of the mothers had killed within five weeks of delivery. The authors provided information about how many of the 13 parents had a specific diagnosis, but did not relate this to the gender of the parent or any other variable. Of the 13 parents, two were designated as “extended suicide”. In one of these, the attempt was nonfatal, while it was not clear whether the other parent's attempt was fatal, and whether it was made before or after the psychiatric evaluation.

Bourget & Bradford proposed a new classification system in this study, which will be further discussed in Chapter 6.
Lomis (1986)

Lomis (1986) studied eight women who had killed one or more of their children. Lomis wanted to investigate the role played by the gender of the victims and the cultural/immigration status of the mothers. She found that non-immigrant mothers killed more boys than girls. She speculates that these cases were motivated by revenge against the father. Two of the immigrant women killed girls. The author acknowledges that the number of subjects in her study is too small to generalize. However, she quotes national Canadian data that appear to support her findings.

Comments on Lomis (1986)

It is unfortunate that Lomis did not present national statistics of some other countries that are culturally close to Canada. Several studies (Alder & Polk, 2001; Bourget & Gagne, 2002) suggest that retaliation, as a motive for maternal filicide, might be rarer than has been assumed for a long time.

Marleau & Laporte (1999) and Marleau, Roy, Laporte, Webanck & et al. (1995a) suggested that the tentative finding that maternal killing of male children might be related to motives of revenge against the father deserved further research. These same authors also presented some tentative findings that girls might be more likely to become victims of mfs mothers when altruistic motives that tend to be associated with extended suicide, play a role.
Studies outside of North America

Lukianowicz (1971)

Lukianowicz (1971) discussed and compared three cases of filicide. One was a case of mfs with a serious and almost lethal, yet nonfatal suicide attempt. The second case was clearly associated with psychosis and had involved prior hospitalization. Although there had been suicidal ideation in the past, the homicide of the two sons was not accompanied by a suicide attempt. The third case was a psychopathic woman, who had not demonstrated any suicidal behavior in conjunction with the filicide. The mfs case will be discussed more fully in chapter 8.

Stanton, Simpson, & Wouldes (2000)

In New Zealand, Stanton et al. (2000) interviewed six women who had killed one of their children. They provide the mothers’ verbatim statements about what they felt prior to the filicide, and what they were thinking when they were killing their child. Stanton et al. divides the six women in three categories, each containing two mothers: psychotics, manic-depressives, and depressed mothers, and reports the following:

- The psychotics and the manic-depressives experienced a sudden irresistible urge to kill, while the depressed mothers had been thinking about it for days, sometimes weeks.
- All of them only killed one child, often the youngest, while most had more than one child.
- The act was not premeditated or planned for the psychotics or the manic-depressives. Apparently, the depressed mothers had engaged in some planning.
- Some of the mothers had experienced suicidal ideation, but none of them made a serious suicide attempt in conjunction with the filicide.
• Most mothers reported that the experience of raising the child that they eventually killed was
different from the experience of raising their other children.

• These mothers appeared to be high functioning and well-adjusted prior to the onset of their
mental illness. Therefore, the acts of these women can be better explained by mental illness
than by stressors or psychodynamics.

Comment on Stanton et al. (2000)

Apparently, there was not a filicidal, let alone filicidal-suicidal process preceding these cases,
except to some extent for the depressed mothers, who had been thinking about killing their child for
days or weeks before they did it. The women do not appear to share characteristics that can be
considered risk factors for maternal filicide, let alone mfs, except perhaps that the raising of the
victim was experienced differently from raising the other children.

It is unfortunate that the authors did not discuss that some mentally ill mothers make serious
and often fatal suicide attempts in conjunction with their filicide, and that these mothers may
experience a process of filicidal-suicidal ideation that can be as long as suicidal processes in
regular suicide. Readers of Stanton's study may get the impression that maternal filicide, including
mfs is impossible to prevent because 'it comes out of nowhere', i.e. there is no history suggesting
the possibility of maternal filicide. This definitely is not true for most mothers who make serious
suicide attempts in conjunction with their filicide. (Alder & Polk, 2001; Graser, 1992)
Lewis et al. reported that psychotic women were 11.2 times more likely than non-psychotic women to use weapons when killing their children. Older children were more likely to be killed with weapons than younger children. The chance of being killed with a weapon increased with 25% for each year of the child. Psychotic women killed children of all ages with weapons, not only the older children where sheer force might have posed difficulties. In fact, the authors report that mothers who had used weapons to kill younger children invariably were psychotic.

The subjects of the study were 60 mothers who had been referred for psychiatric evaluation of their ability to stand trial as well as their sanity at the time of the act. Of the 60 referred mothers, 8 had killed two children and 4 had killed three children, and the remaining 48 had killed or tried to kill at least one 96 child. Mothers who had made a fatal suicide attempt were not included in this study nor were mothers who had been committed to a mental hospital without psychiatric evaluation, if there were any. Lewis et al. did not provide information about suicide attempts by the sixty women in this sample.

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96 This study only included children who had died as a result of the mother’s filicide attempt and their mothers. It is, therefore, possible that some of the 48 mothers who had killed one child had made nonfatal attempts to kill additional children.
The following demographics were reported: Caucasian 60%, black 38%, Asians 2%, 29 years as the average age, 81% not employed, 44% no high school diploma, and 30% married.

The incidence of delusions, hallucinations, and psychosis among the various mothers is illustrated in Table 5.6. It can be seen that of the 60 mothers, 37 had been found to have delusions and 28 hallucinations. It may be important to note that Lewis et al. remarked, “For the purpose of further analysis, psychosis was identified as a primary variable encompassing the other characteristics of delusions and hallucinations” (p. 614). This quote plus the data in Table 5.6 suggests the following:

- Hallucinations and delusions were the only manifestations of psychosis that were studied.
- The presence of either hallucinations or delusions was sufficient to be assigned to the category of psychosis.
- Some of the 60 mothers had both hallucinations and delusions.
- Delusions were more prevalent than hallucinations.

Table 5.6: Relationship between use of weapons and the presence of hallucinations, delusions, and psychosis

<table>
<thead>
<tr>
<th>Hallucinations: N</th>
<th>Weapon (gun, knife)</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delusions: N</td>
<td>15</td>
<td>44</td>
<td>59</td>
</tr>
<tr>
<td>Delusions: absent</td>
<td>02</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Delusions: present</td>
<td>13</td>
<td>24</td>
<td>37</td>
</tr>
<tr>
<td>Hallucinations: N</td>
<td>14</td>
<td>44</td>
<td>58</td>
</tr>
<tr>
<td>Hallucinations absent</td>
<td>05</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>Hallucinations present</td>
<td>09</td>
<td>19</td>
<td>28</td>
</tr>
<tr>
<td>Psychosis: N</td>
<td>15</td>
<td>45</td>
<td>60</td>
</tr>
<tr>
<td>Psychosis absent</td>
<td>01</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Psychosis present</td>
<td>14</td>
<td>25</td>
<td>39</td>
</tr>
</tbody>
</table>
Lewis et al. introduce the notion of high rates of psychotic symptoms in describing the 14 mothers who used weapons. They also reported that 75% of these 14 mothers were in psychiatric treatment at the time of the act, and that many had communicated their fears about killing one or more of their children.

Our study found that filicidal women used weapons one quarter of the time. Although women who kill their children with weapons represent a minority of filicidal mothers, they may be a group particularly amenable to efforts at prevention. The women who killed with weapons have high rates of psychotic symptoms including hallucinations and delusions. These symptoms can be identified, monitored, treated, and assessed by astute clinicians. The majority of women who used weapons to kill their children had had past psychiatric treatment and about three quarters were in treatment at the time of the filicide. More than half had expressed fears about their children to family or clinicians and about an eighth had contacted the police. These findings are in accordance with previous observations that a significant number of filicidal mothers have expressed concern to mental health providers preceding their crime. (p. 617)

Lewis et al. do not speak much about the 25 mothers who were found to have been psychotic and did not use weapons (Column, “Other”, in Table 5.6). Yet, the distinction between psychotic mothers using weapons and those not using weapons may be important because Lewis et al. suggests that the psychotic symptoms of women using weapons “can be identified and treated” (p. 617), while they do not comment on whether the psychotic symptoms of non-weapon-using mothers can also be identified and treated.

The issue of a possible distinction between psychotic mothers using weapons and psychotic mothers not using weapons also arises with respect to child abuse, “Because many psychotic women who kill their children have not abused their children in the past, programs aimed at preventing child abuse may not target them effectively” (p. 617). It is not clear whether the absence
of child abuse among psychotic mothers applies equally to those using weapons and those not using weapons. In this context, they also state,

> These suggestions [for assessment, diagnosis, and treatment] focus on prevention of weapon related filicide deaths. Further investigation is needed to address prevention for other subgroups of filicidal women. What is clear is that filicidal women use heterogeneous methods to kill their victims, and that effective prevention methods are likely to be heterogeneous as well. (p. 618)

Apparently, Lewis et al. believe that there are various subgroups of filicidal women and that these subgroups differ in the methods used for filicide as well as the rate and/or configurations of psychotic symptoms. The authors do not provide additional information, yet the data in their study allow for additional analysis. Such an additional analysis will be done with a view towards clarifying differences between various subgroups of filicidal women, especially subgroups of psychotic filicidal women.

**Re-analysis of Data**

A number of issues will be addressed in the process of re-analyzing the data.

*Relationship between severity of psychosis and the use of weapons.*

Even though Lewis et al. do not speak much about the 25 mothers who were found to have been psychotic and did not use weapons, they appear to be suggesting that the psychotic symptoms of these 25 mothers, on average, might be less serious. The reason that Lewis et al. can be seen to make this suggestion is that they stated, “The women who killed with weapons have high rates of psychotic symptoms including hallucinations and delusions” (p. 617). This statement suggests a contrast between weapon-using mothers and non-weapon-using mothers.
The implied contrast suggests that, if weapon-using mothers have been associated with high rates of psychotic symptoms, maybe the non-weapon-using mothers do not have high rates of psychotic symptoms. This implicit suggestion is further reinforced by the example Lewis et al. gave of a weapon-using psychotic mother: one who stabbed her infant 45 times, because she thought the devil was in the child.

On the other hand, while 9 of the 14 weapon-using mothers suffered from hallucinations, 19 of the 25 psychotic non-weapon-using mothers did as well. There is no information about the contents or the seriousness of the hallucinations. For instance, there is no information about command hallucinations, which generally are regarded as serious symptoms of psychosis (DSM-IV TR; 2000). Therefore, detailed comparisons between the psychotic weapon-using and psychotic non-weapon-using mothers in this study with respect to the contents of their psychotic symptoms would be difficult to make.

Non-weapon-using psychotic mothers: a heterogeneous group

Even when, on average, these 25 mothers have lower rates of psychotic symptoms than the weapon-using mothers, some of them may have high rates as well. After all, while weapon use is reportedly associated with high rates of psychotic symptoms, and might even be a sufficient condition for psychotic symptoms, it is not a necessary condition.

The methods used by these 25 mothers (see Table 5.7) suggest that they might be a heterogeneous group, and that it might be possible to distinguish subgroups among this group of 25 mothers. These subgroups might have different rates or configurations of psychotic symptoms.
For instance, the fact that 10 of these 25 mothers smothered and/or strangled suggests that there might be a subgroup of postpartum mothers, who are known to often use smothering or strangle when they kill their infant. There might be a subgroup of severe schizophrenics who may use "unusual" methods such as burning, which was used by 3 of the 25 mothers. In addition, there could be a subgroup of mfs mothers who are known to use methods such as drowning, which were used by 5 of the 25 mothers, as well as other methods perceived as painless, such as poisoning.

Table 5.7: Methods used for filicide
Table copied from Lewis et al. (1998), page 615

<table>
<thead>
<tr>
<th>Method</th>
<th>Total Sample (n = 60)</th>
<th>Psychotic Mothers (n = 39)</th>
<th>Non-Psychotic Mothers (n = 21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gun N = 8</td>
<td>8 13%</td>
<td>7 18%</td>
<td>1 5%</td>
</tr>
<tr>
<td>N = 7</td>
<td>7 12%</td>
<td>7 18%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Strangling/Smothering N = 18</td>
<td>18 30%</td>
<td>10 26%</td>
<td>8 38%</td>
</tr>
<tr>
<td>N = 8</td>
<td>8 13%</td>
<td>2 5%</td>
<td>6 29%</td>
</tr>
<tr>
<td>Other N = 19</td>
<td>19 32%</td>
<td>13 33%</td>
<td>6 28%</td>
</tr>
</tbody>
</table>

Other Methods Include: Burns (5%), Poisoning (2%), Drowning (8%), Falls (4%), Motor/Vehicle (2%), Neglect/Starvation (12%).

The possibility of maternal filicide-suicide

Lewis et al. did not provide information on suicide attempts among the 60 mothers. Nor did they clarify how a mother who might have made a nonfatal suicide attempt after having killed one
or more of her children for “altruistic” reasons would be classified. If the mothers had used a weapon, Lewis et al. most likely would have classified them as psychotic. However, mothers involved in MFS seem to be less prone to use weapons than mothers who kill a child without a concomitant suicide attempt. This is especially true for mothers who make a fatal suicide attempt (Graser, 1992), but it also may apply to a considerable degree to mothers whose suicide attempt is nonfatal.\footnote{The lack of weapon use by MFS mothers applies to both mothers making fatal suicide attempts and nonfatal suicide attempts, although it may apply less to the ones making nonfatal attempts, as impulsivity may play a larger role here. Comparison with other studies (Alder & Polk, 2001; Meszaros & fisher-Danzinger, 2000) provide some indications that mothers with multiple victims who do not kill all their victims and/or make a nonfatal suicide attempt have higher rates of psychotic symptoms than mothers making only fatal filicide attempts and a fatal suicide attempt. These studies also indicate that mothers making nonfatal attempts at filicide and/or suicide may have been more prone to use a gun or a knife.}

While Lewis et al. did not report on suicidal behavior among the 60 mothers in their sample, it is possible that some of the mothers had made suicide attempts and that these were known to the authors. There are also indications that Lewis et al. might have classified any mothers who made a nonfatal suicide attempt in conjunction with an act of filicide as psychotic, even when they did not use a weapon:

- Of the 25 non-weapon-using, psychotic mothers, 10 used strangling/smothering, 2 beating, and 13 “other methods” (see Table 5.7).
- MFS mothers are known not to use beating with the exception of retaliating mothers who after beating their child to death sometimes make a suicide attempt after some time has passed and out of remorse rather than as part of a preconceived filicide-suicide plan. (D’Orban, 1979)
- With respect to the “other methods” in Table 5.7: Of the 19 mothers in the category “other methods”, 6 were non-psychotic and 13 psychotic. The data provided indicate (see Table 5.7)
5.8) that of these 19 mothers, 3 used burns, 1 poison, 5 drowning, 2 fall, 2 motor vehicle, and 7 neglect/starvation. Based on other studies (D’Orban, 1979) it appears likely that most of the seven cases of neglect/starvation can be accounted for by non-psychotic mothers. This would mean that the 13 psychotic mothers using “other methods” accounted for all of the cases of burn, poison, drowning, fall, and motor vehicle.

- Therefore, of the 25 psychotic mothers who did not use a weapon, i.e. a gun or a knife, 16 used filicide methods that are often used by suicidal mothers. Of these 16 mothers, 10 strangled or smothered, and it is likely that 5 of them drowned their child or children, and that one of them poisoned.

<table>
<thead>
<tr>
<th>Methods included in “Other”</th>
<th>% of 60 women involved</th>
<th>Likely number of mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burning</td>
<td>05</td>
<td>03</td>
</tr>
<tr>
<td>Poison</td>
<td>02</td>
<td>01</td>
</tr>
<tr>
<td>Drowning</td>
<td>08</td>
<td>05</td>
</tr>
<tr>
<td>Fall</td>
<td>04</td>
<td>02</td>
</tr>
<tr>
<td>Motor Vehicle</td>
<td>02</td>
<td>01</td>
</tr>
<tr>
<td>Neglect/Starvation</td>
<td>12</td>
<td>07</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>19</td>
</tr>
</tbody>
</table>

Comparison between psychotic and nonpsychotic mothers

The main conclusion of the study by Lewis et al., “Odds ratio showed that psychotic women were 11 times more likely to kill their child with a weapon than their non-psychotic counterparts” (p.618), is somewhat confusing. The conclusion is based on the finding that of the 15 mothers using a weapon, 14 were psychotic and one was not psychotic. Parallel to this observation, Lewis et al. also reported that out of the 60 filicidal mothers, 39 were psychotic and that 14 of these 39

98 Mothers who kill their child while they are suffering from post-partum psychosis also often use strangling, smothering and drowning. However, there are indications in the literature that these mothers do not often make suicide attempts in conjunction with their filicide, especially fatal suicide attempts.
psychotic mothers used a weapon, while 25 did not. It would have been clearer when Lewis et al. had reported that when a mother who kills a child uses a weapon to do so, there is a chance of 14 out of 15 that she is psychotic, and one out of 15 that she is not psychotic. In addition, they could have reported that when a mother kills a child, there is a chance of 39/60 that she is psychotic (which really should be more than 39 to account for fatal suicide attempts), and that when she indeed is psychotic, there is a chance of 14/39 that she will use a weapon.

**Race, killing of multiple children and maternal filicide-suicide**

Black women who make up 38% of the sample (23 of the 60 mothers) rarely make suicide attempts in conjunction with filicide. In addition, killing of multiple children by a mother often is associated with a suicide attempt. (Meyer & Oberman, 2001) Therefore, it would be interesting to know to what extent the mothers in this sample who killed multiple children were Caucasian, attempted suicide, and had been assigned to the psychosis category. If they had made a suicide attempt and had been assigned to the psychosis category, it would be interesting to learn whether they had been assigned to the weapon-using psychosis category or the “Other” category. In fact, it would be interesting to learn to what extent these mothers would confirm the findings of other studies that indicate that mfs mothers do not often use weapons.

**The proportion of deaths due to maternal filicide accounted for by maternal filicide-suicide**

It may be important to note that the 12 mothers who had killed multiple children comprise 20% of the sample of 60 mothers, and are responsible for 28 of the 76 deaths, almost 40%. As stated earlier, there is a strong possibility that many of these 12 mothers made a nonfatal suicide attempt. In addition, there may be mothers in the sample who killed one child, and subsequently
made a nonfatal suicide attempt. Considering that mothers with fatal suicide attempts in conjunction with filicide are not included in this study, it is possible that the number of children killed in conjunction with a fatal or nonfatal suicide attempt by their mother may comprise half of the fatal victims of maternal filicide, and probably more than that for Caucasian mothers. This would be in line with the findings of several other studies. (Somander & Rammer, 1991; Bourget & Gagne, 2002)

*Final Note.* Considering that in many studies, half of the child deaths due to maternal filicide are associated with suicidal behavior, it would be important to learn more about suicidal behavior among these 60 mothers.

Based on the findings of other studies it is likely that any mfs mothers in this sample have been diagnosed as psychotic at the time of the mfs act, and have been assigned to the category of non-weapon-using psychotic mothers. The psychotic symptoms may have included delusions of altruism or delusions of salvation/rescue. In many studies, such delusions were not recognized as delusions prior to the act, and instead considered as cognitive distortions or superstitions. Therefore, it would be particularly important to learn whether Lewis et al. believe that these delusions of altruism/salvation/rescue can be identified, monitored, assessed, and treated to the same extent that they believe that this is possible for weapon-using psychotic mothers. About these weapon-using psychotic mothers, the authors remark, “Although women who kill their children with weapons represent a minority of filicidal mothers, they may be a group particularly amenable to efforts at prevention” (P.617).

99 Some of the mothers who killed one child and subsequently made a nonfatal suicide attempt might also have made additional filicide attempts that were nonfatal.
Holden, Stephenson Burland, & Lemmen (1996)

Holden et al. (1996) examined the charts of 20 mothers who, in Michigan between 1976-1989, had killed one or more of their children and had been found not guilty by reason of insanity (NGRI) in order to compare these data with those of 8 filicidal mothers who had not been found NGRI, and instead Criminally Responsible (CR). They reported that,

All of the women in the NGRI group described psychotic motivations for their murders. Common themes included the delusional conviction that the child was defective or monstrous in some way (such as possessed by Satan, or half human and half dog), hallucinatory commands to kill the child, and the idea that the child could be saved from disaster (fates such as being raped, becoming a prostitute, or undergoing torture) only through death. (p. 32)

In addition, they reported the following data:

- The 20 NGRI mothers had 42 children. Of the 42 children, 26 were victims. Of these 26 victims, 23 died.

- There were 15 mothers with one victim, 4 with two victims, and one with three victims. Not all victims were killed: 17 mothers had killed one child and 3 had killed two children. There is no specific information how these data applied to the five mothers with multiple victims.

- Of the 20 mothers, 32% reported 100 had other children that were not victims, while 68% did not. These data suggest that there were 14 mothers killing or trying to kill all their children, while there were six mothers that had children whom they did not kill or try to kill in addition to the ones whom they killed or tried to kill.

With respect to other relevant data, Holden et al. reported the following:

- Eighteen had no employment at the time of the offense

- Eleven had a psychiatric history

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100 It is not clear why the authors changed to multiples of 4 (32 and 68%) when discussing the presence of children who were not victims while they had been using multiples of 5, e.g. 65%.
• Eleven had made a nonfatal suicide attempt in conjunction with the filicide

• Eleven of the 20 NGRI mothers were Caucasian, and nine were black

• Eight of the 26 victims were attacked with weapons (shot, stabbed, throat cut) which may suggest a “high rate of psychotic symptoms” according to Lewis et al. For the other 18 children the following methods had been used:
  o strangling 5
  o shot 3
  o stabbed 2
  o drowning 3
  o beating 3
  o drugged 2
  o suffocating 2
  o neglect 1
  o burned 2
  o throat cut 3

• None of the mothers would have been placed in Resnick’s categories of unwanted child, revenge, or accident. Therefore, there were no cases of fatal child abuse.

• The mothers were between 20 and 33 years.

• The children's age was between 0 and 120 months, with an average of 37.4 months. There were no neonaticides.

• Seventeen of the 20 NGRI mothers suffered from hallucinations. Nine of these had command hallucinations, which generally are regarded as a serious symptom of psychosis.

• 45% had a history of drug abuse.

• The number of years of education shows an average of 12, and a range of 5-16. It is interesting that the CR and NGRI groups reportedly were similar to each other in terms of education. However, this similarity only applies to the average number of years of education, while there is a large difference in the range of years of education. For the NGRI, the range runs from 5 to 16 years, while for CR it runs from 11 to 12.

• Twelve mothers were diagnosed with schizophrenia at the time of the act, and 7 with psychotic depression.
Holden et al. do not explicitly mention that women who had made a fatal suicide attempt were not part of the study. There is no information on the methods used in the nonfatal suicide attempts.

Comments on Holden et al. (1996)

The study clearly states that all 20 NGRI mothers were psychotic, and that 18 of them were unemployed. Even though the authors report that 11 mothers made a suicide attempt in conjunction with the filicide, they do not elaborate on the suicidal aspect. The reader is left with the impression of low functioning women who may have acted under the influence of a psychotic attack, and that the nature of suicidal behavior and any motives for suicide are not relevant.

However, close reading of the data suggests that the picture might be more complex, and it might be worth speculating about the characteristics of the mothers who were reported to have made nonfatal suicide attempts.

There might be two or three subgroups among these 20 psychotic mothers. One might consist of mothers intending to commit mfs, whose altruistic motives (e.g. to protect child against the possibility of being raped) were labeled “delusions of salvation” which caused the mothers to be designated psychotic, while there may not have been psychotic symptoms before the act\textsuperscript{101}. The

\begin{quote}
101 The authors’ statement that all NGRI women described psychotic motivations is followed by examples, “child defective”, “child possessed by Satan”, and the idea of saving the child from disaster by killing it. With respect to the idea of saving the child from disaster by killing it, Holden et al provided some examples of such disasters. These included the child being raped, becoming a prostitute or undergoing torture. Therefore, the information about psychotic motivation and its
\end{quote}
fact that 11 mothers made a nonfatal suicide attempt in conjunction with the filicide suggests that some of them probably would fall in this category of (delusional) altruistic motives. Considering that there were five mothers with multiple victims,\footnote{Meyer & Oberman reported that 68\% of mothers involved in filicide-suicide had multiple victims. This included fatal suicide attempts. Most studies suggest a similar picture.} it would not be a stretch to speculate that at least five of the 11 suicidal mothers were involved in extended suicide. Other indications for the presence of an mfs subgroup are the methods used for the 26 victims. Drowning, suffocation and drugs are often used in mfs cases, although their use is not limited to mfs. Strangling, shooting, and burning are also mentioned in regards to mfs cases, although less than drowning, suffocation, and drugs.

Close reading of the data also suggests that there is a fairly strong possibility that most of the mfs mothers would be white, as black mothers generally have low suicide rates and filicide-suicide is extremely rare for them. In terms of employment and education, there is a possibility, based on other studies (Somander & Rammer, 1991) that some of the mfs mothers in this study may have been functioning at or near professional levels and may have had several years of college, and had chosen not to be employed rather than being involuntarily unemployed.

What may be particularly important in this context is that the multiple victims usually are associated with suicidal behavior of the parents. Therefore, it is likely that the 11 mothers who had made a nonfatal suicide attempt account for more than 55\% of the 26 victims.

\footnote{Meyer & Oberman reported that 68\% of mothers involved in filicide-suicide had multiple victims. This included fatal suicide attempts. Most studies suggest a similar picture.}

contents represents a wide range: from severe (possessed by Satan) to possibly mild (fear of a bad future for the child), or from motivation characterized by "high rates of psychotic symptoms" (Lewis et al., 1998) to motivation characterized by lower rates of psychotic symptoms.
In addition, it is important to recognize that this study was conducted for forensic and prosecutorial reasons, comparing NGRI with CR mothers. Therefore, there was no reason to include mothers who made a fatal suicide attempt. However, the absence of fatal/fatal filicide-suicide cases and its consequences for the conclusions somehow tends to recede in the background in most studies on filicide that only include parents who are still alive.

This exercise in speculation has been carried out to illustrate that from a point of view of prevention it would be important to pay attention to different types, “rates”, and configurations of psychotic symptoms. It would be equally important to pay attention to the possibility that suicidal motives may have been the dominant factor for a portion of the 11 mothers with nonfatal suicide attempts, and that psychotic aspects may not have been the dominant factor leading these mothers to make an attempt at mfs.

Selected Sample based on Newspaper accounts

*Meyer & Oberman (2001)*

Meyer & Oberman (2001) examined 239 cases of maternal filicide that occurred between 1990 and 1999. Their main source of information consisted of newspaper accounts. They wanted to understand the various types of maternal filicide, their commonalities, and differences. Instead of using the alleged motives as a typology, they explored the filicide in the context of the mothers'
lives, and they combined cultural, mental health, social, economic, and legal viewpoints. The resulting descriptive characterizations of the lives of the mothers led to five categories: neonaticide, coerced/assisted infanticide, neglect, abuse/battering, and purposeful infanticide. Purposeful infanticide, of which they included seven cases in their publication, describes those women who intentionally killed one or more of their children, who were older than 24 hours. In other words, they use infanticide for situations where most authors use filicide.

Meyer & Oberman devote much attention to the role of mental illness in filicide in general and in purposeful filicide in particular. They explain the different ways in which infanticide and filicide were treated in various periods and cultures, which included encouragement, tacit approval, and moral rejection. Only in the 20th century, the act of filicide was declared a mental health problem. Meyer & Oberman believe that too much of a focus on mental illness has limited attention for other contributing factors. They prefer to speak of psychological vulnerability, which under certain circumstances can lead to feelings of hopelessness, or even psychotic feelings, although they add that most psychotic people who kill still know that what they are doing is wrong. In fact, they believe that the way mothers deal with the expectations and constraints that society puts on them, no matter how different in time and place should be taken into account as a potentially contributing factor when explaining filicide/infanticide by mothers.

103 Meyer & Oberman examined all 79 cases of purposeful filicide that they found in newspapers. They included seven of them in their publication.

104 Meyer & Oberman illustrate the unfavorable consequences of predominance of mental illness as an explanatory factor by referring to what would happen if DSM-IV criteria for the various mental disorders were applied to all criminals in the USA. Practically all of them would receive one or more diagnoses.
Meyer & Oberman remarked that society as well as some people in the mental health field tends to see infanticidal mothers as mad or bad. In other words, according to Meyer & Oberman, society believes that women have to be mentally ill, like in insane or psychotic, to kill their children, and if they are not mentally ill, they have to be monsters. To a certain extent, this belief is reflected in the legal system, where one is either sane or insane. Instead, the authors believe that it would be much more appropriate to speak of a continuum of mental health problems with only a small number of women being clearly psychotic.

*Patterns observed by Meyer & Oberman*

As Meyer & Oberman preferred narratives to lists of risk factors, they described certain patterns that they had found in the group of 79 purposeful infanticides/filicides.

*Multiple killings.* Of the women in the category of purposeful infanticide, 39% killed more than one of their children. Of mfs mothers, a subset of purposeful infanticide, 68% killed more than one child. It is important to note that only fatal filicide attempts were included. Meyer & Oberman mention that it is not possible to give an accurate picture of why so many of these mothers killed more than one child. The authors speculate that the mothers might have wanted to save their children from a bad and hopeless future. They report that some of the motives mentioned in suicide notes include a mother’s wish to spare her children the pain of growing up without her, financial pressures or the wish to “ensure there were no siblings left behind to mourn the deaths of their brothers and sisters” (p.87).
Meyer & Oberman did not report what proportion of purposeful infanticides was accounted for by mfs mothers.

Failed relationship. Meyer & Oberman remarked that most of the women involved in purposeful infanticide had recently been divorced or separated, and/or were still involved in difficult custody proceedings. If they had custody, they had to deal with being a single parent and, quite often, with financial issues. If they were still in the relationship, it also often was a failed one. In such cases, the women hesitated between on the one hand putting up with a bad, and often abusive relationship that could include paternal abuse of the children, and on the other hand living with the fear of what would happen to them and the children, if there were to be a separation.

Devotion. Neighbors generally saw the women as devoted mothers. There were no known reports of child abuse in these cases.

Fire. Close to 1/3 of the mothers started a fire in their house or in their car. Meyer & Oberman report that leaving one’s children in a car or in a house, where a fire has been set, may have made the killing easier for the mothers “as they could remove themselves from the scene” (p.88). The authors suggest that for some of these mothers a passive approach, such as setting a fire might be easier than active approaches as drowning or stabbing.

Being reunited after death. Of mfs mothers, 25% believed that they would be re-united with their children, a belief that most likely facilitated the acting out of the plan.
Cultural issues. Meyer & Oberman report that many of the women in the purposeful infanticide group were recent immigrants who may have been dealing with stress related to immigration or the negative stigma attached to mental illness in some cultures.

Threatening situations. Meyer & Oberman present seven cases in their chapter on purposeful infanticide of which two were clearly psychotic while five were not. The circumstances in these five cases pointed to a situation that had been bad for some time, and where the mothers had perceived a threat that the situation, particularly for their children, would soon get so much worse, that it would be beyond control or beyond what they would be willing and able to live with. Killing the children could easily have been seen by the mothers as a way to save the children from this imminent, unavoidable fate.

Preventive Actions suggested by Meyer & Oberman

Meyer & Oberman comment that those who come into contact with suicidal or potentially suicidal women should keep the possibility of concomitant filicide in mind and adjust the assessment and treatment accordingly. They point out that society has paid much attention to child abuse prevention in the last decade, but attention is also needed for prevention of murder-suicides, which so often involve multiple filicides. They call for a national effort to find risk factors that can be used to help therapists and other mental health and hotline workers in identifying mothers who might commit murder-suicide, as well as in making appropriate interventions.
Comments on Meyer & Oberman

Sorenson & Peterson (1994) found that child homicides involving multiple children were more often reported in newspapers than homicides not involving multiple children. Other studies reported that homicides that have something unusual about them receive more attention in newspapers. This may explain the finding that 1/3 of the maternal filicides in the study by Meyer & Oberman are associated with fire.

Multiple killings, devotion, failed relationships, cultural/migration issues, fire and situations perceived as highly threatening, are all mentioned in most studies describing extended suicide as important themes and/or relevant risk factors. The suggestion by Meyer & Oberman that psychosis did not play a dominant role in many cases is supported by several other studies (Alder & Polk, 2001; Alder & Baker, 1997; Bourget & Gagne, 2002). Therefore, the authors' description of the role of mental illness in filicide as operating on a continuum can easily be seen as an example of the stress-diathesis theories of suicidal behavior (Bonner & Rich, 1987).

As in most other studies on murder-suicide, filicide-suicide, and extended suicide, the suicidal behavior is described by Meyer & Oberman as a possible part of filicide, certainly purposeful filicide. However, it appears that as of yet very little effort has been made to study the suicidal behavior of these mothers in its own right or to explore links between the extensive literature on risk factors for regular/simple suicidal behavior and the suicidal behavior/ideation of filicidal women.
Review and Background Studies

Review Study by Stroud (1997)

Stroud (1997) reported that mental disorders were not given adequate attention in the prevention of child homicide. She based this on a review of studies that demonstrated the role of mental disorders. She pointed to the interaction between mental disorders, personality features, and psychosocial stressors. Understanding the role of mental disorders and its interactions with the other two factors has not been given the priority it should have. Instead, social work and child protection services have given too much weight to social and economic factors that commonly are associated with child abuse. Psychiatrists, when involved, based their opinions solely on a conversation with the mother, who was able to make a better impression than was justified by the facts that were known to others. In addition, psychiatrists as well as others involved in the child protection and social work side of things did not exchange information that could have supplemented their own impressions in ways that might have prevented the child homicide.

While Stroud made it clear that much child homicide is preceded by regular child battering, as had been the professional opinion, she does not pay attention to the fact that 40 to 60% of the deaths of children are associated with suicidal behavior of a parent. Three or four of the four studies used for the main portion of the review only contained cases of parents who had not made a suicide attempt or who had survived an attempt that had been made in conjunction with the filicide.
**Review Study by Stanton & Simpson (2002)**

Stanton & Simpson (2002) published a review of population studies on filicide that paid little attention to the important role of parents’ suicidal behavior in conjunction with their acts of filicide. The population study by West (1965) was described as one of the studies using outdated classification systems and ill-defined samples, while the sample studied by West included all cases of h-s in the Greater London area from 1954 to 1962. The description of the symptoms was so detailed that readers do not have to resort to the classification systems of West’s days, but could use their own.

Population studies about homicide-suicide are not included. Some of these include much information on filicide-suicide, especially paternal cases (Milroy, 1995a, 1995b; Milroy, Dratsas, & Ranson, 1997). One study exclusively deals with filicide-suicide (Byard, Knight, James, & Gilbert, 1999), where the parent’s suicide attempt was fatal. Australian studies (Alder & Polk, 2001; Alder & Baker, 1997) are not included in Stanton’s review, although these Australian authors emphasized that their findings differed from other studies on filicide precisely because they had included cases of parental suicide, both the fatal and the nonfatal attempts. Studies by Okumura & Kraus (1996) and Meszaros & Fischer-Danzinger (2000) about extended suicidal behavior by mothers who made nonfatal suicide attempts were not included in the review by Stanton & Simpson either.

In their section on maternal suicide, Stanton and Simpson reviewed D’Orban (1979), Cheung (1992), and Bourget & Bradford (1990) all of whom only deal with mothers who made a nonfatal suicide attempt or no attempt.
Stanton & Simpson reported that the findings of the studies by Cheung (1992) and D’Orban (1979) were quite similar to each other. Yet, they did not report that there are indications that the degree to which fatal suicide attempts by filicidal mothers are underrepresented may be considerably larger in the Cheung study than in D’Orban’s study, as has been suggested in this dissertation.

Stanton & Simpson quoted Resnick (1969), who reported that most of the mothers reported on in his study were suicidal, in support of their conclusions. However, the 88 mothers in Resnick’s study included only four cases of a fatal suicide attempt because most of the material for Resnick’s review study came from hospital studies that, by definition, only deal with people who have not made a suicide attempt or a nonfatal one.105

Stanton & Simpson reported that in general filicidal fathers are less involved in filicide-suicide and more in fatal child abuse. When they reviewed the Swedish study by Somander & Rammer (1991), Stanton & Simpson correctly reported that 77 children had been killed by 65 parents (41 father and 24 mothers) between 1971 and 1980 in Sweden. They also reported correctly that 58 of these 77 children had been killed in conjunction with a fatal or nonfatal suicide attempt by the perpetrating parent (30 fathers and 13 mothers). Yet, the relevance of the suicidal aspect is diminished by them. They report that many of the filicidal fathers, including the suicidal ones were criminal or abusing substances, while the data provided by Somander & Rammer (1991) clearly state otherwise (see Table 5.9). The fathers not making a suicide attempt are

105 The information that only 4 of the 88 mothers had made a fatal suicide attempt was not particularly prominently displayed in Resnick’s study, by the way.
described by Somander & Rammer as “alcohol-intoxicated, prior crimes, and alcohol-abusers”,
whose motive consisted of disciplinary measures, while many of the suicidal fathers were high
functioning, but could not deal with problems associated with partner-relations (separation,
divorce), custody, or economical problems related to separation and custody.

Stanton & Simpson, therefore, do not pay sufficient attention to the prominence of suicide
among cases of filicide, and to the fact that 30 to 70% of all childhood deaths due to filicide happen
in conjunction with suicidal behavior by the parents. In fact, in most countries it is over 50%.

When Stanton & Simpson speak of maternal filicides, they give much weight to mental
illness, which they implicitly define as insanity. The fact that mothers who make fatal suicide
attempts tend to have prepared the act of mfs well, and that these mothers tend to be described as
different from outright schizophrenics and psychotics (McDermaid, 1955; Okumura & Kraus, 1996), and often are quite high functioning, is not reflected in this review study.

Background Studies

Bourget & Labelle (1992)

Bourget & Labelle (1992) described various patterns of homicide and how these were related to cases of filicide and infanticide. They did not provide new insights, and did not report findings of new research. They described the classification system, which they had proposed earlier (Bourget & Bradford, 1990) again.

Marleau & Laporte (1999); Marleau et al. (1995a)

Marleau & Laporte (1999) and Marleau et al. (1995a) suggest the possibility that mothers might be more inclined to believe that their daughters rather than their sons might have as miserable a life as they have had. This motive would put girls at greater risk in some situations than boys. Marleau did not differentiate between simple filicide and filicide-suicide.

Marleau (2001)

Marleau (2001) described the various classification systems used in filicide and evaluated them on clarity and usefulness. They also made suggestions about criteria for classification systems. The topic of classification systems will be more fully discussed in Chapter 6.
CHAPTER SIX

SUMMARY OF THE FINDINGS OF THE LITERATURE REVIEW

The goal of the literature review has been to collect and critically review information about the prevalence, the contents, and the etiology of maternal filicide-suicide (mfs) ideation in order to determine what role this ideation might play in outpatient, ongoing psychotherapy of depressed and potentially suicidal mothers of young children (dpsmyc) as well as to determine what additional research might be needed and how such research could be structured. The desired outcome is that clinicians will be better able to assess the presence and severity of mfs ideation. Identifying potential risk factors forms a critical part of this.

As there are no studies specifically about mfs ideation, the last three chapters have been devoted to learning more about mothers who had made a fatal or nonfatal suicide attempt after having made a fatal or nonfatal filicide attempt in order to determine what patterns, if any can be identified among these mothers and to what extent there was ideation prior to their act.

In this chapter, I will summarize the main findings of the previous three literature review chapters, and I will do so from the following four vantage points:
The clinician's vantage point, i.e. the clinician working with dpsmyc on an outpatient, ongoing basis who is assessing his or her client for the presence and severity of mfs ideation and wonders to what extent such ideation, if present, might impact psychotherapy, and might be a precursor to actual mfs behaviors.

2. Nature and Quality of information

3. Explanations and Theories

4. Follow-up: what questions need to be further addressed?

In order to help the reader get a good overview of the material covered so far, I have organized the information by vantage points: the clinician who may be more interested in the clinical implications of the research than in the details of the research itself; the researcher who is interested in the details of the process whereby information was gathered, processed and interpreted; and the theoretically oriented person who is particularly interested in explanations and theories that have been proposed in the various studies.

Finally, it is possible that any conclusions presented in this chapter will be altered in light of information presented in chapters 7 and 8.

The Clinician’s Vantage Point

I am specifically assuming the vantage point of a clinician in California who needs an overview of the literature on mfs in order to know when he or she would be allowed or required to breach confidentiality. I am limiting the information to the main findings of the previous three chapters, and more specifically to the studies published in the last 15 years. Comments on the quality of the information will be made in the next section.
Findings of a Definitional and General Nature

• Mfs is different from other types of filicide, especially fatal child abuse. In addition, it is not predominantly a postpartum phenomenon, as some believe. Furthermore, it is also different from those types of homicide-suicide (h-s) which dominate the contents of studies about homicide-suicide, i.e. spousal homicide-suicide of the morbid jealousy variety.

• Different categories can be discerned among mfs mothers based on the extent to which mothers exhibited symptoms of thought disorders prior to their attempt as well as on the extent to which the mfs attempt was prepared well and carried out deliberately.

• There is no information on mfs ideation except what is known about the lives of mothers who made fatal or nonfatal mfs attempts.

• Mfs is regarded as primarily suicide rather than homicide. There is a preconceived plan with two parts, mostly sequential, sometimes simultaneous for filicide respectively suicide. Therefore, in the great majority of cases the motive for suicide after filicide is not guilt or remorse related to a just committed filicide. Despite the similarity with simple suicide and despite the fact that most recent filicide systems have a special category for filicide-suicide, there has been no application of suicidology concepts, not even a comparison between changes in the mfs rate and those in the rate for simple suicide.

Prevalence

• Fatal and nonfatal mfs attempts are rare. The prevalence of fatal maternal filicide attempts followed by a fatal or nonfatal suicide attempt is similar in most countries, and represents a range of one mother per 2 to 8 million of the general population in most developed countries, including the USA. In fact, the majority of prevalence data of the last 15 years are to be found in a range from 1 mother per 3.5 to 6 million of the general population. Japan appears to be the main exception with an mfs rate that might be 5 to 15 times higher than in the West.

• In addition to the narrow range between countries, there also is a certain degree of stability over time. Changes in the mfs rate tend to co-vary with changes in the rate of female simple suicide.
• Filicide deaths associated with a fatal or nonfatal suicide attempt by either parent confirm this picture. The results of most studies are to be found in a range of 0.3 to 0.95 child per million of the general population, with the majority between 0.4 and 0.7 child per million of the general population.

• The percentage of victims of filicide that is accounted for by the fatal or nonfatal suicide of either parent is to be found in a range of 40 to 70% (Bourget & Gagne, 2002; Somander & Rammer, 1991) and has been rising due to reductions in deaths associated with other forms of filicide in several countries. This reduction in the rate of fatal filicide in general appears to be due to improved medical rescue techniques as well as government initiatives with respect to abortion and child abuse.

• There are indications that the number of mothers who attempt to take one or more of their children along in their suicide represents at least 5% of all mothers of young children who make fatal suicide attempts. There are indications that the number of dpsmyc who are experiencing mfs ideation may represent a similar percentage of at least 5%. There is information about the prevalence of suicidal ideation in the USA by gender and age. One study reports that 6.9% of all women between 25 and 34 experienced suicidal ideation during the 12 months prior to being asked about it. (Crosby, Cheltenham & Sacks)

• The percentage of mfs mothers receiving treatment for mental health issues in recent studies is between 70 and 100 (Alder & Polk, 2001; Bourget & Gagne, 2002; Meszaros & Fisher-Danzinger, 2000). Most of them had received psychotherapy, some of them until days before the mfs attempt.

Motives and Classification Systems

Homicide-suicide Classification Systems

Classification systems used for h-s usually include categories for the offender and the victim as well as specifiers in regards to motives (Nock & Marzuk, 1999), and a varying number of other aspects, such as method used, whether the offender was using substances etc. (Hanzlick & Koponen, 1994) Studies about h-s, where both the offender and the intended victim died and that use one of these classification systems usually report a ratio of male to female perpetrators of at least 10 to 1 (Palmer & Humphrey, 1980), and often higher. They also report that almost all females involved killed their children and had an altruistic motive.
Filicide Classification Systems

Classification systems for filicide usually have six (D’Orban, 1979; Haapasalo & Petaejae, 1999; Resnick, 1969) to eight or more (Wilczynski, 1997b) categories that often are based on motive. Mfs mothers making fatal or nonfatal\textsuperscript{106} suicide attempts are usually found in two or three of these categories: altruistic, retaliation and acute psychotic episode/no motive. Mothers making fatal rather than “fatal or nonfatal” suicide attempts in conjunction with filicide are rarely to be found in the acute psychotic episode or retaliation categories.

Recently developed or revised classification systems for filicide usually have a special category for filicide-suicide, sometimes with subdivisions for mothers making a fatal suicide attempt and those making a nonfatal suicide attempt. Some of the classification systems have defined the filicide-suicide category in a manner that it appears that all mfs cases are assigned to it regardless of the mother’s mental state or motive (Bourget & Gagne, 2002).

Meanwhile, a second approach is followed by other systems that define their filicide-suicide category in a way where the suicide motive must have been present prior to the attempt and dominant over the filicide attempt (Alder & Baker, 1997; Alder & Polk, 2001). In classification systems following this second approach, mfs mothers who are in an acute psychotic episode are assigned to a category of extreme psychiatric disturbance.

\textsuperscript{106} While most h-s studies, as just described, only deal with mfs mothers whose suicide attempt was fatal, filicide studies contain both mfs mothers with a fatal suicide attempt and mfs mothers with a nonfatal suicide attempt.
Alder & Baker argued that the alleged loss of control at the time of the attempt that often is associated with mfs acts only explained a relatively small portion of mfs attempts among mothers studied by them (3 out of 11), and that attempts associated with a loss of control often were ill prepared and carried out impulsively rather than deliberately. The eight mothers making fatal rather than nonfatal suicide attempts after their filicide usually had not acted due to a loss of control, and prior to the attempt had not been known to be vulnerable to a loss of control that could represent a danger to self or others.

**Difference between mfs with fatal and nonfatal suicide attempts**

Recent studies (Alder & Baker, 1997; Alder & Polk, 2001; Bourget & Gagne, 2002) that included both fatal and nonfatal suicide attempts showed a clear difference between mothers making a fatal and those making a nonfatal attempt. This was in sharp contrast to several studies (Barraclough & Harris, 2002; Nock & Marzuk 1999) where it was argued that clinically filicides followed by a nonfatal suicide attempt were similar to filicides followed by a fatal suicide attempt.

**Nature and Outcome of Mfs Attempts**

Two basic approaches can be identified in regards to the nature and outcome of mfs attempts as well as a third approach that has elements of both basic approaches.

**Ill prepared, Impulsively Carried out, Survivors**

The first approach refers to mothers who are ill-prepared and carry out the mfs attempt in an impulsive manner. Often they do not kill all intended victims including themselves. The choice of
method appears to be more based on immediate availability than perceived painlessness. In cases of obvious psychotic episodes, it even may be a very violent and painful method. If they have more than one child, they often do not target all their children and, in fact, many mothers only target one child.

**Well prepared and Deliberately Carried out, Mostly Fatal**

The second approach refers to mothers who prepare their mfs attempt well and carry it out deliberately. They usually kill all intended victims including themselves. Most of these mothers use methods for the filicide that are perceived as painless. For the suicide, they mostly use the same method as for the filicide. When they use a different method it tends to be more violent, although not always more lethal.

**Mixed approaches**

The third approach represents a variety of approaches, most of which are similar to the second approach except for a few aspects, and some of which are more similar to the first approach.
The Need for Profiles of Pre-Attempt Mfs Mothers

Combining the information from "Motives and Classification Systems" and "Nature and Outcome of Mfs Attempts" we see two basic profiles of mfs mothers’ lives prior to their mfs attempt and a third profile that represents a combination of elements of the basic two profiles.

Overt Profile

The first basic profile refers to mothers described as ill-prepared and carrying out the mfs attempt impulsively. Often these mothers show behaviors and symptoms prior to their mfs attempt, such as obvious symptoms of a thought disorder, that are so overt that people in their environment know that these mothers are at risk of loosing control of themselves. In California, the clinician working with a dpsmyc who would show these symptoms would be allowed and possibly even required to breach confidentiality. The clinician would know that the mother who is at risk of loosing control of herself also might be experiencing mfs ideation and, if so, might be in danger of acting on it. In other words, the risks associated with such a mother would be overt. It is also noteworthy that a clinician working with dpsmyc on an ongoing, outpatient basis would not be very likely to have overt mothers in his or her practice, as they might be more likely to be in in-patient treatment. If the clinician did have such a mother as a patient, it would be fairly easy to identify this overt mother as a potential danger.

Covert Profile

The second basic profile refers to mothers who would be assigned to a filicide category associated with altruism rather than retaliation or extreme psychiatric disturbance, and whose mfs attempt mostly fits the description of mothers who are well prepared, carry out their attempt
deliberately, and kill those intended to be killed including themselves. Prior to their attempt these mothers do not exhibit behaviors or symptoms that would make people in their environment, including clinicians, consider them as so vulnerable to losing control that special interventions would be needed. They can be considered as covert.

*Mixed Covert-Overt Profiles. The Notion of a Continuum*

The third, mixed overt-covert category may contain several subcategories. It could be the mother whose behavior and symptoms are similar, if not identical, to mothers in the covert category except for the fact that it is known that at some point in her past she made a suicide attempt. In fact, approximately half of mfs mothers whose pre-attempt lives were described in recent studies had made a prior suicide attempt. It was implied in these studies that the clinicians knew about this but there is also a possibility that they did not know about it, and only found out after the fact. Approximately 2/3 of mfs mothers with prior suicide attempts were very similar to mothers in the covert category except for the suicide attempt.

The presence of a mixed covert-overt category can also be seen as an indication of a continuum from clearly covert to clearly overt with many mothers whose profiles contain aspects of both the covert and the overt profile.

*Role of Overt and Covert Profiles in Clinical Practice*

Knowledge of the lives, behaviors, thoughts, and symptoms of mfs mothers, and especially of the covert ones, is critical for the clinician who needs to assess for mfs ideation among dpsmyc. Dpsmyc presenting with symptoms placing them in the overt category might be relatively easy to
identify and not much additional information might be needed for the identification of mfs ideation. However, most dpsmyc do not present with overt signs, which marks the beginning point of the challenge for the clinician. Many may not experience mfs ideation at all. Meanwhile others may experience mfs ideation in varying degrees but conceal it successfully from the clinician. Knowledge about the lives of mothers who made an attempt at mfs and who could have been considered covert prior to their attempt is, therefore, critical for a clinician who has to assess the dpsmyc for the presence and severity of mfs ideation. If the dpsmyc’s life exhibits similarities with that of the covert mfs mother, clinicians should be especially alerted to the presence of mfs ideation in their dpsmyc patients.

*Tentative Profile of Covert Mothers*

Some of the characteristics not infrequently seen in the descriptions of the lives of covert mfs mothers prior to their attempt are the following:

- **Attempt-Related**: pre-attempt communication about intentions; a “standby” suicide note written weeks before the event “just in case”.

- **Demographic features**: age of oldest child younger than seven; age of mother 27-35, most mothers have one or two children, some have three; employed prior to becoming stay-at-home-mother; race (in the USA the rate among white mothers is significantly higher than among black mothers); not lower economic status.

- **Predisposing factors**: Childhood abuse, often psychological, sometimes sexual; first or second-generation immigrant, long-term/chronic emotional problems, and poor marital or intimate relationship, sick or disabled child.

- **Precipitating factors**: abandonment and fear of being abandoned, e.g. by significant other; (the prospect of) loosing custody of children. Abandonment fears may also refer to a generalized fear of annihilation.
• Personality features: The Typus Melancholicus personality type (Okumura & Kraus, 1996): performance-oriented, orderly, very responsible, anxious and hypnomic, or overly inclined to follow rules.

• Mental illness: Mixed anxiety-depression, melancholic features, social anxiety, and rejection sensitivity.

• Other symptoms, thoughts and behaviors: overconcern about the well-being of a child, fear of future; tendency to experience fusion/merger with her child or children; vulnerable to ruminating and ideas of doom and rescue (through mfs). Overall, many covert mothers were high functioning, and had experienced long-term emotional problems.

Characteristics often attributed to filicide and “by association” to mfs that in reality are not widespread among mfs mothers, and most likely largely absent in covert mothers include obvious symptoms of a thought disorder, abuse of children, and substance abuse.

There is a striking similarity between many of the characteristics in the lives of the covert mfs mothers and phenomena that are commonly known as risk factors for simple suicide. This similarity and the effect of the convergence and interaction of various factors will be discussed in Chapter 7, the Vantage Point of Suicidology.

At this juncture, it might also be prudent to remind the reader of certain similarities between the lives of covert mfs mothers and the lives of other mothers of young children who are not experiencing mfs ideation.\footnote{For instance, Hawton & Roberts (1985) report that 30% of mothers admitted to an Emergency Room after a suicide attempt were found to be abusing their children or to be at high risk of abusing them. However, generally mothers who have made mfs attempts, especially the covert ones, are known not to have been involved in child abuse. Other disorders or syndromes to}
Nature and Quality of Information

There are no studies that specifically address mfs ideation or mfs. Information on mfs can be found in studies that deal with filicide or homicide-suicide. This section has three subsections:

- Methods of gathering information
- The manner, in which the information is processed, i.e. how it is measured, interpreted and presented
- The result and consequences of the nature and quality of the information.

Methods of Gathering Information

The studies reviewed in chapters 4 and 5 reflect the results of major improvements in the methods of information gathering during the last 15 years. The most significant of these improvements are the following:

Population Studies. Studies with both fatal and nonfatal suicide attempts.

There has been a greater reliance on so-called population studies where all cases of mfs in a specific area during a specific period were included rather than on selected samples from hospitals or prisons. While older population studies mostly included only mothers who were still alive, some of the recent population studies (Alder & Baker, 1997; Alder & Polk, 2001; Bourget & Gagne, 2002) contain mothers where both the filicide attempt and the suicide attempt were fatal be included in the context of a discussion differential diagnosis include obsessions of infanticide as well as mothers of young children with ideation about simple suicide.
(so-called ff cases) as well as mothers where the filicide attempt was fatal and the suicide attempt was nonfatal (fn). The presence of both ff and fn cases allows for a comparison between these two types that used to be very difficult, if not impossible.

**Increased Use of the Psychological Autopsy Method**

The psychological autopsy method has been increasingly used, and has proven to be especially useful for ff cases, which were not included in earlier research studies with the exception of West (1965). The psychological autopsy method pays much attention to people and circumstances in the mother’s life during the weeks and months prior to her mfs attempt. Parallel to the increased use of the psychological autopsy method, we have seen increased interest in mfs from the disciplines of criminology and victimology, both of which take a greater interest in the deceased person’s environment than traditional psychological approaches.

**Contributions associated with psychiatric evaluations**

There has been a wider and more effective use of psychiatric evaluations for a variety of reasons, especially in Scandinavian countries. For instance, a known suicide attempt in these countries is usually followed by a psychiatric evaluation.

In addition, psychiatric evaluations now follow a more standardized approach, which makes it more feasible to compare their findings over time, if such evaluations have been conducted at various points in a mother’s life (which they might be in some countries, especially
after someone has made a suicide attempt) and with the findings of other mothers. The findings of psychiatric evaluations together with findings of psychological autopsy studies have made it possible to gain better insight in the lives and the mental state of mothers prior to their mfs attempt, and possibly at the time of the attempt as well. This is particularly important when an assessment is done after the attempt for legal and/or clinical reasons because at that point there is a tendency to assume that a mother must have lost all control and have been insane to make such an attempt.

Closely related to the increased use of psychiatric evaluations is the fact that in several countries there is much information stored in centralized locations about individuals in general, such as standardized entrance tests for various school types. This information is available for research purposes.

More psychotherapy by covert mothers

There appears to have been an increase in the participation in psychotherapy by covert mothers who later made a fatal mfs attempt. As a result, there is now information available about them that was, in many cases, not available in older studies. The reason for the increase in participation in psychotherapy might be that therapy is more widely available and participating in it is less stigmatizing than it may have been. As a result, covert mothers may seek treatment for anxiety and depression, while in the past psychotherapy was not considered an option.
No major Improvement in Information Gathering in Clinical Interview

As to gathering information in a clinical interview in order to determine the presence of the danger of h-s, Nock & Marzuk (1999) report that the most important aspect of assessing h-s is to be aware of the possibility. This suggests how little prepared many clinicians may be.

Processing, Interpretation and Presentation of Information

While more information is available, it is not necessarily processed, interpreted, or presented in a manner that furthers a better understanding of mfs. Earlier discussed obstacles to processing, interpreting, and/or presenting information include the following:

Differences in the relative size of the age cohort that contains mothers at risk for mfs

For instance, the age cohort of 28-35, which contains most mfs mothers, especially those of the covert type, might account for 10% of the general population in one country and 15% in another country. Yet, in comparisons of the mfs rates of various countries, this difference is not taken into account.

Lack of accurate data due to registration methods

Sakuta (1995) quotes a study by Sato (1979) that suggests that Japanese mfs rates are 5 to 10 times higher than in most Western countries. However, the system of registration of mfs incidents in Japan makes it difficult to make accurate comparisons with other countries. Meanwhile,
in the USA a lack of central registration of h-s events at a federal level as well as in many states results in incomplete data.

*Link between ss and h-s rates ignored*

Meta-studies about trends in h-s rates generally do not refer to the possibility that differences in h-s rates (not just mfs) between countries or changes over time may be influenced by changes in suicide rates. In fact, Coid (1983) suggested this possibility when he pointed out that parallel to the decrease in h-s rates in England and Wales between 1969 and 1979 there was a strong decrease in rates of simple suicide. However, studies about h-s rates do not mention this particular observation by Coid.

*Differences in the explanation and interpretation of mfs incidents*

In many studies in the USA and Canada, mfs incidents were considered primarily as a form of fatal child abuse, referred to as “child abuse gone awry” (Silverman & Kennedy, 1988, p.124). As a result, the number of child victims in connection with parental suicide attempts was not accurately reported and certainly not in a manner that would show that 30 to 50% of the filicide deaths were associated with such suicide attempts. A mechanism that appears to contribute to this distorted picture consists of the practice to record only one offender and one victim in cases of homicide and h-s, including maternal filicide and mfs, even when there are multiple offenders and/or multiple victims. In mfs, almost half of the mothers involved kill or try to kill more than one
child, and more than half of the child deaths due to mfs occur in incidents that involve more than one child\textsuperscript{108}.

\textit{Inaccurate Quoting about extent of fatal suicide attempts}

Many studies refer to the fact that D'Orban (1979) assigned only 24 of the 89 filicidal mothers examined by him to a category of \textit{mentally ill}. However, only few of these studies mention that D'Orban suggested that the mentally ill category would have been much larger, both in absolute numbers and in relation to the size of the other five filicide categories used by him, if mothers who had made a fatal suicide attempt had been included in his study in addition to the current 89 mothers who either had not made a suicide attempt or a nonfatal one.

When studies do refer to the fact that mothers with a fatal suicide attempt were not included in D'Orban's study, they never refer to the magnitude of the problem. D'Orban, however, reported that mothers with a fatal suicide attempt, as shown in a particular study covering a previous period were almost twice as numerous as mothers making a nonfatal suicide attempt or no attempt.

\textsuperscript{108} The practice of recording only one victim and one offender in cases where there are multiple offenders and/or victims would cause much less distortion in fatal child abuse cases or most cases of spousal h-s, where the number of victims practically always is one because in most h-s studies a dead h-s offender is not counted as a victim.
Mfs lumped together with other forms of filicide

A clear example of the tendency to lump mfs together with other forms of filicide is provided by Holden, Burland & Lemmen (1996). These authors compared 20 filicidal mothers who had been found “Not Guilty by Reason of Insanity” (NGRI) with 8 filicidal mothers who had been found to be Criminally Responsible (CR) in order to examine to what extent the NGRI determination had been applied in a consistent manner. The data on which they based their findings contained information about race, killing of multiple children, years of education and suicide attempts in conjunction with the suicide. The findings did not mention any of these four variables specifically, let alone any connections between them. Careful examination of the data suggests that the five mothers killing multiple children may have been among the eleven who made a suicide attempt, and also might have been white, and with some college education. This typical covert profile would contrast with other mothers in their study who had acted on the basis of command hallucinations and had only killed one child. If the presence of a subset of mothers with these covert characteristics were to be confirmed by further research, it would also confirm that mfs practices and rates among white mothers in the area (Michigan) and during the period studied (1976-1989) would be similar to those in other parts of North America and Europe.

Generalizing/Extrapolating findings of local studies to estimates of national prevalence

Studies about filicide and filicide-suicide as well as about overall h-s in the USA are often conducted in urban areas where there is a large black population. Black women, especially when not part of the middle class, have one of the lowest suicide rates in the USA. Their mfs rate appears to be equally low. At the same time, black women have a significantly higher filicide rate than white women, which according to Goetting (1988, 1990) is a correlate of poverty rather than
race, and which mostly is associated with child abuse. As a result, mfs rates in these urban areas are lower than what is seen in many countries in Western Europe, especially when additional demographic and logistic factors associated with low mfs rates play a role in these urban areas\textsuperscript{109}. In addition, there is a tendency to present mfs data as a percentage of overall maternal filicide or overall h-s\textsuperscript{110} depending on the study. This usually results in a lower percentage for mfs than is seen in other locations than these urban areas because both h-s and filicide have a relatively high prevalence in these urban environments.

Therefore, when estimates of the prevalence of h-s in the USA, both overall and of the component parts, are based on (an extrapolation of) the findings of studies conducted in selected cities rather than on the results of a national survey, and many of these selected cities are the type of urban areas referred to earlier, it can be no surprise that Nock & Marzuk (1999) conclude that filicide-suicide is less prevalent in the USA than elsewhere. It is also interesting that the recent study about child homicide in the entire state of California between 1981 and 1990 shows that the number of filicide victims associated with parental suicide attempts is on the high end of the range in which rates of most countries can be found.

\textsuperscript{109} Other demographic factors might include the relative size of the age cohort (27 to 35) that contains most mfs mothers. Logistic factors could include the number of people, including children, in one household. The larger this number is, the more difficult it might be to prepare and carry out an mfs plan.

\textsuperscript{110} In most countries, and especially in the USA, more than 90% of h-s offenders are males involved in spousal h-s. Black males participate in this to the same extent as white males. It is also extremely rare for a woman to kill both her husband/partner and herself. As a result, it can be no surprise that Berman (1979) reported that there were no cases of filicide-suicide (by either parent) in his study of h-s in the combined population of Baltimore, Philadelphia and Washington DC during the two-year period of 1974 and 1975, while there were 15 cases of spousal h-s, morbid jealousy variety.
**Confusing Numerical Relationships**

Many studies report that fewer than 5% of mothers who kill a child under the age of one make a fatal suicide attempt in conjunction with the filicide, while 20% of those killing a child older than 12 months do so. This easily can be misinterpreted, as it happens in some studies quoting these data, to mean that mothers with children under the age of one present less of a risk for mfs. Close examination of the data in some of the studies that allow such an examination show that the actual numbers of mfs cases with a fatal suicide attempt do not differ for mothers with children under 12 months, and those with children between 12 and 48 months. The low percentage among mothers with children under the age of 12 months is mainly due to the relatively higher number of mothers killing their child during its first year as a result of child abuse, postpartum issues, or unwanted births compared to mothers with older children.

Another example of confusing numerical relationships can be seen in studies that report that the relationship between male and female perpetrated h-s in a particular country, for instance England and Wales, has changed and is now similar to that seen in other countries. This manner of presentation could easily obscure the real significance of this change, which consists in the example of England and Wales of a sharp decrease of mfs rates, while the rate of male perpetrated h-s has remained the same.

**Cross References, Differentiation, and Disaggregation**

A Lack of Cross References. A good example of a lack of cross references in many studies in which mfs is addressed is provided by Haapasalo & Petaejae (1999). These authors include a wealth of variables in their very well researched study about maternal filicide, including filicides followed by nonfatal suicide attempts: stressors, psychological problems, childhood abuse
issues, methods used, and types of filicide, yet they do not make any cross references between these variables. For instance, it would have been very helpful if Haapasalo & Petaejae had provided more specific information on the filicide-suicide mothers, such as the age of the mothers and the children, the number of children targeted and killed, methods used etc. This information could have been compared with other studies that did provide these details.

A Lack of Differentiation. A problem related to cross references is the lack of data needed for cross-referencing. For instance, Coid (1983), who in his metastudy of h-s did not make any references to the gender and age of the perpetrators or their victims, reported that the h-s rates in the 1950's were almost identical in Denmark and Philadelphia without mentioning that h-s in Denmark consisted mainly of mfs and in Philadelphia of spousal h-s perpetrated by males. The notion that such similar rates could go hand in hand with such differences in the contents of h-s was not alluded to. It is also interesting that more recent studies (Nock & Marzuk, 1999, Milroy, 1995a) that refer to Coid did not note this phenomenon, especially because there are indications that the initially identical rates may have diverged considerably.111

The Need for Disaggregation of Data. Disaggregation refers to the practice, where the contributing components of findings are reported separately allowing for a comparison of variables and categories of persons that was not possible before. Disaggregation has played a major role in this dissertation and occurred when I re-examined the findings of certain studies. For instance,

111 Rates of spousal h-s, morbid jealousy variety, have increased in the USA (Milroy, 1995), which is likely to have affected the h-s rate in Philadelphia. Meanwhile the mfs rate in Denmark, which was by far the highest in Europe prior to the mid 1960’s and was associated to some extent with the use of toxic coal gas and a lack of effective birth control, appears to have decreased. Further research about the situation in Denmark with respect to mfs rates is needed to provide relevant details.
D’Orban’s (1979) study about maternal filicide included a category of *mentally ill* that contained 24 mothers, of whom 13 had made a suicide attempt. Yet, the data that were presented about these 24 mentally ill mothers did not distinguish between the 13 mothers who had made a nonfatal suicide attempt and the 11 mothers who had not made a suicide attempt. Re-examination of the data and a comparison with data in similar studies allowed me to make certain tentative suggestions about differences between the mothers who had made a suicide attempt and those who had not. These suggestions included the possibility that the diagnosis of reactive and neurotic depression may have been typical of many of the suicidal mothers, while a diagnosis of postpartum psychosis may have been typical of half of the mentally ill mothers who had not made a suicide attempt. These suggestions, when confirmed by further research, would be particularly relevant in light of the assumption made in several studies\(^{112}\) that for mfs to occur the mother must have been seriously mentally ill and probably insane.

A related aspect to disaggregation refers to the potential for improved risk analysis (Pritchard & Bagley, 2001; Stroud & Pritchard, 2001). For instance, if mothers in ongoing, outpatient psychotherapy who made a fatal suicide attempt after a filicide were all 27-35 years old, with three children under the age of seven, a college education, and not involved in substance or child abuse, it might be easier for a clinician to identify which dpsmyc could be at risk for mfs ideation. Adding more variables could further improve the risk analysis.

\(^{112}\) This includes studies referring to D’Orban (1979)
Use of the terms mental illness, psychiatric disorders, insanity, psychosis, and psychotic identification

Especially in older studies, the term mental illness was used frequently. However, it was often not clear whether the author meant ‘any psychiatric disorder’ or ‘insanity’. When they were using the term insanity, it often was not clear whether they meant insanity as in “Not Guilty because of Insanity” (NGRI) or as a serious symptom of a thought disorder. For instance, Haapasalo & Petaejae (1999) report that 63% of 33 non-neonaticide filicidal mothers were regarded as not legally responsible for their act due to insanity, while only 30% of them were known to have been suffering from psychotic symptoms prior to the mfs attempt.

As to the term psychotic identification, the way some authors define it suggests merger or fusion rather than psychosis.

Lewis, Baranoski, Buchanan, & Benedek (1998) report that 14 out of 15 filicidal mothers who had used a knife or a firearm to kill their child, were

- psychotic
- had “high rates of psychotic symptoms” (Lewis et al., p. 617)
- were exhibiting the kind of psychotic symptoms that can be identified, monitored, and treated.

As a result, Lewis et al. imply that there is a category of low rates of psychotic symptoms. These authors may also imply that it might not be as easy to identify, monitor or treat psychotic symptoms that are different from the “high rates of psychotic symptoms” seen in these weapon using mothers. However, the authors do not elaborate on this.
The Quality of Information and the Degree of Understanding of Mfs

Descriptions of Mfs behavior have become much more accurate and complete due to improvements in information gathering. As a result, the earlier tendency, which was particularly common in the USA, to explain all filicide in terms of fatal child abuse or postpartum conditions and, concomitantly, to ignore the specific characteristics of Mfs has lost much of its strength. Yet, it remains hard to understand that the insight that Mfs was primarily suicide has not led to a wider application of concepts of suicidology. Meanwhile, the increased knowledge about the lives of Mfs mothers and especially those with a fatal suicide attempt has revealed many aspects that commonly are regarded as risk factors for simple suicide among women. This may encourage further application of suicidology concepts. This dissertation can be seen as part of this effort.

The improved quality of the information has also made it clear that the percentage of filicide deaths that are associated with parental fatal or nonfatal suicide attempts has been increasing in most countries, while the absolute numbers of such deaths appear to have remained stable. The relative increase of filicide deaths associated with parental suicide is mainly accounted for by the fact that fewer children are now dying as a result of other forms of filicide due to a variety of factors such as improved birth control, legalization of abortion, the success of programs to reduce child abuse and improved medical rescue technology. This increased (relative) prominence of filicide-suicide deaths in statistics about the prevalence of filicide may provide additional motivation to learn more about filicide-suicide, including Mfs.
Explanations and Theories

Early explanations of mfs

Schizophrenia and/or displaced aggression were considered necessary conditions for mfs to occur. Not much of an effort was made to explain which type of patients suffering from schizophrenia and/or vulnerability to expressing displaced aggression were most at risk for mfs or what factors might be responsible for triggering mfs behavior. In the 1950's and 1960's this started to change. Studies containing descriptions of the mothers’ thoughts and behaviors during the years prior to their mfs attempt started to include references to the following phenomena (McDermaid & Winkler, 1955, Tuteur, 1959, West, 1965):

- feelings of inadequacy as a mother
- overconcern for the child’s well-being, including fears that something could happen to it
- the presence of sickness or disability in the child
- feelings of being overburdened, and being trapped

In addition, there is a good deal of attention for symptoms that suggest the presence of:

- mixed anxiety and depression
- rejection sensitivity
- Fear of the future, including a sense of a foreshortened future.
- Ideation about simple suicide and nonfatal suicide attempts
- childhood experiences that included feeling that one was not properly mothered as a child and/or that one is not loved/accepted by an important person in one’s family of origin
- the notion of altruism
It appears that circumstances increasing a mother’s vulnerability have received more attention. The possibility that displaced aggression or schizophrenia might have played a role was not ignored but the presence of both or either was no longer a necessary or a sufficient condition.

However, many older studies as well as some recent ones (Bourget & Gagne, 2002) would refer to the presence of psychotic symptoms when describing mothers who were experiencing delusions of altruism. Meanwhile, other studies (Alder & Baker, 1997; Alder & Polk, 2001; Meyer & Oberman, 2001) prefer to speak of ideas of altruism because they do not recognize a psychotic element in these ideas, at least not in the mothers that were included in their studies. In fact, I have argued that what some studies refer to as delusions of altruism or doomsday delusions would be regarded as superstitions or cognitive distortions that, although serious, may not be all that uncommon.

As to the notion of altruism as a motive, it reflects the belief that the mother would kill a child thinking it would be better off dead in light of the bleak future the mother saw in store for the child, especially if she were to commit suicide without taking the child along. This particular line of thinking by the mother was widely recognized as playing an important role despite some disagreement about the question to what extent this type of motive should be designated altruistic because mfs could be considered as a syntonic act carried out by the mother to deal with her own problems.

The only one of the older studies that proposed an overarching explanation for phenomena associated with altruism, filicide and mfs was presented by McDermaid & Winkler (1955). These
authors coined the term Child Centered Obsessional Depression (CCOD), which focused on the overconcern these mothers would exhibit, the reasons underlying it, and the consequences it could have among those who were particularly vulnerable.

*Mfs explained as form of child abuse*

In the 1970's and 1980's many studies, especially in the USA, explained all filicide, including mfs, as a result of child abuse that accidentally resulted in death or as a result of postpartum issues. Suicide was not discussed as a primary motive, although it was associated with 30 to 50% of the number of children dying as a result of filicide.

*Resurfacing of role of suicide*

In the 1990's altruism and the role of suicide resurfaced. As a result, recent studies now have a separate category for filicide-suicide, where most, but not all mothers had altruistic motives. These studies described several characteristics of the mothers’ lives and suggested that some of them may have played a role, such as a bad marital relationship, abandonment (fears), or issues around immigration.

*First overarching theory of (some forms of) mfs behavior*

Okumura & Kraus (1996) were the first to publish a study that focused exclusively on mfs mothers who had survived their suicide attempt. They also were the first after McDermaid and Winkler to propose an overarching explanatory framework for one of the three subgroup of mfs mothers that they distinguished and which they referred to as *endogenously depressed*. This framework was organized around the *Typus Melancholicus (TM)* personality type, of which the
characteristics are performance-oriented, orderly, very responsible, anxious, and hypernomic (overly carefully adhering to rules out of fear to violate them). An attempt at mfs by these mothers usually was based on altruistic motives. Considering the characteristics of the TM personality, it can be no surprise that the altruistic motive was based on the mother's perception of not being able to meet expectations that society or those in her immediate environment had of her in addition to believing that not meeting expectations would be disastrous for herself and for her children.

Okumura & Kraus described how the lives of mfs mothers in this particular subgroup may have been shaped by the TM personality in a way that they had become vulnerable to experiencing ideation about simple suicide, and after becoming a mother, about filicide-suicide. The authors described the mothers' needs to identify with other persons and impersonal social roles and the concomitant inability to build a solid sense of self. In many cases these identification processes led to women who as adults were high functioning and meeting the expectations of society, although the mothers themselves may not have been convinced of that and may have perceived themselves as barely adequate. In their role of mother, their lack of a solid sense of self caused them to experience their child as an extension of themselves. This led to the assumption that whatever was bad about the mother would also apply to the child. When anxiety about this led to feelings of doom, the mothers increasingly believed that suicide would be the only solution. Because the child was experienced as part of their self—the authors speak of an extended self—the child would automatically be included in a suicide attempt. The authors speak of a psychotic identification between mother and child that accounts for the mfs behavior. However, it appears that what the authors describe as psychotic identification is rather similar to what has been referred to in the
literature as merger or fusion behavior that often is associated with women who are suffering from a Borderline Personality Disorder.

The description that Okumura & Kraus give of mfs mothers with a Typus Melancholicus personality constellation strongly resembles the description of mfs mothers whose life, prior to their mfs attempt, exhibited a covert profile. Considering that the TM profile describes characteristics often seen in people who are in outpatient, ongoing psychotherapy, we can expect that many dpsmyc who are in therapy will fit the description of the TM profile. There is a possibility that needs further research that a Typus Melancholicus personality profile is a necessary, but not sufficient condition for the presence of mfs ideation among dpsmyc who do not have an overt profile. Knowledge about the contents of a TM personality type may be of help to clinicians working with dpsmyc who need to assess for the presence of mfs ideation.

Additional Explanations

Additional explanations (Alder & Baker, 1997; Alder & Polk, 2001; Meyer & Oberman, 2001) focus on the expectations that society has of motherhood and the burdens that this might impose on some mothers who are not in a position or think that they are not in a position to meet these expectations.

Another aspect of recent explanations is highlighted as the convergence of mental health issues, personality features, current stressors, as well as predisposing and precipitating factors. The most important feature of even the recent explanations is the absence of an effort to make use of what has been learned about simple suicide despite the acknowledgement that mfs is primarily
suicide rather than homicide. Starzomski & Nussbaum (2000) who applied the escape theory of suicide (Baumeister, 1990) to spousal h-s, morbid jealousy variety, may be signaling the beginning of a trend. In the next chapters, I will explore to what extent Starzomski & Nussbaum’s theory might be applicable to the study of mfs.

Further Research

The literature review has enabled me to suggest a profile of mothers in outpatient, ongoing psychotherapy who might be experiencing mfs ideation. Further research is needed to validate or alter this profile. Specific attention is needed for improved prevalence data: the percentage of suicidal mothers who take one or more of their children along and the percentage of mothers with suicidal ideation who are also experiencing mfs ideation. In addition, more research is needed about the usefulness and validity of concepts that have been proposed by me, especially

- the notion of different profiles for covert, overt and mixed covert-overt mothers
- the importance of characteristics associated with the Typus Melancholicus personality profile
- the notion of the importance of convergence and interaction of specific stressors, predisposing and precipitating factors, personality features and specific symptoms of psychiatric disorders
- the applicability of suicidology concepts

Most of the aspects of mfs that need further research will be addressed in the next three chapters, of which the role and contents already were discussed in chapter One.
Suicidology is a field of study, rather than a specific theory, and addresses all aspects of suicidal behavior and ideation. There appears to be an emphasis, however, on preventing fatal attempts rather than on the explanation of nonfatal behaviors or ideation.

Many authors consider most forms of homicide-suicide and especially mfs to be primarily suicide rather than homicide. Yet there has been no systematic effort to use the concepts of suicidology for the study of homicide-suicide, including mfs. Maris, Berman & Silverman (2000) refer to homicide-suicide and mfs as manifestations of suicide in their textbook on suicidology, although they devote less than 1 out of 625 pages to it.

This chapter describes the elements of suicidology that are particularly relevant for the study of mfs and mfs ideation. These elements will be applied to data from my review of the literature on mfs in order to determine to what extent and in what manner suicidology concepts and the findings of studies on simple suicide might contribute to the understanding of mfs. The elements that I will describe are:
• pathways towards suicide and the suicidal process

• prevalence

• ideation

• nature and outcome of the attempt, which includes a discussion of
  o methods used
  o suicide notes and other aspects of communication
  o time, place and opportunity

• demographic aspects

• explanatory approaches
  o the psychiatric approach
  o theories
  o other approaches

• assessment

Pathways and Processes

Maris (1981) argues that suicides do not happen in a vacuum. He speaks of suicidal careers following pathways to suicide. In this context, pathways refer to events in one's childhood that can set in motion certain other events which interact and result in suicidal behavior and ultimately in a fatal suicide attempt or a serious nonfatal attempt.

Runeson, Beskow & Waern (1996) refer to suicidal process as the period that ends with a fatal suicide attempt. They speak of the first communication to others about the possibility of suicide as the start of the process. However, in the same study the authors also speak of the first thought about suicide as the beginning, without referring to the communication of that thought. The
suicidal process, therefore, can be seen as that part of the pathway, where suicidal ideation is present.

In terms of severity, the suicidal process includes ideation, planning, aborted attempts, nonfatal, and fatal attempts. There is a somewhat implicit assumption that there is a sequence from mild ideation to a fatal suicide attempt, although persons may shift from the phase of a non-fatal attempt back to mild ideation.

One component of the simple suicide process that might be particularly relevant for mfs ideation that is missing in most process studies is that of the aborted attempt, defined as having been on the verge of making a serious attempt but having stopped short of actually “doing it” (Barber, Marzuk, Leon & Portera, 1998). As a result, no injuries are incurred. An aborted attempt at simple suicide reportedly happens as often before as after a nonfatal suicide attempt, and is associated with an increased risk of a subsequent serious attempt. Barber et al., therefore, recommend that clinicians inquire about any aborted attempts.

Maris, Berman, & Maltsberger (1992) present a model of suicidal behavior that graphically illustrates aspects of the pathway and the process (see Figure 7.1). This model includes concepts of a suicidal zone, where one is considered being at very high risk, as well as precipitating, predisposing, and protective factors. In addition, attention is given to lifecycle elements. Particularly noteworthy is the possibility of cycling back and forth between various risk categories.

Figure 7.1 Pathways to Suicide (From Maris et al., 1992, p. 668)  
(See Figure on next page)
### Precaution:

<table>
<thead>
<tr>
<th>PRIMARY</th>
<th>SECONDARY</th>
<th>TERTIARY</th>
</tr>
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<tbody>
<tr>
<td>Precipitating Factors</td>
<td>Predisposing Factors: Vulnerabilities</td>
<td>Protective Factors</td>
</tr>
</tbody>
</table>

#### Interactions

1. **Psychiatry**/
   - Diagnosis

2. **Biology**/
   - Family History/
     - Genetics/
       - Neurochemistry

3. **Personality**/
   - Psychology

4. **Sociology**/
   - Economics/
     - Culture

#### Trait (Birth) ➔ State ➔ Suicide Zone ➔ Suicidal Career ➔ (Death)
**Application to Mfs and Mfs Ideation**

The concepts of pathways and process appear to apply to mfs and mfs ideation. However, the pathways of mfs mothers might be hidden. For instance, some of the mfs case descriptions contained in the various studies suggest that having young children appears to make certain mothers vulnerable to having some of their own childhood traumas reactivated. Therefore, childhood sexual abuse or abandonment experiences, both of which have been associated with increased suicide risk as an adult, may take on additional significance for mothers with young children. These mothers might fear that their children will be subjected to the same traumas.

As to process, a mother with mfs ideation might have alternating ideas of simple suicide and mfs. Simple suicide may appear problematic to her because it would leave the child alone, while mfs may seem too daunting. A "cry for help" mfs attempt that is not intended to be lethal, as is the case with many “cry for help” attempts at simple suicide (Maris, 1981) appears unlikely because the mother would have to start with the children. Such a mother might be a candidate for aborted attempts at mfs or simple suicide.

The issue of hesitation between simple suicide and mfs has not been specifically addressed with the exception of Marneros (1997). In a German language study, this author speaks of Homizoidal or a homisuicidal period with respect to homicide-suicide in general, where homicidal and suicidal urges appear to alternate or are present simultaneously.

The possibility of vacillation can also be surmised by the fact that at least half of the mothers who made a fatal or nonfatal suicide attempt after a fatal or nonfatal filicide attempt are
reported to have made prior attempts at simple suicide. Some of these simple suicide attempts precede the mfs attempt only by a few months, while other attempts occurred before any children had been born.

In this context, it may be useful to point out that in many mfs cases fears about the children and their future appear to have been the main reason for mfs. This particular aspect is sometimes obscured when studies suggest that an mfs attempt is mainly motivated by the mother’s desire to commit suicide. Such mothers supposedly take their children along because leaving them behind without the protection of their mother would expose them to many risks and make their life miserable. It appears that the mother who is contemplating mfs primarily to protect her children might experience fewer obstacles to acting on her ideas. Alder & Baker (1997) report that such mothers see it as their maternal duty to protect their children from a miserable future. The mother who would primarily act on the basis of a desire to commit suicide and who is contemplating taking her children along may experience more restraints because of guilt about being selfish. These motives may be overlapping and hard to distinguish in many cases. Yet, it may be helpful to consider the distinction for assessment purposes. In addition, many of the case descriptions indicate that the motive to protect children tends to be much more prevalent or, where both motives are present, tends to be much stronger than the motive to take the children along.

In the context of vacillation between simple suicide and mfs, it might be noteworthy that Iga (1996) reports that in Japan a mother who makes an attempt at simple suicide without taking her children along is the object of disapproval, while the mother who does take her children along is seen as deserving of sympathy.
**Aborted Mfs Attempts**

In regards to aborted mfs attempts, further research is needed to determine what is dominant: a mother’s motivation to protect her children or her intent to commit suicide and take her children along.

The consequences of aborted attempts for the (rest of the) suicidal process in potential mfs mothers also may be worth examining. Aborted attempts may release anxiety and help decrease the severity of the mfs ideation, which would be similar to suggestions about the role of aborted attempts with respect to ideation about simple suicide. Meanwhile the aborted attempts also might bring some mothers closer to an actual attempt because of an approximation effect.

A mother experiencing mfs ideation might be especially hesitant to disclose any aborted attempts. She might fear panic and disapproval from others, including clinicians, which could lead to involuntary hospitalization. Fear of disclosure of aborted attempts might be particularly relevant for a mother who is experiencing social anxiety and rejection sensitivity because, as will be pointed out later, having something to conceal tends to increase the social anxiety (Gilbert, 2001).

The clinician may want to be alert for indirect communication about aborted attempts, such as the expression of ideas about possible future acts of mfs or aborted attempts in the past that are minimized as mere ideation. Further inquiring about such “past” aborted or future attempts when brought up by the mother might clarify much.
Prevalence

The prevalence of suicidal behavior reportedly varies by country, culture, age, gender and other variables. Currently, each year in the USA 11 persons per 100,000 make a fatal attempt at simple suicide. Meanwhile, for every fatal attempt there are reported to be six to eight persons making a nonfatal attempt (Kushner, 1995). Crosby, Cheltenham & Sacks (1999) found that 0.7% of respondents to a telephone survey among the general population had made an attempt during the 12 months prior to the survey, which suggests approximately 60 nonfatal attempts for every fatal one. It has to be kept in mind that the number of nonfatal attempts probably also depends on the definition of nonfatal attempt and on the methodology of the study. Generally, younger persons and women have more nonfatal attempts than the elderly and men.

While the ratio of 100 nonfatal attempts for every fatal attempt usually is associated with teenagers, Crosby, Cheltenham & Sacks (1999) found that 0.7% of those aged 25-34 from a sample of the general population made a nonfatal suicide attempt during the 12 months prior to a telephone interview. The figure for “all ages” was also 0.7%. A figure of 0.7% for nonfatal attempts means that out of 100,000 persons 700 made a nonfatal attempt. With 11 persons per 100,000 making a fatal attempt, we have a ratio of approximately 60 nonfatal attempts among persons aged 25-34 for every fatal one, as was mentioned earlier. This is seven to ten times as high as reported by most other studies. Crosby et al. do not discuss how unusual this particular finding is. Further research is needed with respect to the nature of nonfatal attempts and how questions

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113 The 0.7% figure refers to all persons in the 25-34 age group regardless of gender. Since the differentiation by gender for “all ages” did not show major differences, I assume that the same applies to the 25-34 age group.
about nonfatal attempts are phrased. For instance, it would be important to know whether nonfatal attempts in the study by Crosby et al may have included so-called aborted attempts.

Linehan & Laffaw (1982) report that 33% of patients of an outpatient clinic and 24% of the general population reported to have experienced suicidal ideation during their lifetime. Linehan & Laffaw also report that their findings are similar to those of other studies. There is a possibility that differences between studies in regards to the data on the prevalence of suicidal ideation are associated with the definition of ideation used in the studies. Differences in the definition of ideation are likely to reflect different degrees of severity. Also, older persons by virtue of having lived longer may be more prone to have experienced suicidal ideation during their lifetime than younger persons.

In terms of prevalence of various shades of suicidal ideation during the last 12 months Crosby et al. found that for the entire sample, i.e. “all ages”, 5.6% had experienced ideation, 2.7% had made a specific plan, and 0.7% had made an attempt.

To get a clear picture of the relevance of the data about prevalence of simple suicide behavior for mfs and mfs ideation, additional information is needed, especially about simple suicide behavior in the age bracket most often associated with mfs mothers, 27-35. As indicated earlier, it would be helpful to know the percentage of simple suicide mothers involved in child or substance abuse, as these behaviors are not commonly observed among mfs mothers.
In addition, there are earlier described instances of a strong connection between the overall prevalence of fatal simple suicide attempts by women and the prevalence of mfs cases, where both the filicide and the suicide attempt were fatal (ff cases): the sharp decrease of simple suicide and mfs after detoxification of coal gas in England and Wales as well as the low prevalence of suicide and mfs among black women in the USA. Further research is needed about the precise nature of such links.

Additional research is also needed about a possible link between mfs ideation and simple suicide ideation among women with respect to prevalence as well as other aspects. This will be explored in the next section.

**Suicidal Ideation**

The following points may be relevant with respect to ideation about simple suicide and its relationship to mfs ideation.

- Ideation forms a part of the suicidal process that extends from the first thoughts about the desirability of death up to a fatal attempt. It can occur before and after nonfatal or aborted suicide attempts.

- The term suicidal ideation includes many shades of severity, from occasional thoughts about the desirability of death to serious contemplation of a suicide attempt. Some studies would include having a serious plan as part of suicidal ideation, while others refer to a plan as a separate stage.

- Generally, the more specific the thought or plan, the more serious it is likely to be. Examples of contents of suicide ideation can be found in instruments such as Beck’s Suicide Ideation Index (Beck, Brown & Steer, 1997; Joiner, 2002)
Duration of ideation is likely to vary with the length of the suicidal process. 114

Ideation, once engaged in, may develop a momentum of its own (Bonner & Rich, 1988; Joiner, 2002) and lead to more and more serious ideation due to

- Cognitive sensitization, where fewer, weaker, and less specific triggers are sufficient to trigger ideation.

- The working of the opponent process theory (Joiner, 2002), where the thought of actually committing suicide tends to become associated with calmness, while at first it was more associated with fear and discomfort.

- Increased isolation after the start of the ideation, which may further increase the ideation. Isolation might be associated with certain symptoms of depression, such as worthlessness, guilt, and rejection sensitivity.

- Depression may lead to negative life events that may exacerbate the depression, including suicidal ideation, which is one of the possible symptoms of depression.

Persons with suicidal ideation, especially when they have serious plans of killing themselves, are reported to communicate their intentions, sometimes overtly, sometimes covertly, especially to people in their environment. However, Shea (1999) reports that many patients receiving psychiatric help have problems disclosing the full extent of their suicide ideation, and sometimes even its presence to their clinician. Shea attributes this to shame as well as to fear of hospitalization.

I have found that etiology of and risk factors for suicidal ideation do not receive much attention in the literature, possibly because they are considered similar to the etiology and risk factors associated with fatal suicide attempts. Nevertheless, there are some studies (McGee, Williams & Nada-Raja, 2001; Rudd, 1990) pointing to certain childhood issues that are associated with a higher likelihood of depression and suicidal ideation. In addition, Rudd (1990) reported that suicidal ideation is associated with depression, while serious fatal or nonfatal suicide attempts are associated with hopelessness.

The predictive value of suicidal ideation with respect to the danger of a fatal suicide attempt is more closely associated with ideation at its worst point rather than ideation at

114 According to Runeson, Beskow & Waern (1996), Borderline Personality Disorder and Schizophrenia are associated with a longer suicidal process, which, in addition, may be longer for women than for men. The median duration of the suicidal process in cases of Borderline Personality Disorder, regardless of gender, is reported to be 30 months. Adjustment disorder and Depression were reported to have a shorter duration.
the time of the clinical interview\textsuperscript{115} according to Beck, Brown, Steer, Dahlsgaard, & Grisham (1999)

- Data about the prevalence of suicide ideation often are not broken down by gender. When they are broken down, the differences between genders appear to be minor. However, further research about this issue could provide additional clarification.

\textit{Implications for Mfs and Mfs ideation}

- Considering that apparently most simple suicide attempts have been preceded by ideation and considering that at least half of the mfs cases where the mother made a fatal suicide attempt after killing one or more of her children have been preceded by simple suicide attempts at some point in the mothers' lives\textsuperscript{116}, there is a high likelihood that dpsmyc experiencing mfs ideation may also experience or have been experiencing ideation about simple suicide. Therefore, it is highly likely that simple suicide ideation experienced by a dpsmyc can be considered a necessary condition for mfs ideation.

- Approximately half of the mfs mothers in the various studies exhibited or were reported to exhibit features of the so-called Typus Melancholicus personality profile which was described in chapter 6. This profile appears to be closely associated with rejection sensitivity, atypical depression, and symptoms of social anxiety. A study (Lecrubier, Wittchen, Faravelli, Bobes, Patel & Knapp, 2000) among the general population found that 45% of persons with depression and a comorbid social anxiety disorder, especially of the generalized and early onset kind, had made a nonfatal suicide attempt, while a total of 77% were suffering from suicidal ideation or had done so during their lifetime.

- The likelihood that a mother with mfs ideation might make a nonfatal mfs attempt is probably lower than the likelihood that a person with equally strong ideation about simple suicide might make a nonfatal suicide attempt because in mfs a mother would have to start with the children. She would only do this if she were strongly motivated to start and complete the mfs attempt. As a result, there is a possibility that the mfs mother might be more prone to make an mfs attempt that she subsequently aborts. She might find it difficult to disclose such an attempt.

- If persons contemplating simple suicide have problems disclosing the full extent of their ideation because of shame and fear of hospitalization and stigmatization, then there is a substantial possibility that a dpsmyc experiencing mfs ideation might have even more

\textsuperscript{115} The patient is asked during the interview about suicidal ideation at its worst point.

\textsuperscript{116} There is hardly any information on whether prior simple suicide attempts took place while the dpsmyc was a mother.
severe problems disclosing her ideation. The presence of aborted attempts would only add to that.

- Based on the above, it appears that the phenomenon of “ideation developing a momentum of its own” due to approximation, cognitive sensitization and the notion of opponent process may be particularly relevant for mfs ideation.

Nature and Outcome of Attempts

Information about the nature and outcome of attempts at simple suicide may provide clues about the degree of motivation and preparedness of the suicidal person, as well as about his or her suicidal ideation. Components of the nature and outcome include suicide notes, communication of intentions prior to the attempt, aspects of opportunity, and last but not least, methods. Issues in the discussion of nature and outcome include the seriousness and lethality of attempts as well as the question of impulsivity vs. rationality.

Before discussing the various components, it may be useful to remind the reader that 70% of all fatal simple suicide attempts represent first attempts (Maris, 1981). This percentage is approximately 50% for women under 45 (Maris, 1981). In addition, 10 to 15% of all those who ever made a nonfatal suicide attempt eventually die of suicide. These data need to be seen in the context of the discussion around seriousness and lethality. Whether a serious attempt is also

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117 On the other hand, I also believe that there is a possibility that the mother’s love for her children might prompt her to seek help and disclose her ideation. Being pulled in two directions, the mother might at one point disclose her ideation or part of it, and at another point, she might minimize whatever ideation she disclosed earlier.
lethal, depends on more than the fact that the person is serious about wanting to die.

Preparedness plays a role as well. The degree of preparation probably is a function of how long one has been serious about wanting to make a suicide attempt. Time allows for preparation as well as reinforcement of the motivation.

**Suicide Notes**

The following information about suicide notes in studies about simple suicide may be relevant in regards to understanding mfs and mfs ideation.

- Between 15 and 35% of fatal simple suicide attempts are reported to have been preceded by a suicide note (Maris, Berman & Silverman, 2000). In regards to the percentage of persons making a fatal suicide attempt leaving a note, Maris et al. refer to the possibility that those finding notes may keep their existence a secret for a variety of reasons such as hostility in the note expressed to surviving family members or the terms of life insurance policies.

- Maris et al. reviewed studies about the question of whether there is a difference in those writing and those not writing a note in terms of age, gender, method or other variables. They concluded that support for the absence of differences was strong, although there appeared to be some support for the possibility that being female, single, choosing a passive method, such as prescription drugs, and deliberately carrying out a preconceived suicide plan are associated with a higher likelihood of a note. Of particular interest to the study of mfs was their comment that Fishbain, D. A., D'Achille, L., Barsky, S., & Aldrich, T. (1984) suggested that there might be a connection between the high percentage of suicide notes in a group of persons whose death was associated with a suicide pact and the premeditated nature of such suicides.

- Very little is known about notes made by those whose suicide attempt was nonfatal. If those whose suicide attempt was nonfatal were less prone to have written a suicide note, one would wonder about the reasons for this. Impulsivity, which often is associated with a nonlethal outcome, may play a role. However, other factors may be involved as well. For instance, those making nonfatal attempts may destroy their note before others can see it, if they have the opportunity to do so. In fact, Brevard, Lester & Yang (1990) referred to a study by Shneidman & Farberow (1961) that notes had been found among 2% of persons
making nonfatal suicide attempts. Brevard et al. added that it was likely that this estimate probably was affected by efforts by the suicide attempters and others to destroy notes before authorities could see them.

- As to the contents of suicide notes, there often are expressions of guilt and sympathy for the survivors explaining that one could not go on. In a number of cases, there are expressions of hostility towards one or more survivors, often implicitly or explicitly blaming them for leaving the suicidal person no alternative but to kill themselves. The contents of some notes can be rather mundane, e.g. a reminder to pay the electric bill. Most notes appear to be written just before the suicide.

- There are no references in the literature on simple suicide about notes written days or weeks prior to a suicide at a time when one was still contemplating the possibility of suicide and maybe was using the note to achieve some clarity and also to leave those to be left behind with a better understanding of the reasons for the suicide. Such notes, to which I will refer as “standby” notes, have been mentioned in one particular study on homicide-suicide and mfs (LeComte & Fornes, 1998).

**Application to Mfs and Mfs Ideation**

- Bourget & Gagne (2002) report that out of 11 ff\(^{118}\) mfs mothers, 9 left a note. In contrast, out of the four fn mfs mothers, none left a note.

- Alder & Baker (1997) reported that 7 of the 11 mfs mothers (ff+fn\(^{119}\)) had indicated in a suicide note or in communications to friends and family before the mfs attempt that filicide would be in the best interest of the children. Both these acts show that there was mfs ideation prior to the attempt.

- Nock & Marzuk (1999) report that there was no suicide note in most homicide-suicide cases. However, most studies that were reviewed in their study had a predominance of spousal homicide-suicide, morbid jealousy variety.

- Lecomte & Fornes (1998) report that approximately half of 56 perpetrators of any type of homicide-suicide (four or five were mfs mothers) had left a suicide note. In addition, they mention that some of these were written between the homicide and the suicide, while some of the other notes appeared to have been written a long time prior to the homicide-

\(^{118}\) *ff* refers to fatal filicide attempts followed by a fatal suicide attempt, *fn* to fatal filicide attempts followed by a nonfatal suicide attempt.

\(^{119}\) *fn* refers to fatal filicide attempts followed by a nonfatal suicide attempt, *ff* to a fatal filicide attempt followed by a fatal suicide attempt.
suicide act which I referred to earlier as *standby notes*. The authors did not define a *long time*. With respect to these standby notes a number of observations can be made.

- Lecomte & Fornes remark that some of the homicide-suicide cases appeared to have been planned some time prior to the attempt, and that the implementation of some of these attempts appear to have been triggered by unexpected events, and therefore, showed certain characteristics of impulsivity. Although there might be a connection between the homicide-suicide attempts that had been planned some time before the attempt and suicide notes written some time prior to the attempt, there is insufficient information in the study to actually make this connection.

- There is some information in the study that suggests that suicide notes, especially the so-called standby notes were particularly prevalent among those killing for altruistic reasons as opposed to morbid jealousy. However, there is no information that clearly demonstrates that the mfs mothers wrote notes, or if they did, that they were the ones writing the “standby” notes.

- It appears noteworthy that so many of the ff mfs mothers wrote a note, while this apparently is much less common among persons involved in fatal simple suicide attempts. Overall, the fact that the extent to which the planning of simple suicide attempts has been associated with a higher degree of note writing seems to confirm that ff mfs cases are well planned. This suggests serious mfs ideation.

**Communication**

Most persons making a fatal suicide attempt reportedly have given clues about their intentions to people in their environment (Maris, Berman & Silverman, 2000) which, due to mechanism of denial and minimization, are often not recognized by those for whom they were intended until it is too late.

With respect to mfs mothers, most of them, regardless of the outcome of their suicide attempt, have communicated about the possibility of an attempt (Alder & Polk, 2001; Bourget & Gagne, 2002). This suggests that there must have been ideation about such an attempt. It also
raises the question of how many dpsmyc mothers with mfs ideation are communicating about their ideation.

Aspects of Opportunity

As to opportunity, Chew & McCleary (1994) suggest in their study "A Life Course Theory of Suicide" that motivation with respect to suicide has dominated the discussion about suicide at the expense of opportunity. They argue that the two key aspects of opportunity, access to methods and the degree of privacy one enjoys vary with the stage of life one happens to be in. In this context, the authors refer to degree of privacy also as the degree to which one is supervised. For instance, the elderly who are living in a nursing home or with their own children can be said to be supervised more closely than when they were still living alone. In the remainder of the section on nature and outcome, we will see that their theory, which was developed for simple suicide, may account for much of mfs behavior. For instance, Harrer & Kofler-Westergren (1986) described cases of mothers who drowned their children in a brook, after which they made a nonfatal attempt to drown themselves. Such cases suggest both a lack of other methods such as a weapon and a lack of opportunity in one’s dwelling.

The issue of a possible relationship between suicidal ideation and opportunity is not addressed in Chew's study. Such a relationship, if it exists, could suggest that the opportunity to carry out a suicide attempt might get a person thinking about it or thinking about it more.
Methods

The Relationship between the Availability of Methods and the Rate of Simple Suicide and Mfs

Clarke & Lester (1989) described how characteristics of methods and the availability of certain means could influence the rate of simple suicide. The availability of firearms is a prime example of this tendency. The availability and characteristics of domestic gas that had not been detoxified also has been described in detail by these authors. The fact that the simple suicide rate by women in England and Wales dropped by approximately 40% after the detoxification of domestic gas and another 20% after the withdrawal of prescription drugs often used for suicide, while the suicide rate for males only showed a minor drop in comparison is significant for the study of mfs for two reasons. First, it strongly suggests a strong connection between simple suicide by females and mfs, which dropped from 12 to 5 cases per year (approximately 60%) in England and Wales. Secondly, it shows the importance of the availability of certain methods for mfs.

What makes these data significant is that the availability of domestic gas apparently had become a necessary condition for many women contemplating simple suicide or mfs. Considering that 55 to 60% of simple suicides by women had been committed with the use of domestic gas prior to its detoxification (McClure, 2000), we can estimate that a 40% drop in the rate of simple suicide by women means that a portion (maybe as much as half) of those who would have made a fatal suicide attempt using gas before its detoxification, had not made an attempt at all or made a nonfatal suicide attempt. The rest apparently substituted another method and made a fatal suicide attempt. Although it is not known how many of the nonfatal suicide attempts were due to problems
with the substituted method or due to the fact that some of the women continued to use coal gas, of which the detoxification had only occurred gradually, it can safely be said that a good portion of those who originally would have made a fatal suicide attempt using coal gas did not substitute another method. These data become particularly salient in light of a study by Brown (1979) who reported that most of the women who used gas for suicide shortly after it had been introduced early in the 20th century had characteristics that suggested that they would not have committed suicide before the introduction of gas. In other words, there was no substitution effect.

The relevance for mfs of Brown's findings about the probable relationship between methods and suicide rates for women is that it appears that whatever characteristics of coal gas that were responsible for the elevated rates of simple suicide by women are also responsible for the rates of mfs.

Specific Aspects of Methods and the Decision to make an Attempt at Mfs

The characteristics of methods described by Clarke & Lester (1989) that people would take into account when contemplating a suicide attempt include but are not limited to

- availability
- ease of operation
- reversibility
- the disfiguring impact of the method
- the chance of being interrupted
- perceived pain.
While there have been various publications explaining a possible link between the detoxification of coal gas and a drop in the rate of simple suicide by women (Brown, 1979; Kreitman, 1976), there has been no such attempt for mfs, although the possibility of a link has been suggested (Allen, 1983; Milroy, 1995b). I believe that a study explaining the reasons for a possible link between the rate of mfs and detoxification of coal gas, might be the single most important contribution to an understanding of the phenomena of mfs and mfs ideation, especially in the context of the covert/overt classification system. It may be helpful to remind the reader that coal gas, and especially toxic coal gas, is no longer available in most countries where it was used by most women making fatal suicide attempts. However, a better understanding of the reasons why coal gas was used so widely for mfs and why its detoxification was followed by such a sharp and lasting drop of 60% in fatal mfs attempts helps to shed light on the relationship between mfs and methods in general.

The covert mfs mother has been described earlier as a high functioning person who will only make an mfs attempt after she has prepared the attempt well and when she believes that she can carry it out in a deliberate manner leading to a fatal outcome for herself and her children. Even more important, it is likely that she will only start the process of preparing for the attempt after a lengthy weighing of alternatives. In addition, perceived painlessness of the method to be used for the filicide has been mentioned as an important factor. Against this background, it is easy to see why domestic gas is so attractive for mothers contemplating mfs.
Painlessness. Coal gas appears to be painless, especially when the mother has made sure that her children are sleeping, for which she may have used drugs.

Filicide and Suicide Simultaneous. Another feature of coal gas is that the mother can plan her suicide to occur more or less simultaneously with that of her children.

Reversibility. Perceived reversibility appears to be a special characteristic of coal gas. The mother can put her children to bed, turn on the gas jets, tape the windows, and put a pillow in the chimney, while she believes that she can stop the process at any moment, just by opening a window\textsuperscript{120}. She may believe that if she opens the window, her children will wake up the next morning without any memory of what their mother tried to do to them. Whether that belief is accurate may not matter, when she makes the attempt\textsuperscript{121}.

Rehearsibility. Related to the feature of reversibility is that of rehearsibility. The mother can turn on the gas jets, when she is home by herself and see how long it takes for her to be affected. She can experiment with various types of tape. She can even experiment with sleeping drugs on herself or her children. Rehearsal of attempts may have an approximation effect. Once the mother realizes what she has to do, and how easy it is, she may be more tempted to make an attempt, especially when she believes that it is reversible.

\textsuperscript{120} Because there may be cases where the mother was physically incapacitated to open a window, even if she wanted to reverse the process, one has to speak of perceived reversibility. In addition, the gas may change the mother’s state of mind and decision making capabilities in a way that she may not have expected.

\textsuperscript{121} There are studies on how persons who had made nonfatal simple suicide using gas may have suffered lifelong damage due to the effect of the gas.
In addition, the mother can rehearse the attempt, prepare for it, and carry it out, all in the privacy of her home. It has been found that most mfs attempts take place in the home, especially in the children's bedroom. The process of preparation can include figuring out what time would be best, i.e. at what time she would be least likely to be interrupted, and how reversible and concealable the process would be if she were to be interrupted.

*Some Other Aspects associated with Coal Gas*

The number of children in the household and their age might play less of a restraining role because the mother can be less concerned about what it would take to kill several children or older children, which she would have to take into account with most other methods. For instance, if she were to use a firearm, she would have to kill the children sequentially, while she could do it simultaneously with gas. As long as she believes that her children will not wake up while she is carrying on and will not try to interrupt her, the simplicity of the logistics of an mfs attempt with domestic gas may have served to lower the threshold of making an attempt.

The introduction of domestic gas in the early 20th century had led to the suicides of women who previously would not have made attempts according to Brown, as already pointed out. Brown's study does not discuss the aspect of social class here. It appears likely to me that domestic gas for cooking purposes may have been introduced first in the cities and the homes of the middle class. This opens up vistas of nuclear families without live-in maids or extended family members, which may have encouraged potentially suicidal women to make an attempt. A similar dynamic might
have been at work for the mfs mothers in England and Wales. The number of adults living in the same household might have been low and, especially in mfs cases, may have been limited to the mfs mother and her husband.

Finally, there is the fact that the use of gas for suicide was so widespread in England and Wales that suicide almost may have become synonymous with gassing. Everyone must have heard of people who had used gas to make a suicide attempt. Those who had survived their attempt may have recounted how painless it was. All of this may have lowered the threshold for making suicide and mfs attempts considerably.

It can easily be seen how all of the facilitating aspects of domestic gas may have encouraged both covert and overt mothers. However, there are no specific data to show that covert and overt mothers were equally encouraged by the gas and discouraged by its detoxification. Yet there is some circumstantial evidence that overt mothers, especially those with known prior symptoms of a thought disorder, might be more prone to substitute another method. If their decision was made impulsively, they might simply use the first method that would come to mind or, if an object was used, the object to which access was easiest regardless of the lethality of the method to be used. According to that logic, overt mothers would use gas for mfs when it was available, simply because it was so accessible.
Availability of Methods and the Prevalence of Mfs: Some speculative remarks

It is interesting that the mfs rate in England and Wales dropped to the low end of the range of mfs rates seen in most Western countries, yet remained within this range, while prior to the detoxification it was at the high end of the range. If Coid's theory that the similarity (between countries) of the epidemiology of psychiatric disorders is responsible for the similarity of overall homicide-suicide rates, is correct, then a next step could consist of showing that the even narrower range for mfs attempts, as shown above, is suggestive of a more specific subset of psychiatric disorders, of which the epidemiology is similar between countries. The fact that the English rate after the detoxification has remained at the low end of the range for at least 25 years, suggests the possibility that the low end of the range might represent a base rate of mfs that is similar in most countries because the epidemiology of psychiatric disorders is believed to be similar in most countries. The “surplus”, i.e. the portion of the mfs rate that is higher than the low end of the range, may be accounted for by factors such as the availability of certain means (coal gas!) or the attitude of society towards mfs, such as the relative tolerance in Japan. At this point, there is not enough information to claim that the concepts of a base rate and a surplus are a valid representation of what is going on, and should be considered as speculative.

Increase in homicide-suicide in Hong Kong due to use of charcoal brigs

What gives the speculative possibilities just suggested more support is that currently in Hong Kong we are seeing a veritable epidemic of homicide-suicide (Lee, Ou, Lam, So & Kam, 2002), including mfs, carried out with charcoal brigs. This method has many of the facilitating
characteristics seen in domestic gas before its detoxification, such as the perceived painlessness. In Hong Kong, the number of homicide-suicide cases is much higher than in the past (Lee et al.) suggesting that the surge in homicide-suicide incidents perpetrated with charcoal brigs is not accompanied by an equivalent decrease of homicide-suicide cases perpetrated with other methods. This suggests a similarity to the situation in the early 20th century in England and Wales, when toxic domestic gas became available. As mentioned earlier, Brown (1979) pointed out that there was no decrease in the use of other methods than domestic gas. The reason for this was that the sort of people that started to use domestic gas for suicide attempts were not known for making suicide attempts.

A comparison with other methods frequently used in Hong Kong for simple suicide and mfs (Cheung, 1986) may throw some light on the recent rise increase of homicide-suicide and mfs in Hong Kong. For instance, one such method, jumping from one of the many high-rise buildings, in which much of the population lives may show why charcoal could represent a much lower threshold for an mfs attempt than jumping. The lower threshold is associated with factors such as reversibility and rehearsability. In addition, another method that often is used for mfs, car

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122 The process of one method of suicide being replaced by another method is referred to as substitution or displacement: Brown (1979) referred to the replacement of coal gas as a method for suicide with other methods in England and Wales after the mid 1960’s as substitution, while Clarke & Lester (1989) speak of displacement.

123 Because the availability of certain means might play a key role in determining where homicide-suicide and mfs rates can be found in a range of rates, a discussion of the potential interaction between the availability of specific methods and other factors that are relevant in regards to mfs and mfs ideation might be appropriate, as long as one is aware of the speculative nature of some of the possible scenarios. The recent history and current situation in Hong Kong may have certain characteristics that could illustrate some of the dynamics of mfs and mfs ideation. The extent to which “possibilities” in Hong Kong can be generalized to other countries, of course, remains to be seen, and should also at some point be considered.
exhaust, may be less feasible in Hong Kong. Maybe car ownership is less widespread, or the availability of garages attached to the house or the availability of quiet locations on this very densely populated island.\textsuperscript{124} In addition, gun ownership is less likely to be widespread.

Therefore, the emergence of charcoal as a prominent method may be due to latent urges that could not be satisfied with previously available methods. Therefore, the recent surge in homicide-suicide and mfs attempts suggests that prior to this surge in attempts, mfs ideation might have been present but was not acted on because of the lack of availability of the “right method”. However, there also might be parents who may not have considered filicide-suicide before the availability of this “easy” method but who are considering it now.

In addition to the easy availability, the amount of attention that has been paid to the rise of this phenomenon in the popular media also may have played a role. The role of attention in the popular media also has been referred to as the contagion effect. This contagion effect has been studied in regards to regular suicide. In regards to mfs, the possibility of such a contagion effect has been mentioned (Goldney, 1977) but has not yet been the object of a study.

\textsuperscript{124} Factors such as whether a garage is attached to the house (for those who live in house rather than an apartment building) appear to have a certain significance, and one comes across this factor when reading case descriptions. In the case of a garage being attached to the house, it has been found that most mothers prefer to make an mfs attempt in their own house rather than go elsewhere. The presence of a garage attached to the house meets that particular requirement, and most certainly should be included in an assessment of mfs risk. Similar remarks can be made about other elements of the mfs puzzle.
Time and Place of the Attempt and a Link to Opportunity Aspects

West (1965), who only reported on cases where both the homicide/filicide attempt and the suicide attempt had been fatal, reported that mothers who were suffering from an endogenous depression were more likely to make an attempt early in the morning. He also reported that there are twice as many cases in the summer than there were during the fall. There are some indications that statistics about timing of regular suicide among persons with a similar pathology may show a similar pattern. In addition, weekdays were more “popular” than weekends which is the opposite of fatal child abuse, and Monday and Tuesday were more “popular” than other weekdays. Insofar these data are similar to simple suicide, there may be information in studies about simple suicide that could be applied to the study of mfs. Baumeister (1990) offers, in his escape theory of suicide, a number of suggestions that help explain some of the timing questions in regular suicide as well as in mfs. These will be discussed later in this chapter.

There is also a link with the opportunity aspect. Mfs attempts tend to be carried out in the home, especially when there are no other adults around. Various case studies describe that mothers would carry out their attempt as soon as their spouse had left for work.

There are indications that attempts in the early morning mostly are carried out by coverts and mixed covert-overts, which may be associated with the phenomenon that endogenously depressed persons tend to feel particularly bad in the early morning.

As to place, before the reduction in the size of the household and the number of people living in one house in most countries, most of the time there may have been someone present-
especially adults and older children living in the house- to prevent an mfs attempt in the house. 

Accounts of mfs attempts while other adults or older children were present often involved persons acting under the influence of an acute psychotic episode. Descriptions of such cases usually, but not always, indicate clear prior symptoms of delusions and/or hallucinations (Goldney, 1977), which points to mothers with an overt profile.

Mothers without an opportunity for mfs in their home may have chosen not to carry out an attempt at mfs or they may have found a location outside of the home. Several case descriptions speak of brooks, in which mothers drown their children and try to drown themselves, although the suicide attempt often is interrupted or not fatal for other reasons.

These observations suggest how important it would be for a clinician to inquire about not just the presence of mfs ideation but also about details involving plans. The details could indicate the severity of the ideation, and also the extent of the potential danger to self and/or others. This would be particularly important in the case of covert mothers. Overt mothers, by virtue of being overt, are known to be at a higher risk for danger to self and/or others.

Concluding Remarks on the Nature and Outcome of Attempts in Simple Suicide and Mfs

The discussion about suicide notes, communication prior to the mfs attempt, many aspects of opportunity and methods used strongly suggests that many of the mfs mothers, regardless of the outcome of their suicide attempt, experienced mfs ideation for some time prior to their mfs attempt.
Demographics

Suicidology contains many references to relationships between demographic factors and suicidal behaviors. For instance, it is well known that women make more nonfatal suicide attempts than men, while men make more fatal suicide attempts than women. The same applies to young people who are known to make nonfatal attempts more often than older people, while older people make fatal attempts more often than younger people. In this context it is important to be aware of the fact that while 70% of all fatal simple suicide attempts represent the first attempt, 10 to 15% of those who ever made a nonfatal suicide attempt will eventually die of suicide. Another well-known relationship is that in the USA, black women have a far lower rate of fatal suicide attempts than Caucasian women.

Marital Status

Married women have lower simple suicide rates than divorced, widowed, or single women (Gove, 1972; Petronis, Samuels, Moscicki, & Anthony, 1990). Studies about mfs vary with respect to the role of marital status. West (1965), Bourget & Gagne (2002) and Haapasalo & Petaejae (1999) report that most mfs mothers were married. At the same time, Alder & Baker (1997) report that 8 out of 11 mfs mothers (including both mothers who made a fatal suicide attempt and those who made a nonfatal suicide attempt) were divorced or separated from the father of their children, while the three married mothers were in very bad marriages.

Being married can become a risk factor for mfs, when it is experienced by the mother as contributing to her hopelessness, and when the mother’s beliefs about the children’s future
preclude a role for the father, e.g. because she thinks he will abuse them. Therefore, clinicians should not automatically assume that being married and a parent of young children are always protective factors.

There is no specific information about how being married and a parent might affect mfs ideation. However, certain components of mfs ideation can easily be surmised such as the just mentioned fears that mfs is the only way to prevent one’s children from being abused by their father.

*Parenthood and Number of Children*

Veevers (1973) found that motherhood is associated with a lower suicide rate. Hoyer & Lund (1993) report that the suicide rate of parents drops with each additional child. Women reportedly have a lower suicide rate when they have children under the age of two.

With respect to mfs and the number of children, it must be remarked that even without knowledge of this particular statistic many clinicians associate the presence of young children with an extremely low danger of a serious attempt at simple suicide. As a result, their evaluations of their female clients’ suicidality may be less thorough, and even when suicidal ideation or plans are found, they may not be considered as serious possibilities because of the presence of children. This line of thinking probably does not take into account the possibility of mfs ideation.

Appleby (1996) reported that while women with young children have a lower suicide rate, this does not hold true for women who were experiencing postnatal depression. In addition, he
reported that 5% of the women who made a fatal suicide attempt during the first year after giving birth due to reasons of postpartum depression also killed their child. Appleby does not provide additional information on whether the child killed was the first child or, in case there were more children, the mother killed or tried to kill these too.

Social Class

The role of social class is somewhat controversial. Overall, data apparently do not show a link between social class and fatal suicide attempts. Meanwhile, it might be possible that the various social classes exhibit different patterns with respect to suicidal behavior that may “even out” and result in an overall picture of similarity.

In this context, it is particularly noteworthy to remind the reader that several studies found a significant link between child abuse and (nonfatal) suicide attempts (Hawton & Roberts, 1981; Hawton, Roberts & Goodwin, 1985; Roberts & Hawton, 1980). In light of the fact that child abuse and low income also have been associated with each other, we see a potential connection between low income and nonfatal suicide attempts. To what extent this carries over into fatal suicide attempts is something I have not been able to ascertain so far. However, on the basis of the low prevalence of completed suicides and the high prevalence of child abuse, only a fraction of suicide attempts by child abusing mothers needs to be fatal to have a substantial impact on the rate of completed suicides. In addition, it is important to remember that child abuse and particularly fatal child abuse are associated with children under the age of three and women whose
demographic profile differs in many respects from the “typical” mfs mother (Alder & Polk, 2001; Bourget & Gagne, 2002).

With respect to social class, a notion that there is no relationship between social class and simple suicide may divert attention from women who because of their middle class background and expectations, such as many of Typus Melancholicus women, might be particularly tense about whether they are perceived as meeting the middle class expectations of persons in their environment. As a result, they may at the same time experience serious suicidal ideation and also intend to hide their suicidal thoughts.

Employment

Employment is said to increase suicide rates among married women because of the demand on their time in addition to their duties as wife and mother (Davis, 1981). Yet, it has also been regarded as helping to decrease female suicide rates because employment may represent a stimulating connection with the word outside of the nuclear family (Johnson, 1979). It appears that women who have to work full time to provide for their family's needs are at a higher risk than women for whom work is a choice, especially when they do not work full time. This pattern may differ among countries depending on their social safety net.

The potential relevance for mfs is that some case descriptions refer to mfs mothers who gave up successful careers and became stay-at-home mothers. None of the studies containing these cases remarked on this phenomenon in their findings.
Explanatory approaches

Suicidology is primarily focused on predicting the possibility of a fatal suicide attempt, and secondarily on the possibility of nonfatal attempts involving injuries. Less ideation is given to ideation. When there is attention for ideation, it usually is as a precursor of suicide attempts, and only rarely, if at all, as a source of suffering.

I will first discuss the psychiatric approach, which addresses possible links between specific diagnoses and suicidal behavior, and then various other theories and approaches, such as the escape theory of suicide (Baumeister, 1990) and the notion of depression due to arrested flight (Gilbert, 1998).

Psychiatric approach

Introductory Remarks

Mental illness is said to be present in 90% of persons who make a fatal suicide attempt (Moscicki, 1995). Currently, mental illness in the context of a fatal suicide attempt is generally defined as one or more psychiatric disorders that can include one of the thought disorders. However, there is no longer an implied assumption that mental illness in cases of suicide refers to insanity and one of the thought disorders. In cases of mfs, this implied assumption remained

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Some explanatory approaches are labeled theories; others are referred to only as approaches. The difference is not always clear.
prevalent for a longer period than in cases of simple suicide and to some extent there are important vestiges of it. On the other hand, Meyer & Oberman (2001) remarked that mental illness defined as the presence of a DSM-IV psychiatric disorder is meaningless in explaining maternal filicide and mfs because approximately 30% of the general population has suffered from one or more psychiatric disorders during their lifetime.

With respect to the psychiatric approach, it is worth noting that Coid (1983) attributed the similarity of homicide-suicide rates between countries and over time to the fact that the epidemiology of psychiatric illness was also similar between countries and over time. The fact that studies of the last 15 years have demonstrated an even more pronounced similarity between countries with respect to the rates of maternal filicide followed by fatal or nonfatal suicide attempts suggests the possibility that the epidemiology of psychiatric illness in cases of mfs might be even more pronounced than it is for overall homicide-suicide.

While this dissertation primarily deals with mfs and mfs ideation of depressed and potentially suicidal mothers of young children (dpsmyc) who are in outpatient, ongoing psychotherapy, it may be useful to consider possible scenarios for maternal filicide and mfs, where a psychiatric disorder does not play a role. However, the issue of to what extent mothers making attempts at filicide or mfs due to thoughts about impending disaster that are based on reality is not well researched. Harder (1967) remarks that maternal filicide did not occur with an unusual frequency in concentration camps. Harder saw this as proof that the notion of altruism as an explanation for filicidal behavior was not correct. However, Harder did not provide support for this statement.
There is anecdotal evidence of Jewish refugees in the Netherlands who committed
familicide upon the Nazi-invasion of the Netherlands in May of 1940. There is also anecdotal
evidence of many women in the eastern part of Germany who committed suicide when the Russian
forces were approaching. Fear of rape and torture are mentioned as motivating factors. It is quite
possible that some of these women included one or more of their children in their attempt or
considered doing so.

The possibility that a realistic fear of impending disaster may lead to suicidal and mfs
behavior emphasizes the potential role of a sense of a foreshortened future. It is not hard to
imagine how a sense of a foreshortened future that is associated with fear of an impending disaster
that is not based on reality may have the same effect. In addition, the question to what extent fear
of an impending disaster is indeed based on reality may be difficult to answer in many situations.

The current discussion about the psychiatric approach focuses on the extent to which
existing knowledge about a relationship between psychiatric disorders and mfs can be enhanced
by applying concepts and findings from the study of simple suicide, suicidology. Understanding the
relationship between psychiatric disorders and simple suicidal behaviors and ideation might help to
better understand mfs. More specifically, it might help the clinician to know what risk factors he or
she should be looking for.

*Existing knowledge about a relationship between psychiatric disorders and mfs*

Meszaros & Fisher-Danzinger (2000) summarize the existing knowledge about a
relationship between psychiatric disorders and mfs by reporting that the main risk factors are:
• severe depression with psychotic symptoms and/or delusion,
• paranoid type of schizophrenia,
• severe personality disorders,
• personality traits of the Typus melancholicus (hypernomic\textsuperscript{126}, orderly, anxious, overly responsible, obedient, and depressed)
• intoxication in multiple substance abusers, and
• the additional occurrence of acute stressful events, such as marital and/or financial problems (Meszaros & Fisher-Danzinger, 2000, p. 9).

As stated before, this dissertation is primarily about mothers with a Typus Melancholicus personality. All of the five mothers with a Typus Melancholicus personality in the study by Meszaros & Fisher-Danzinger were reported to be suffering from severe depression with psychotic symptoms and/or delusions, as well as with anxious-avoidant personality disorder (ICD-10) but not from other personality disorders.\textsuperscript{127} They also were overwhelmed by stressors (overstrain). Meanwhile none of the five Typus Melancholicus mothers were reported to be suffering from paranoid schizophrenia or intoxication in multiple substances. In terms of symptoms of Typus Melancholicus, Okumura & Kraus (1996) also spoke of performance oriented.

In addition, as described earlier, the person with a Typus Melancholicus personality style often has a poorly defined sense of self and, as a result, easily (over)identifies with others and with social roles (Okumura & Kraus, 1996). Okumura & Kraus describe how mothers who easily (over)identify with others might be prone to experience a psychotic identification with the child or children which they are about to take along in a suicide attempt.

\textsuperscript{126} Hypernomic refers to a tendency to be overly inclined to follow rules.

\textsuperscript{127} The four mothers that did not have a Typus Melancholicus personality were also diagnosed with depression with psychotic symptoms. However, instead of avoidant-anxious personality disorder they had paranoid, borderline, or combined borderline/narcissistic personality disorders.
I will describe those disorders and comorbidities between disorders that I believe are most relevant for the understanding of mfs behavior among dpsmyc with a Typus Melancholicus personality style.

Depression

In a review of the literature Tanney (2000) reports that most studies find that mood disorders, often in comorbidity with other disorders, play a major role in suicidal behavior. In the same review of the literature, Tanney also observes that a comparative analysis of studies on the relationship between suicide and depression "clearly indicates that completed suicide is much more significantly linked to unipolar disorder [than bipolar disorder]" (Tanney, 2000, p. 325). In addition, Tanney reports: “For suicidal acts that are nonfatal, persons with unipolar and bipolar depressions appear equally involved” (p. 325), for which he refers to Lester (1993).

In regards to mfs, depression is considered virtually a necessary condition for a mother making a fatal or nonfatal suicide attempt after having killed one or more of her children (Bourget & Gagne, 2002; Haapasalo & Petaejae, 1999; Meszaros & Fisher-Danzinger, 2000; West, 1965). There is not enough information about the question whether mfs mothers suffer more often from unipolar than bipolar information.

Most studies report that many aspects of suicidal behavior among persons with depression depend on comorbid disorders, which will be discussed shortly in this chapter. This discussion will
also address the role of some specifiers of depression: atypical, melancholic, and psychotic features.

The role of Anxiety

Fawcett, Clark & Busch (1993) found that among depressed patients who had made fatal suicide attempts those who made a fatal attempt within a year after their first evaluation (the short-term group) showed more symptoms of anxiety than depression. Those who made a fatal suicide attempt more than 12 months after their first evaluation (the long-term group) showed more symptoms of depression than anxiety.

Comparison of the two groups of suicide cases (short-term and long-term) revealed certain characteristic patterns of symptoms. The primary signs and symptoms significantly associated with short-term suicide were panic attacks, severe psychic anxiety, impairment of concentration, psychomotor agitation, global insomnia, moderate alcohol abuse, and severe anhedonia. The signs and symptoms significantly associated with long-term suicide are a striking contrast. For example, more than 60% of patients who died by suicide early in the follow-up period had suffered from panic attacks at the time of enrollment in the study, whereas fewer than 20% of those whose suicide occurred more than a year after their enrollment had had panic attacks.

The spectrum of symptoms related to anxiety—severe psychic anxiety, panic attacks, and overuse of alcohol—could be interpreted as an index of severity of depression or as features of a variant of depression characterized by extreme anxiety and agitation.

The symptoms all related to a state of anxious agitation or ‘psychic pain,’ based on a six-point rating scale of SADS [Schedule for Affective Disorders and Schizophrenia] items characterized by worry and fear of impending disaster that was not grounded in fact (Fawcett et al.1993, p. 247-248).

The characteristics discussed by Fawcett et al. are noteworthy, especially those associated with persons who made a fatal suicide attempt within a year of having been evaluated.
for the fact that more attention is paid to anxiety than in most studies on simple suicide. In addition, this study is one of several studies that show a relationship between suicidality and the presence of comorbid anxiety and depression. The authors also address temporal aspects.

Fawcett et al. mention fear of impending disaster that is not grounded in reality but they do not further elaborate on it. This particular fear may suggest a similarity to the notion of a sense of foreshortened future, one of the symptoms of PTSD as well as to the depression specifier *psychotic features*.

The role of moderate alcohol abuse mentioned in this study, where there was only mild use beforehand (personal communication)\(^{128}\) may represent an effort to deal with depression as well as anxiety. The increase from mild social drinking to moderate abuse which only happened during the twelve months prior to the fatal suicide attempt could easily be overlooked in studies dealing with a relationship between alcohol abuse and suicidality, as these studies generally deal with alcohol abuse that has been severe and chronic. The mentioning of alcohol abuse by Fawcett et al. in connection with anxiety and depression suggests the possibility of other behaviors that could serve the same purpose such as resuming smoking after a number of years of not smoking. Further research might confirm such behaviors which could represent additional warning signs to clinicians.

In terms of the relevance of the study of Fawcett et al. for mfs, Haapasalo & Petaejae (1999) report that 15 out of 33 filicidal mothers had anxiety symptoms prior to the filicide which

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\(^{128}\) Dr. Fawcett was one of the speakers during a conference on 11/22/2003 about suicide prevention.
consisted of “fear of death, fear of harming the child, overconcern for the child’s health, phobias, nervousness, and tension” (Haapasalo & Petaejae, 1999, p.226). Close examination of the data (see Chapter 5) suggests that most of the 13 mothers who made a nonfatal suicide attempt after the filicide may have been among the 15 mothers with anxiety symptoms. It is also noteworthy that 27 of the 33 mothers were reported to have been suffering from depression prior to the filicide, thereby providing additional support to the comorbidity of anxiety and depression reported by Fawcett et al.

Expanding from the findings by Fawcett et al. about anxiety associated with fears of an impending disaster it is noteworthy that virtually all studies dealing with mfs report that many of the mfs mothers were fearing an imminent disaster that would threaten the well-being and the future of their children and themselves.

The other symptoms of Fawcett’s short-term group, moderate alcohol abuse, global insomnia, severe anhedonia, and particularly the combination of depression and extreme anxiety also correspond with the contents of many of the descriptions of mfs cases.

Finally, considering that mfs mothers with a Typus Melancholicus personality style generally are most at risk for making an mfs attempt during a limited period of two to four years, they may be more similar to the short-term than to the long-term group.  

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129 Mothers with a fatal suicide attempt were not included in the study.

130 The limited period of vulnerability to acting on mfs ideation may be due to a combination of the age bracket of most mfs mothers (27-35) and the age of their children, especially the oldest child, as discussed in the section on Demographics.
Anxiety: Social Anxiety and Rejections Sensitivity

In terms of a relationship between specific anxiety disorders and simple suicide that could help explain the symptoms found in mfs, social anxiety appears to be prominent. Wittchen & Fehm (2001) report that 7% (4.9% for males and 9.4% for females) of the general population is suffering from social anxiety disorder. Meanwhile, Furmark, Tillfors, Stattin, Ekselius & Fredrikson (2000) found that 2% of the general population is suffering from a generalized social anxiety, which is the most severe subtype of social anxiety and usually is marked by early onset as well as comorbidity with depression. In fact, Angst, Gamma, Sellaro, Zhang & Merikangas (2002) report that atypical depression is strongly comorbid with a number of disorders, including social anxiety. Atypical depression is known for rejection sensitivity and reactivity of moods. According to Alpert et al. (1997) persons with social anxiety disorder, especially when the social anxiety is of the general type and marked by early onset, usually are also suffering from Avoidant Personality Disorder131, in which rejection sensitivity is one of the defining characteristics.

In terms of suicidal behavior and ideation, 45% of those with the severe form of social anxiety disorder reported to have made one or more suicide attempts, while 77% have suicidal ideation or had it during their lifetime (Lecrubier, Wittchen, Faravelli, Bobes, Patel & Knapp, 2000). These data suggest the possibility that many persons found to be suffering from rejection

131 While almost all persons with social anxiety also meet criteria for Avoidant Personality Disorder, only 40% of those with Avoidant Personality Disorder meet criteria for social anxiety disorder. This comorbidity also draws attention to recent proposals that speak of a social anxiety spectrum (Schneier, Blanco, Antia, & Liebowitz, 2002).
sensitivity might be diagnosed with social anxiety disorder, and that a high prevalence of suicidal ideation also applies to them. In other words, a person with rejection sensitivity who perceives being rejected by those whose approval he or she craves might become more vulnerable to ideation about simple suicide.

The relevance for mfs is that rejection sensitivity is likely to be prominent among mothers with a Typus Melancholicus personality style in light of the presence of symptoms such as performance orientation, hypernomy, and obedience. Furthermore, the fact that the mfs mothers diagnosed by Meszaros & Fisher-Danzinger (2000) as having a Typus Melancholicus style also were diagnosed as having an ICD-10 Avoidant-Anxious Personality Disorder may be an additional indicator of the likelihood of the presence of rejection sensitivity.

Rejection sensitivity may lead to over-identifying and merger behaviors (Okumura & Kraus, 1996) which often are associated with Borderline Personality Disorder and Dependent Personality Disorder. As discussed in Chapter 4 of this dissertation, Okumura & Kraus argue that some mothers exhibiting these behaviors were probably suffering from a form of psychotic identification, when the object of the merger behavior was their child. In terms of relevance for mfs, the mother who is vulnerable to rejection sensitivity might fear that her child or children are being or will be rejected by their peers just as she was rejected in her own childhood, a phenomenon which I have earlier (Chapter 6) referred to as extended rejection sensitivity. The mother’s rejection sensitivity would be especially dangerous, if the mother attributes the perceived rejection of herself and her children to her own personality deficits rather than to more external factors, such as race, religion, or social class.
Considering that most persons diagnosed with social anxiety disorder have comorbid Avoidant Personality Disorder (Alpert et al., 1997), it is important to point out that Millon (1996) stated that fantasy is the defense mechanism most often used by persons diagnosed with Avoidant Personality Disorder. In terms of suicidal behavior and ideation, it is important to explore the fantasy, especially in light of what might happen when the fantasy crashes.

Having fantasies usually implies “positive” events, and often seems to contain themes of rescue. Some suicidal patients may have positive thoughts attached to their ideation such as getting rid of pain, worry, shame, intolerable affect states, the misery of life, as well as the fantasy of peace or union after the end of life. It could be argued that these thoughts could be considered as fantasies. However, I see a distinction between thoughts about what will happen as a result of one’s death and thoughts about how changes in one’s current life will come to one’s rescue.

At the same time, the very notion of fantasies also reminds us of the possibility of fantasies about negative events, although fantasies about negative events are not considered a defense mechanism as fantasies about positive events are. The phenomenon of doomsday fantasies may emerge as a risk factor and as a component of suicidal ideation, or at least one of the thoughts occupying the mind of the person experiencing suicidal ideation.

A study by Ollendick & Hirshfeld-Becker (2002) illustrates why social anxiety might play such an important role in simple suicide and in mfs. Ollendick & Hirshfeld-Becker discuss genetic, environmental, and cognitive aspects of the etiology of social anxiety.
Environmental aspects refer mainly to parental contributions that include modeling insecurity and avoidance behavior, exposing children to depression, and an inordinate focus on opinion of others.

In regards to the cognitive aspects, Ollendick & Hirshfeld-Becker discuss the tendency of a person with social anxiety to suffer from selective attention to negatives, as well as potential and future negatives. In addition to focusing one's attention on an overly limited selection of events, there may be a tendency to not observe those events accurately thereby compounding the problem of the limited selection. Finally, Ollendick & Hirshfeld-Becker recount how most adults suffering from Social Anxiety Disorder cannot remember a time in their life that they were free from social anxiety. Although this observation may be associated with a selective and state dependent memory, it may have an impact on the person's hope of improvement.

The remarks by Ollendick & Hirshfeld-Becker about the etiology and contents of social anxiety are particularly relevant for mfs and mfs ideation. It is easy to imagine how selective attention to sources of rejection and inaccurate observations of being rejected can generalize to the potential sources of rejection of one's children by their peers as well as inaccurate perceptions of such rejection actually occurring while, in fact, it may not be occurring. Once a mother starts to generalize and projects her own social anxiety onto her children, she may also fear that her children will never be free of social anxiety for the rest of their lives. Her own (perceived) inability to do something about her children’s current and future suffering may lead to self-blame. When social
anxiety is comorbid with depression, and especially with melancholic features, the possibility of pathological guilt emerges.

With respect to the mother's perception of her own role, it is also relevant to take into account the remarks by Ollendick & Hirshfeld-Becker about the parents' role in the etiology of Social Anxiety Disorder in their children. Their remarks included modeling insecurity and avoidance behavior, exposing the children to parental depressions and the parent's inability to arrange playmates and play dates for their children as well as the parents' inability to supervise their children's play with their peers. Ollendick & Hirshfeld-Becker's remarks take on a special meaning when these parental deficits are recognized by a mother who is socially anxious, although Ollendick & Hirshfeld-Becker did not discuss that particular possibility. The mother's tendency to blame herself for the perceived rejection of her children by their peers, based on projection, selective attention, and possibly inaccurate observation, will be reinforced when she recognizes these specific deficits in herself. Considering that 77% of persons with generalized social anxiety suffer from suicidal ideation (Lecrubier, Wittchen, Faravelli, Bobes, Patel & Knapp, 2000), the suffering the mother envisions for her children, and the degree to which she blames and sees herself incapable of improving their situation, it can be imagined that mfs ideation may start to intrude into this mother's thinking.

Gilbert (2001) reports that persons with eating disorders who are also diagnosed with social anxiety suffer more when they are concealing their eating disorder. This may also be relevant for the mother experiencing mfs ideation and even more for the mother who may have made unreported nonfatal mfs or aborted attempts. Not disclosing this mfs ideation and behavior,
therefore, may exacerbate the mother’s social anxiety, and her fears of what could happen to her, if her ideation and behavior became known. In addition, concealment may play a more general and broader role, and, as a result, add to the mother’s fear of being rejected.\textsuperscript{132}

Anxiety: PTSD

As to a relationship between suicidal behavior and other anxiety disorders, PTSD has been reported (Kotler, Iancu, Efroni, & Amir, 2001) to represent a risk factor for suicidal behavior. In terms of relevance for mfs, certain known etiological factors for PTSD such as childhood abuse are also found in the histories of mfs mothers (Haapasalo & Petaejae, 1999; Okumura & Kraus, 1996; Resnick, 1969). In addition, the similarity between the PTSD symptom of a foreshortened sense of future and the fear of an impending disaster that is not based on reality reported by Fawcett et al. (1993) is noteworthy. Further research is needed to determine to what extent the presence of other PTSD symptoms is associated with mfs ideation or behavior. For instance, it would be interesting to explore to what extent the PTSD symptom of avoidance behavior is seen in mfs mothers.

\textsuperscript{132} The socially anxious mother might be concealing much of what she believes could hurt her, if it became known. A person suffering from rejection sensitivity who easily merges with others in order to have some sense of security and subsequently feels hurt and abandoned when the reality does not live up to the fantasy may engage in behaviors that she is ashamed of after the episode of merger is over and the dominant experience is that of abandonment. The fear of exposure of such behaviors may be a particularly heavy burden for the person suffering from rejection sensitivity, especially when not protected by the fog of a new merger experience.
The personality disorders that appear to be most prominent among the mfs mothers with a Typus Melancholicus personality style are Avoidant, Borderline, and Dependent Personality Disorders. In terms of a link between these personality disorders and suicidology, Avoidant Personality Disorder has already been discussed in the context of social anxiety which is highly comorbid with Avoidant Personality Disorder.

Borderline Personality Disorder, which is characterized by identity issues (DSM IV TR), has been associated extensively with both parasuicidal behavior and fatal suicide attempts. Linehan (1993) found that studies describing women with parasuicidal behaviors showed symptoms that were strikingly similar to those in studies describing women with Borderline Personality Disorder. As a result, she concluded that the two types of studies may have been discussing the same patients. Linehan also reports that while Borderline Personality Disorder is primarily associated with parasuicidal behaviors, i.e. nonfatal attempts and serious ideation, approximately 9% make fatal suicide attempts, “Nor is the suicidal behavior of borderline patients always nonfatal. Estimates of suicide rates among BPD [Borderline Personality Disorder] patients vary, but tend to be about 9%. (Linehan, 1993, p. 4)

Borderline Personality Disorder also is the only personality disorder where suicidal ideation is listed as one of the possible symptoms. Paris (2002) believes that Borderline Personality Disorder women are mainly engaged in parasuicidal behaviors in their 20’s, while they are at

133 Antisocial Personality Disorder has been associated with maternal filicide and also with maternal suicide attempts (Meyer & Oberman, 2001). However, it has not been associated with mfs mothers with a Typus Melancholicus personality style.
higher risk of a fatal suicide attempt in their 30’s. By then, they have lost hope in potential solutions such as those offered by engaging in psychotherapy. This could cause hopelessness, considered a key factor in suicide attempts. In the context of the observations by Paris about the age of 30+ as a risk factor, it may be noteworthy that the age range of mfs mothers with a Typus Melancholicus personality is 27-35. It may also be noteworthy that childhood abuse, especially sexual abuse, often is associated with PTSD and Borderline Personality Disorder. (Herman, Perry & Van der Kolk, 1989; Van der Kolk, Perry & Herman, 1991; Zanarini, 2000; Zanarini, Yong, Frankenburg, Hennen, Reich, Marino, & Vujanovic, 2002).

In regards to the possible role of Borderline Personality Disorder or Borderline traits in mfs, we find potentially useful clues in the work of Okumura & Kraus (1996). These authors report that mfs mothers with a Typus Melancholicus personality style were experiencing identity issues, which is a characteristic of various personality disorders, especially of Borderline Personality Disorder. These identity issues may have led these mothers to over-identify with others and with social roles. Okumura & Kraus believe that the characteristic of overidentification may explain what they refer to as the mothers’ psychotic identification with their child. In addition, the likely presence of rejection sensitivity in many of the mfs mothers with a Typus Melancholicus personality style suggests a special vulnerability to abandonment, a key aspect of Borderline Personality Disorder.

While it has been relatively easy to locate information about the relationship between suicidal behavior and the Avoidant and Borderline Personality Disorders, it has been much harder to do this for Dependent Personality Disorder. Considering the comorbidity of Dependent Personality Disorder with other psychiatric disorders that are known for elevated risk of suicidal
behavior such as depression and various anxiety disorders, we may have to take into account the possibility that suicidal behavior and ideation are important features of Dependent Personality Disorder.

In terms of a possible relationship between Dependent Personality Disorder and mfs behavior, it is important to point to the remarks by Okumura & Kraus (1996) about overidentification by mfs mothers with a Typus Melancholicus personality style. While this overidentification was associated by me with Borderline Personality Disorder or borderline traits, it is also possible to associate this behavior with Dependent Personality Disorder. The tendency to submit to others, the key feature of Dependent Personality Disorder, suggests a vulnerability to abandonment and rejection issues (Millon, 1996) which are likely to be present in mothers with a Typus Melancholicus personality, as described by Okumura & Kraus.

Schizophrenia

Schizophrenia has been associated with simple suicide. There have also been studies suggesting a link between schizophrenia and social anxiety (Himmelhoch, Levine & Gershon, 2001). Rejection sensitivity might, therefore, play a role as well in regards to suicidal behavior among schizophrenic persons, especially those suffering from paranoid schizophrenia. Schizophrenia may account for the behavior of some mfs mothers. However, schizophrenic mothers of young children may be receiving in-patient treatment rather than the outpatient treatment which is the focus of this dissertation. Also, in case dpsmyc are in outpatient treatment, then the schizophrenic symptoms might make it relatively easy for a clinician to determine that there might be danger to self and/or others.
Psychotic Features as a Specifier of Depressive Disorders

Psychotic features as a specifier of depressive disorders include non-bizarre delusions that are congruent with the themes of a patient's depression (DSM-IV-TR, 2000). Depression with psychotic features also has been referred to as *psychotic depression*. It also may be noteworthy that DSM-IV TR refers to an earlier time when the term *schizophrenic*, which is strongly associated with psychosis, was applied to more symptoms than currently is the case.

There are many references in the literature to doomsday delusions, rescue delusions and delusions of altruism. In regards to mfs and mfs ideation these delusions often are referred to as psychotic and/or as symptoms of psychotic depression (Adelson, 1961; Myers, 1970). Although this practice is in accordance with the definitions of psychotic features in DSM-IV TR that was just quoted (as well as most prior DSM editions), the use of the term *psychotic* in many studies on mfs, nevertheless, is somewhat problematic in my opinion for two reasons.

First, the contents of many of the psychotic features, especially the non-bizarre delusions, are very similar to the contents of cognitive symptoms of two other psychiatric disorders. Fantasies are the most prominent defense mechanism in Avoidant Personality Disorder (Millon, 1996), while a sense of a foreshortened future is a symptom of PTSD. In addition, Fawcett et al. (1993) report that patients diagnosed with depression who made a fatal suicide attempt within a year of their first evaluation showed many symptoms of anxiety. Several of these symptoms suggested unfounded fears of an impending disaster.
The phenomenon of pathological guilt which is mentioned in several of the studies on mfs is significant. A mother with a Typus Melancholicus personality who considers herself an inadequate mother, and who feels responsible for events and behaviors of others over which she has no control and with which she may not even be involved, might develop guilt of pathological proportions, when negative events do occur. In the discussion on the designation of cognitive distortions pathological guilt often is referred to as delusional. It may be noteworthy that while pathological guilt is one of the symptoms of another specifier of depression, “melancholic features”, I have only rarely, if at all, encountered references to this specifier. Its association with Typus Melancholicus, however, cannot be a coincidence.

Secondly, many of the thoughts that were labeled delusions and psychotic only received that designation in hindsight. This practice suggests the presence of the tautological notion that for mfs to occur psychosis must have been present. Similar thoughts would often be referred to only as cognitive distortions prior to an attempt at mfs.

The spectrum approach to the diagnosis of mental illness

Recently, suggestions (Maser & Patterson, 2002) have been made to consider the merits of a spectrum approach in comparison with those of a categorical diagnostic system such as DSM-IV TR and several prior DSM editions\(^\text{134}\). According to these suggestions a spectrum approach

\(^{134}\) Maser & Patterson (2002) argue that the traditional categorical approach used in DSM-IV, where a minimum of usually three, sometimes five symptoms must be present before a diagnosis can be made, causes persons suffering from a sub-threshold number of symptoms not to be diagnosed. In addition, it could happen that the symptoms that are present, although less than the number required for a diagnosis, might be causing a great deal of dysphoria. For instance, suicidal ideation is one of nine possible symptoms of a Major Depressive Episode. Meanwhile, for a diagnosis of depression to be made the presence of five symptoms is required. Therefore,
would highlight known and potential comorbidities of disorders as well as provide insight into the possibility of a common etiology of such disorders. In addition, the spectrum approach would take into account a sub-threshold number of symptoms as well as potentially relevant non-symptoms such as personality features. In doing so, the spectrum approach would show a spectrum of degrees of severity in addition to a variety of features.

I believe that a spectrum approach might be particularly appropriate for high-functioning persons, whose vulnerabilities may be hidden behind the mask of high functioning. Considering that many of the mfs mothers with a Typus Melancholicus personality were high functioning, the relevance of a spectrum approach for the evaluation of mothers who may be suffering from mfs ideation might be particularly useful.

In fact, the breadth of the phenomenon of Typus Melancholicus, which although it is primarily a personality style and not a psychiatric disorder, has features of a spectrum approach. Its role in calling attention to the vulnerabilities for mfs ideation among depressed and potentially suicidal mothers of young children (dpsmyc) might be an indication of the potential usefulness of a spectrum approach.

someone might have four of the nine symptoms, possibly including suicidal ideation, and experience a great deal of distress, and yet not be diagnosed as having a Major Depressive Disorder. In addition, the categorical system could lead to several disorders being present in “sub-threshold” form simultaneously, which again does not lead to a diagnosis. Meanwhile, the person experiencing two disorders in a sub-threshold manner might be diagnosed as having a disorder if the categories were defined differently. Finally, non-symptoms, such as certain personality features are not taken into account in the current categorical system, although some of the non-symptoms might be included as a V-code or lead to a “Not Otherwise Specified” diagnosis. Meanwhile, the non-symptoms could signal a certain vulnerability to one or more disorders. Not including them could hamper research and ultimately understanding of psychiatric illness. A spectrum approach has the potential of incorporating many of the elements that could be overlooked in a categorical approach.\textsuperscript{134}
Configurations of disorders and symptoms for which spectrum proposals have been developed include social anxiety (Schneier, Blanco, Antia & Liebowitz, 2002), post-traumatic stress (Moreau & Zisook, 2002) as well as mood disorders (Cassano, Frank, Miniatti, Rucci, Fagiolini, Pini, Shear & Maser, 2002) and autism (Willemsen-Swinkels & Buitelaar). There also have been proposals for a bipolar spectrum (Akiskal, 2002; Himmelhoch, 1998; Perugi & Akiskal, 2002). According to these authors, the bipolar spectrum could include depression with atypical features, social anxiety, panic disorders, avoidant personality disorder, as well as Borderline Personality Disorder.\textsuperscript{135}

\textit{Concluding Remarks about Psychiatric Approach}

The relationship between the psychiatric approach and simple suicide has been shown to contain many elements that can be applied to mfs and mfs ideation. Therefore, awareness of the symptoms of various psychiatric disorders and their comorbidities as well as what makes a person vulnerable to experiencing these symptoms may help the clinician in the assessment of mfs ideation.

\textsuperscript{135} Various configurations of symptoms would be possible in such a spectrum approach. It is possible to speculate that such a bipolar spectrum could account for the phenomenon that Borderline Personality Disorder and depression often are comorbid. The rejection sensitivity associated with atypical features would dovetail with social anxiety, while the strong reactivity of mood to external events could be seen as dovetailing with the changes in mood seen in bipolar as well as the rapid behavioral and mood changes seen in Borderline Personality Disorder. The anxiety component that would be prominently present in such a bipolar spectrum would dovetail with Fawcett’s (1993) observations that anxiety features prominently in the year prior to suicide.
Theories

Of theories applied to suicide, the cognitive theory of Beck has the advantage that by definition it is focused on cognition and ideation. It very well describes the types of thoughts which suicidal ideators might be having. Lester (1994) included Leenaars’ summary of Beck’s theory with respect to suicide, which consists of the following 10 statements:

- Suicide is associated with depression. The critical link between depression and suicidal intent is hopelessness.
- Hopelessness, defined operationally in terms of negative expectations, appears to be the critical factor in the suicide. The suicidal person views suicide as the only possible solution to his/her desperate and hopeless, unsolvable problem (situation).
- The suicidal person views the future as negative, often unrealistically. He/she anticipates more suffering, more hardship, more frustration, more deprivation, etc.
- The suicidal person's view of him/herself is negative, often unrealistically. He/she views herself as incurable, incompetent, and helpless, often with self-criticism, self-blame, and reproaches against the self (with expressions of guilt and regret) accompanying this low self-evaluation.
- The suicidal person views him/herself as deprived, often unrealistically. Thoughts of being alone, unwanted, unloved, and perhaps materially deprived are possible examples of such deprivation.
- Although the suicidal person’s thoughts (interpretations) are arbitrary, he/she considers no alternative, accepting the validity (accuracy) of the cognitions.
- The suicidal person’s thoughts, which are often automatic and involuntary, are characterized by a number of possible errors, some so gross as to constitute distortion; for example, perseveration, overgeneralization, magnification/minimization, inexact labeling, selective abstraction, negative bias.
- The suicidal person’s affective reaction is proportional to the labeling of the traumatic situation, regardless of the actual intensity of the event.
- Irrespective of whether the affect is sadness, anger, anxiety, or euphoria, the more intense the affect, the greater the perceived plausibility of the associated cognitions.
• The suicidal person, being hopeless and not wanting to tolerate the pain (suffering), desires to escape. Death is thought of as more desirable than life. (Lester, 1994, p. 83)

Much of what is contained in these 10 statements could apply to many mfs mothers. I see Beck’s cognitive theory as a generic theory describing the thought processes involved. Because certain thoughts reflect a certain degree of danger, Beck’s cognitive theory is very well suited to be used in the study of mfs. However, it does not pay attention to what events, characteristics etc. might have led to these thoughts.

**Baumeister’s Escape Theory of Suicide**

Baumeister (1990) has developed the escape theory of suicide. Baumeister’s theory applies to both nonfatal and fatal suicide attempts. In addition, it assumes rationality, although Baumeister acknowledges that rationality may not always be present. The suicidal person wants to escape awareness of his or her negative affect and has reached a so-called deconstructed state where one has to a certain extent succeeded in shutting out negative affect, mainly by shutting out most affect and awareness. When these efforts start to fail, the suicidal person’s next step may be trying to escape awareness by attempting suicide. A similar, yet slightly different scenario occurs when the effort of escaping awareness is interrupted, e.g. when decisions or activities associated with mental pain no longer can be avoided. Stages prior to and leading up to the deconstructed state are:

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136 It may be noteworthy that Starzomski & Nussbaum (2000) applied this theory to the study of spousal homicide-suicide, even though the dynamics of this type of homicide-suicide (mainly committed by males) is different from filicide-suicide and especially mfs, as discussed earlier in Chapter 4.
• A perception of not meeting standards
• Attributions of blame for not meeting standards to Self
• Heightened Self-Awareness due to attributions of blame to Self
• Negative Effect resulting from heightened self-awareness: depression and anxiety

Baumeister emphasizes the person's fear of being rejected by others as well as ineffective efforts to deal with this fear. This makes his theory particularly valuable in explaining the behavior of mfs mothers with a Typus Melancholicus personality style. It is striking to what extent aspects of this style are prominently present in the escape theory of suicide. Being performance-oriented, hypernomic, and prone to depression and anxiety makes one vulnerable to perceive one's performance as not meeting standards, and, as a result, also vulnerable to fear stigmatization, rejection, and ultimately, expulsion. Rejection sensitivity and social anxiety, for both of which the Typus Melancholicus person is at increased risk, probably will further increase the vulnerability. Therefore, a clinician may want to become aware of a dpsmyc's perception of inadequate performance. The perception of falling short in the area of mothering may represent a greater risk for mfs ideation than falling short in other areas, such as employment.

The extent to which a dpsmyc exhibits characteristics of a deconstructed state is another potentially important area of investigation for a clinician, especially in regards to evaluating the seriousness of possible mfs ideation. Passivity and just going through the motions of daily life in a manner that suggests that she is tuning out her environment could be indications that she might be
experiencing serious mfs ideation. Baumeister specifically refers to a tendency to be unusually strongly focused on concrete day-to-day tasks as a symptom of the deconstructed state.

An aspect of the deconstructed state that is of crucial significance is how people react when their ability to tune out is diminished or otherwise interfered with. Baumeister suggests that a suicide attempt is the next phase after the escape potential of the deconstructed state has been exhausted. Often the deconstructed state is incomplete. The notion of incompleteness may be particularly relevant for the dpsmyc who is experiencing mfs ideation. When this mother’s routines that have enabled her to tune out are interrupted or are threatened to be interrupted, she may look for additional escape mechanisms, which may include simple suicide and mfs.

These interruptions of the deconstructed state may dovetail with the phenomenon that simple suicides (and possibly mfs) often happen at the beginning of a new time unit: early morning, the first two days after the weekend, and, possibly after a vacation considering the fact that both simple suicide and mfs rates reportedly are almost twice as high during the summer than during the fall. The dpsmyc who was able to tune out during the weekend or vacation or the evening before may be desperate about insurmountable obstacles when the time to face them again has arrived.

Changes in other aspects of her life that will demand a reaction not compatible with one’s state of mind during a deconstructed state may have the same effect. Examples are (feared) abandonment by a partner or by a parent. Another example could consist of the mother’s fears around one or more of her children being exposed to a new environment such as a new school.
The fears could also consist of doomsday fantasies triggered by certain events such as newspaper reports about a hole in the ozone layer or civil war in a nearby country. The impact of some of these disturbing events and threats might become especially dramatic when there is a convergence of them and/or when they are accompanied by superstitions such as “end-of-the-world” beliefs derived from horoscopes or religious tracts. The clinician, therefore, may want to ask a dpsmyc about doomsday fantasies and superstitions.

*Gilbert: Depression and Arrested Flight*

Gilbert (1998) discusses depression in the context of arrested efforts to escape from humiliation. Gilbert describes related issues in "Evolution and Social Anxiety" (2001), where he draws interesting parallels between the behavior of humans and the behavior of animals, especially when they give up and submit to the dominant animals in their “group”/pack. Persons frequently making new starts in order to run away from untenable situations created by them in their current environment may feel trapped when the running away behavior is blocked.

Also, a reason for running away behavior could occur when someone believes that too many people have too much potentially stigmatizing information about him or her. This could occur when someone with rejection sensitivity over-identifies with others and with social roles and exhibits merger behaviors in a desperate attempt to stave off rejection. After the merger behaviors have failed to achieve the desired result, the person might be overcome by depression when the common way out is blocked. In addition, the person may fear that stigmatizing information will be
revealed about spasmodic and erratic behaviors which he or she may have engaged in as part of the merger behavior and a desperate effort to be accepted.

Applying this to mfs ideation, there is a possibility that having children reduces the potential for running away. Also, in addition to becoming depressed because of hopelessness about her own future a dpsmyc easily might also be overcome with anxiety due to fears about what could happen to her children and whether she should consider actions such as simple suicide or mfs.

A similarity between the concepts of Baumeister and Gilbert refers to the respective behaviors of tuning out and giving up, which, as already indicated, are of little help to the dpsmyc who is fearful about her children’s future. The fears involving the children may be much harder to contain and submerge in a state of submission or deconstruction than one’s hopelessness about life.

Chandler: Cultural Continuity

The theories by Chandler (1994) about cultural continuity have been applied to suicidal behavior. Chandler’s theory describes persons who when confronted with a traumatic event loose their perspective and their ability to see continuity between their life prior to the traumatic event and their life after the event.

Those able to adjust well to these traumatic events and to the changes they may bring about are said to be using warranting strategies that enable them to see continuity. Chandler found that teenagers who did not use these warranting strategies were at an increased risk for suicidal
behavior. Warranting strategies help one warrant one’s existence, where warranting refers to a combination of justification and understanding.

The fact that immigration is often mentioned as a factor both in simple suicide and in mfs makes this approach of particular importance to this dissertation.

In general, experiences which give a person a sense of being different from, and especially less than, one’s peers may bring up fears of exclusion. These fears may be exacerbated when the person lacks a strong support system[^137], which could happen as a result of cultural factors, including immigration or frequent geographical moves. In other words, cultural factors as well as other factors, e.g. childhood sexual abuse, could lead to feeling different from and threatened by one’s peers. In addition, cultural factors could be responsible for a lack of support needed to deal with the sense of being different and feeling threatened.

Applying Chandler’s theory to issues of perceived outsider status and lack of support can become especially relevant in the context of mfs ideation. The dpsmyc who perceives herself to be an “outsider” in a specific environment and who lacks a base of support outside of this specific environment may attribute this to her different background which she cannot change as well as to a lack of personality characteristics needed to deal with and/or overcome her outsider status. Such a depressed and potentially suicidal mother of young children (dpsmyc), when already experiencing

[^137]: For instance, a black teenager in a hostile white school probably may rely on the support of his family. Meanwhile, a gay teenager may fear being stigmatized and ostracized both by his or her peers and by the immediate family. Such teenagers might keep their fears to themselves, and experience anxiety and depression as a result. This may lead to suicidal ideation and behaviors.
ideation about simple suicide or mfs, might become hopeless and dangerous when she gives much weight to her “deficient” background and her perceived lack of coping skills. This would become even more serious when her perception extends to her children, i.e. she believes that her children also lack these skills, due to reasons associated with the mother, and will, therefore, suffer much rejection in their life.

The impaired ability to effectively deal with and integrate traumatic experiences also might manifest itself when a dpsmyc suffers an anxiety attack when events occur such as the earlier mentioned civil war in a nearby country. The dpsmyc may be overwhelmed by newspaper reports about such events. This may also reflect her fear that the consequences of this violence, if it were to spill over to other countries, might affect her children as well as her perceived inability to protect her children and shield them from such dangers.

*Linehan Dialectic Behavioral Therapy.*

Linehan (1993) argues that women diagnosed with Borderline Personality Disorder and women involved in parasuicidal behavior are largely overlapping groups. Linehan also reports that estimates of the percentage of Borderline Personality Disorder women who make a fatal suicide attempt are close to 9%. Her theory of Dialectic Behavioral Therapy helps explain why Borderline Personality Disorder women are particularly vulnerable to suicidal behavior. Much of this theory might be applicable to mfs mothers. I am focusing on two components of this theory that appear to be particularly relevant: Transactional Vicious Cycle and Apparent Competence.
**Transactional Vicious Cycle.** Transactional Vicious Cycle refers to the phenomenon where the adult Borderline Personality Disorder woman in her childhood experienced rejection, and disinterest in what she wished or needed to express. As a result, she increased the intensity and the volume of her message. The parents reinforced this behavior since they only reacted to the child when it exaggerated whatever it wanted to communicate. This process is described as a vicious cycle because it is likely to get worse with time. A potential and easily overlooked, negative side effect of this process could be, in my opinion, that when for whatever reason the adolescent, young adult or maybe even middle aged borderline woman does not react in the expected theatrical or dramatic fashion, the environment might consider this as progress, while, in fact, the woman might be in the pre-suicide stage of deconstruction, where she basically is numbed and tunes out her environment.

**Apparent competence.** Apparent competence refers to the decision to change one’s behavior, where the initial efforts and tentative results encourage the environment to believe that the “patient” finally might be on the right path. Much like New Year’s resolutions, these efforts are often not maintained and thereby causing the person with Apparent Competence to feel even more negative about themselves.

The Borderline Personality Disorder patient, prone to depression and sensitive to rejection may be particularly vulnerable to Apparent Competence and its depressive aftermath because this person may try many approaches in order to avoid rejection or to experience merger. It is likely that shame and guilt also play a role: guilt about disappointing the people in one’s environment yet another time, and shame as a result of having raised expectations that one cannot fulfill. A series
of such apparent competence episodes can leave a person emotionally and mentally exhausted and, as a result, hopeless.

Apparent Competence may apply even more in the area of motherhood. Efforts to improve oneself may not bear fruit soon enough, and even if they do, the dpsmyc might be so distraught that she will not notice.

In this context, it is important to emphasize the possible role of the environment of a patient with Borderline Personality Disorder. The environment may have become used to the patient’s impulsive, often dramatic, and demonstrative expressions of suicidality which may have been intended and/or interpreted as attention seeking and a cry for help rather than as representing a danger of an imminent serious and potentially fatal attempt. It is, therefore, not hard to imagine how the environment of a rejection sensitive, Borderline Personality Disorder dpsmyc might be eager to interpret slight improvements or even the absence of visible symptoms of problems as a positive development causing them to let down their guard in regards to possible signs of suicidal behavior, and even mfs related communications.

General Comments. Linehan’s theory describes how and why behaviors by women suffering from Borderline Personality Disorder and/or parasuicidal behaviors go from one extreme to another extreme. Linehan considers this a symptom of an underlying personality conflict where the behavior of alternating between extremes is seen in several areas of the lives of these women. It might be worthwhile to further investigate to what extent the phenomenon of alternating between extremes could be associated with the phenomenon that women with a fear of rejection, in order to stave off rejection and gain acceptance, may engage in spasmodic, erratic, and, from a superficial point of view, contradictory behaviors.
Additional Remarks on Theories

The theories that were discussed so far as well as the approaches still to be discussed do not assume the presence of a thought disorder. Yet, they assume an elevated vulnerability to suicidal ideation and behavior.

From an overall point of view, these theories might help to identify factors that have meaning in the framework provided while these factors might go unnoticed otherwise. They may give clinicians a reason to look for certain phenomena and help them interpret the significance of these phenomena through the interrelation with other phenomena described by the theory.

Other approaches

Shneidman.

Shneidman (1992) refers to a variety of approaches (documents, familial-developmental, psychodynamic, psychological, psychiatric, demographic, socio-cultural, and sociological etc). Several of these, the demographic and the psychiatric, already have been discussed or they suggest a line of inquiry that overlaps with the psychiatric approach and the life events approach, which will be discussed shortly.

Shneidman also reported that 95% of all completed suicides had 10 characteristics in common, commonalities. The tenth commonality, coping behavior in prior situations of serious stress, may be quite useful for the clinician working with the dpsmyc who might be experiencing mfs ideation.
It would be important for the clinician to find out whether the stress on previous occasions was associated with rejection sensitivity and also which solutions the mother used to deal with the stress and the underlying problem. It may be worthwhile to explore to what extent problems, and especially current problems, are seen by the mothers as beyond solution and entrapment in a dead-end situation.

Shea

Shea (1999) observed in his contacts with suicidal patients that two months prior to a suicide attempt something appeared to have changed in the suicidal person. Shea does not elaborate much on this phenomenon, and remarks that further research is needed in this regard.

It is noteworthy that some of the descriptions of the lives of mfs mothers referred to changes approximately six to eight weeks prior to the mfs attempt. Not enough is known about the cases to draw firm conclusions. However, this is an aspect of mfs behavior that may benefit from further research.

Salient Risk Factors

Maris (1992) compiled a list of risk factors which he referred to as salient. In many ways, these salient factors overlap with factors that are associated with other approaches, especially the psychiatric approach. This set of risk factors is relevant for most suicidal situations, although not all
factors in this list apply to all situations. As a result, suicidologists sometimes refer to a list of salient risk factors in their discussion and use it as a starting point, when investigating the suicidal behavior of specific categories of persons. Maris presents this list of predictors of suicide:

1. Depressive illness, mental disorder
2. Alcoholism, drug abuse
3. Suicide ideation, talk, preparation; religious ideas [reunion after death]
4. Prior suicide attempts
5. Lethal methods
6. Isolation, living alone, loss of support
7. Hopelessness, cognitive rigidity
8. Being an older white male.
9. Modeling, suicide in the family, genetics
10. Work problems, economics, occupation
11. Marital problems, family pathology
12. Stress, life events
13. Anger, aggression, irritability, 5-HIAA
14. Physical illness
15. Repetition and comorbidity of factors 1-14; suicidal careers (Maris, p. 9).

The relevance of this list to mfs ideation is twofold. On the one hand, it lists most of the risk factors known to play a role in simple suicide. Many of these also apply to suicidal behavior of mothers of young children, and, therefore, may contribute to an understanding of mfs ideation. On the other hand, the role of anxiety in simple suicide, although discussed by Fawcett et al. (1990) prior to publication of the study by Maris (1992) is not mentioned at all. As discussed earlier, there are strong indications that anxiety plays a major role in mfs ideation. Because a list like this has an aura of completeness to some of those who read it, absence of the role of anxiety may not be noticed. As a result, the list has some potential to be misleading.
Life Events as Risk Factors

Many phenomena are considered risk factors in simple suicide. In addition, terms associated with these phenomena include predisposing factors, precipitating factors, protective factors, precursors, correlates, signs, life events, and stressors. Many suicidology studies use the term risk factor to denote any phenomenon that is associated with an increased risk of suicidal behavior regardless of whether the phenomenon contributes to the risk or is merely a (warning) sign.

The term risk factor can refer to impersonal factors (demographic, economic), a person’s mental health, life events, and current stressors as well as to behaviors that are known to have the potential to increase the risk of suicide, such as increased alcohol use. They also can refer to behaviors that may or may not be associated with suicidal intentions, such as making out a new will.

My use of the term risk factors includes everything that could inform a clinician of an increased risk. A distinction will be made between predisposing and precipitating factors. I will also mention protective factors separately, because a loss of the effect of protective factors could increase the risk.
Determining what risk factors are involved

Suicidology used to rely mainly on psychoanalytic and psychodynamic explanations for suicidal behavior\footnote{In 1980 the new DSM, DSM-III, had a categorical format, while prior versions of the DSM were primarily based on the application of psychoanalytic theories.}. Although the role of life events and stressors was not ruled out, little or no attention was paid to them in studies about suicidal behavior. Not surprisingly, applying psychoanalytic theories to suicidal behavior led to explanations emphasizing psychoanalytic concepts.

Many studies have been published since the early 1970’s about the relationship between negative life events and suicidal behavior (Paykel, Prusoff, & Myers, 1975; Persson, Runeson, & Wasserman, 1999; Rich, Warstadt, Nemiroff, Fowler, Young, & Warsradt, 1991; Weyrauch, Roy-Byrne, Katon, & Wilson, 2001). Increasingly, these studies also take into account the availability and quality of support systems to persons faced with negative life events (Heikkinen, Aro, & Lonnqvist, 1994)

The main finding is that negative life events may increase the likelihood of suicidal behavior. Studies also show a convergence of negative life events during the weeks and months prior to attempts at simple suicide. It also may be noteworthy that several studies on simple suicide report that seemingly trivial events may become triggers for a suicide attempt because of their interaction with other factors.

The relevance for mfs and mfs ideation is that a mother’s fears about the future of her children and her inability to protect them create a filter through which most life events, and
especially negative life events, are observed and experienced. Therefore, seemingly trivial events may take on extraordinary importance to a dpsmyc. Because the dpsmyc may be aware of how unusual her thoughts and fears are she may be hesitant to disclose them to clinicians for fear of being judged negatively.

Differences and Similarities between risk factors for simple suicide and mfs

Based on the discussion so far it appears that almost all the risk factors that apply to simple suicide and simple suicide ideation also apply to mfs and mfs ideation. As indicated earlier, this may be most noticeable in mfs mothers who are not suffering from thought disorders but instead from a Typus Melancholicus personality style and disorders associated with that, such as depression and anxiety, including the phenomenon of rejection sensitivity. Most of these dpsmyc with a Typus Melancholicus personality style would be considered covert as defined earlier. Nevertheless, a few simple suicide factors may not apply. In addition, some of the factors that apply to both simple suicide and mfs may carry a different weight in simple suicide than in mfs, or show differences in terms of the timing involved, i.e. when the factor is most relevant.

In this subsection, I will only explore general areas of difference between simple suicide (ideation) and mfs (ideation), and what that might mean for the assessing clinician. Areas of similarity between simple suicide and mfs that are particularly relevant for the assessment of mfs will be included in Chapter 8.
Areas of Difference between Simple Suicide and Mfs

In regards to mothers with a Typus Melancholicus personality style, there is one major difference between simple suicide and mfs and a few minor ones. The major difference is that having young children is considered a protective factor against (simple) suicide, while it can be a risk factor for mfs and mfs ideation. The following phenomena appear to be especially relevant in this regards.

- Several studies describe mfs mothers with a Typus Melancholicus personality style as perfect mothers. Their performance orientation and the concomitant fear of being seen as inadequate, if not the love for their children, may lead the mothers to take good care of their children. Clinicians who observe that Typus Melancholicus mothers take good care of their children might be even less prone to question the relevance of the belief that mothers of young children are at a reduced risk for suicide.

- The mother’s general fears for her children and their future which are related to her own perceived inability to protect her children may lead to serious cognitive distortions about potential dangers, especially the probability of the occurrence of events causing the danger, the impact on the mother and her children as well as the mother’s perceived inability to deal with the impact. However, because a mother with a Typus Melancholicus can appear to be high functioning a clinician might not suspect the mother’s irrational fears and, when confronted with them, he or she might dismiss them.

- The presence of a phenomenon (discussed in Chapter 6) that I like to refer to as extended social anxiety or extended rejection sensitivity. It describes how a mother’s own rejection sensitivity and social anxiety generalize to (extend to) her children. She fears for their rejection by their peers. In fact, the mother may be particularly sensitive to incidents that could indicate such rejection, while her children may not be aware of any rejection.

The following differences between simple suicide and mfs also may play a role:

- Mfs mothers, especially covert ones with a Typus Melancholicus personality style are not associated with child abuse or substance abuse, both of which have been linked to an

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140 For instance, a mother’s fear of war and violence may lead her to interpret faraway incidents of violence as dangers for her children.
increased risk of simple suicide (Canetto, 1991; Hawton & Robert, 1985) as well as simple filicide (D’Orban, 1979).

• Shea’s (1999) finding that patients with ideation about simple suicide are hesitant to share their thoughts or the full extent of these thoughts with their clinician because of shame and fears of stigmatization and involuntary hospitalization probably will apply even more to dpsmyc with mfs ideation, especially when they have been on to verge of making an mfs attempts that was subsequently aborted.

• The possibility of reactivation of trauma that the mother experienced in her own childhood, especially when her child reaches the age at which the trauma occurred in the mother’s life.

Concluding Remarks on Explanatory Approaches

Taking into account all explanatory approaches discussed so far, it appears that among suicidal persons there is a subset for whom anxiety in conjunction with depression plays a major role in the suicidal process. In general, anxiety may play such a major role because in addition to not meeting the standards of others, the suicidal person might be afraid of being stigmatized to the point of being ostracized.

It appears that anxiety may play an even more pronounced role in regards to mfs (ideation) because dpsmyc with mfs ideation have more to fear than a person without young children such as what could happen to the children in the future, whether or not to include them in a possible suicide attempt, and, if they are to be included, how to kill them. Most importantly, they have to fear the worst accusation or judgment regarding the taboo of filicide. Finally, I like to remind the reader of the concept of extended social anxiety that I have described in Chapter 6.
Assessment

In regards to simple suicide, during the last few years several authors (Baumeister, 1990; Shea, 1999) have shown an interest in investigating and assessing ideation, including events associated with changes in ideation. In other words, while psychiatric vulnerability, stressors, and the interaction between them remain the bedrock of suicidology thinking, some authors showed more interest in how vulnerability, stressors, and their interaction impact ideation.

Overall, there appears to have been a shift from focusing on personality factors and their psychoanalytic origins to the suicidal process and events shaping that. This allows for much better observation and study of the ideation aspects.

Baumeister’s (1990) escape theory of suicide clearly describes the role of anxiety around performance, does not distinguish between fatal and nonfatal suicide attempts in terms of processes preceding them, and assumes a certain degree of rationality, i.e. it is implied that the theory probably would not apply to those who are schizophrenic.

While Shea (1999) acknowledges the role of risk factors in the assessment process, he explicitly focuses on ideation and the extent to which the patient is willing to disclose it, as well as the clinician's attitude and ability to deal with suicide issues appropriately. Shea recommends ways to learn about the details of a patient's ideation, what triggers ideation episodes, and what determines its severity.
Shea also addresses countertransference and other personal issues related to the therapist that could make it difficult for a clinician to do an effective suicide assessment. In addition, as mentioned before, Shea remarked how shame, guilt, and fear of stigmatization as well as involuntary hospitalization make it difficult for many patients to share their suicidal ideation, and especially the full extent of it. The issues of how important it can be for a clinician to get consultation on suicide related issues also was addressed by Shea (1999).

All of the above directly applies to the assessment of mfs ideation. Nock & Marzuk (1999) stress that awareness of the possibility of homicide-suicide might be the most important aspect when evaluating patients who are suicidal or violent in a way that suggests that they might be homicidal.

Nock & Marzuk also report that aborted attempts are a sign posing an increased risk of homicide-suicide, and that the threat of impending hospitalization intended to prevent attempts actually might precipitate an attempt. Finally, Nock & Marzuk clearly explain the need for consultation when the assessing clinician is confronted with homicide-suicide ideation and is not sure about how to interpret this information and how to react.

Most of the work by Nock & Marzuk addresses issues around spousal homicide-suicide. Yet, they do mention filicide-suicide and especially mfs, and their findings and recommendations appear to be intended for the assessment of mfs ideation as well.
Based on the studies quoted so far, it appears that some clinicians when confronted with the possibility of homicide-suicide ideation, including mfs ideation, might shy away from more intense questioning while that approach would be the appropriate response. In Chapter 8, I will further elaborate on this.

Final Remarks about the Relevance of Suicidology to the Study of Maternal Filicide-Suicide

The question to what extent the study of mfs can benefit from the concepts and findings of suicidology should be considered in the context of the field of suicidology as a whole. The concepts of suicidology are used for groups as different as teenagers and the elderly, whose suicidal behavior is very different. Therefore, there is no compelling reason why this would be different for mfs, especially since there appears to be agreement about the fact that it is primarily suicide rather than homicide. A detailed analysis of the concepts as well as many of the findings of suicidology followed by an analysis of their relevance to mfs and mfs ideation has confirmed that suicidology applies to mfs and that the study of mfs and mfs ideation can benefit from applying the concepts and findings of suicidology.

Perhaps the most important aspect of suicidology in terms of mfs ideation consists of findings around the suicidal behavior and ideation associated with anxiety, especially social anxiety, rejection sensitivity, and performance anxiety (Baumeister, 1990) as well as comorbid disorders, especially depression and the Avoidant, Borderline and Dependent Personality
Disorders. These findings have been linked by me to the findings about mfs behavior presented in various studies that explicitly refer to the Typus Melancholicus phenomenon (Meszaros & Fisher-Danzinger, 2000; Okumura & Kraus, 1996) or do so without using the Typus Melancholicus designation (Haapasalo & Petaejae, 1999).

In the next chapter, the findings of this chapter will be joined with those of chapter 6 in order to identify elements of a special protocol for the evaluation of mfs ideation.
CHAPTER 8
RISK FACTORS FOR MFS IDEATION
Summary and Special Protocol

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}.

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\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.
\end{flushright}

\begin{flushright}
\textsuperscript{142} For instance, an indicator of the phenomenon of overconcern for the well-being of the child can be overuse of medical facilities.
\end{flushright}

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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/filigidal-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
clinician. 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.
Note written by mother 55 days before she killed her two daughters and herself.
Made available by the family.

“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

\(^{145}\) 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.\footnote{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.}

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
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
  o How long
  o How strong
    ▪ at time of evaluation
    ▪ “worst point”

• Prior attempts at simple suicide
  o While having children vs. Prior to having children

• Openness/Secrecy about past suicidal behavior as well as past and current mfs ideation and plans
  o 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
  o With husband and immediate family
  o With friends
  o With acquaintances or strangers

_Sstressors 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.
CHAPTER 9

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

In chapters 1, 2, and 3, I discussed the goal and the importance of this study as well as methodological issues. The difference between maternal filicide-suicide (mfs) and other forms of filicide, such as fatal child abuse, was considered as well as the role that mfs ideation might play in outpatient, ongoing psychotherapy. It was pointed out that this dissertation is primarily about all forms of mfs behavior, especially mfs ideation. This sets it apart from other studies that only deal with fatal or nonfatal attempts.

In chapter 4, studies on homicide-suicide were reviewed in order to extract information about mfs. In chapter 5, the same was done with studies on filicide. In chapter 6 the contents of chapters 3, 4 and 5 was further analyzed. It was pointed out that since 1990 new information had become available that included psychological autopsy studies of filicide-suicide and population studies where all cases in a specific area during a specific period were listed and discussed, while in the past only selected samples such as hospital studies had been used. Estimates on the prevalence of mfs ideation were provided as well as information on the characteristics of mothers.
who had killed or tried to kill one or more of their children followed by a fatal or nonfatal suicide attempt. Chapter 6 also included a summary of explanatory approaches that had been reviewed in the previous chapters. In Chapter 7, the vantage point of suicidology, I demonstrated that the concepts used in suicidology can be applied to the study of mfs and mfs ideation. Also, specific similarities and differences between simple suicide and mfs were highlighted from an assessment vantage point. Finally, Chapter 8 includes a summary of risk factors found in the various studies and a special protocol for the evaluation of mfs. The protocol draws attention to indicators of the presence of risk factors as well as to interaction between the various risk factors.

Conclusions

Four objectives have been pursued in this dissertation. Their contents and the conclusions reached will now be presented. A certain degree of overlap between the conclusions to the various objectives is unavoidable.

Objective #1

The first objective is to identify, analyze, and evaluate information in the literature about the prevalence and content of the various mfs 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. My conclusion in regards to the first objective is:
Mothers who made a fatal suicide attempt after having killed one or more of their children were often high functioning and known as ‘perfect’ mothers, without known symptoms of a thought disorder and not involved in child or substance abuse. Mothers with this profile represent the majority of mothers who are involved in mfs. They prepare the mfs attempt thoroughly and implement it deliberately, i.e. not in an impulsive manner. They tend to target and kill all of their children, and use methods that are perceived as painless or less violent than guns or stabbing such as drugs, gas, or drowning. For the suicide attempt they tend to use the same method as for the filicide. When that is not feasible, they may use methods that are violent such as guns or hanging.

It appears that ideation precedes the attempt. The contents of the ideation often consists of beliefs that a child would have the same kind of miserable life that the mother had had. Therefore, the mother considers it her maternal duty to rescue the children from this terrible future. The only rescue method left to the mother consists of killing her children and herself.

The prevalence of mothers making fatal or serious nonfatal suicide attempts after having killed one or more of their children shows a remarkable similarity between countries and over time, i.e. one mother per year for every three and a half to six million of the general population. Rates that exceed this narrow range primarily occur when the social culture is relatively tolerant of mfs, as in Japan, or when methods are available such as domestic coal gas that are perceived as painless, and allow for thorough preparation and simultaneous death of the mother and her children.
This dissertation focuses on mothers who fit the profile that was just described and who, as mentioned earlier, represent more than half of the mothers who are involved in mfs attempts where the suicide attempt is fatal or when nonfatal, serious and well planned. Moreover, while almost all mfs mothers had received some type of psychiatric treatment, the mothers with the profile just described are the ones most likely to be found in outpatient, ongoing psychotherapy.

As to mothers who make a nonfatal suicide attempt after filicide, some are very similar to mothers whose suicide attempt is fatal. Yet, many of them have characteristics that are rather different, e.g. they may be known to be suffering from a thought disorder, including postpartum psychosis.

Objective #2

The second objective is to develop a classification system of mfs 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. My conclusion in regards to the second objective is as follows.

The mfs mothers with a fatal suicide attempt often had a personality style that made them vulnerable to negative comparisons with others leading to rejection sensitivity and other symptoms of social anxiety which, in turn, made them vulnerable for depression. A number of phenomena often seen in the lives of these mothers can be considered risk factors for mfs and mfs ideation.

These phenomena often include but are not limited to a long history of emotional problems, abuse in the mother’s childhood, as well as ideation about and prior attempts at simple
suicide. The fact that the mfs mothers generally did not show symptoms of a thought disorders and that apparently half of them are not known to have made prior suicide attempts makes it especially important for the clinician to be aware of other signs of mfs ideation. Both the presence of a thought disorder and prior suicide attempts are regarded as very significant risk factors for simple suicide or simple filicide and could bring a clinician closer to breaching confidentiality when symptoms of mfs ideation are suspected.

Other predisposing factors include most risk factors seen in simple suicide by women, including cultural issues that can lead to alienation, such as immigration. Precipitating factors consist of abandonment issues and the occurrence of events that make the mother fearful of an impending disaster.

**Objective #3**

The third objective is to adapt and apply concepts, findings, and theories developed for the study of simple suicide to those mfs behavior cases that are primarily suicidal rather than homicidal. My conclusion in regards to the third objective is as follows.

Mfs is considered primarily suicide rather than homicide. Virtually all concepts used for the study of simple suicide can be applied to the study of mfs. Many of the findings in simple suicide also demonstrate a remarkable degree of similarity with those in mfs. For instance, a remarkable parallel can be observed in the female suicide rate and the mfs rate. Many of the theories and approaches used for the explanation of simple suicide can also be applied to mfs. This is particularly true for the escape theory of suicide developed by Baumeister (1990).
Perhaps the most important aspect of the application of suicidology to mfs is that everything that could be perceived by the mother as potentially relevant for her children’s future is observed through a filter of fear which leads to seriously distorted cognitions. As a result, some factors relevant in simple suicide may not be relevant, for example the belief that having young children is a protective factor against suicide. In addition, the impact of other factors may carry a different weight.

**Objective #4**

The fourth objective is 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 mfs ideation and behavior. My conclusion in regards to the fourth objective is as follows.

The main challenge for clinicians is to be aware of the possibility of the presence and severity of mfs ideation and the impact of that presence on the course of therapy, even when the patient does not act on her ideation. This challenge is made more difficult because of the inaccurate image included in many studies, especially studies published prior to 1990 that mfs is related to fatal child abuse, postpartum psychosis and other thought disorders as well as to anti-social personality disorder, where the mother kills mainly to spite their father.

In addition, even studies that primarily deal with mothers who have the type of profile that was described under objective #1 will only focus on cases where an attempt was made. The
possibility that for each known mfs attempt there might be many mothers experiencing mfs ideation is rarely mentioned, let alone discussed or studied.

In addition to lack of knowledge, clinicians are faced with countertransference challenges, such as the fact that for emotional or cultural reasons it is difficult for them to imagine that a mother might experience mfs ideation, let alone act on it, especially when she appears to be as high functioning as so many mfs mothers are. The fact that the mother with mfs ideation might not disclose much of her ideation out of fear of being judged further complicates the process of evaluating mothers of young children for the presence and severity of mfs ideation.

**Recommendations**

I recommend that efforts are made to convey to clinicians that mfs ideation probably is much more widespread than is suggested by the very small number of known fatal or nonfatal mfs attempts, and that there are strong indications that many of the mothers with mfs ideation are receiving psychiatric treatment, including outpatient, ongoing psychotherapy.

In terms of recommendations for further research, a number of issues stand out in regards to the need for additional research.

First, I recommend conducting a psychological autopsy type of study of a large selection of known mfs cases, where all available documents are used and surviving family members, friends, and clinicians are interviewed. The rationale for such a study is that the current tentative findings
presented in this dissertation are often based on brief case descriptions, which, in turn, were based on selected information from hospital charts as well as reports from the police and the Coroner’s office. A more thorough and comprehensive study may provide a richer and possibly a more accurate picture.

Second, I recommend revisiting earlier studies on filicide and differentiating the findings by filicides followed by suicide attempts and those not followed by suicide attempts. The rationale for this is that there are several studies on filicide, e.g. Haapasalo & Petaejae (1999) that contain detailed information about both the background of filicidal mothers, including psychiatric symptoms and childhood abuse, and the nature of their attempts which usually is reflected in the creation of categories\textsuperscript{147}. Yet, the studies do not attempt to link the findings with the various categories, while it is likely that the findings differ by category.

Third, I recommend collecting information among dpsmyc on ideation about simple suicide and mfs. The rationale for this recommendation is that current estimates of the prevalence of mfs ideation are mainly based on estimates of behaviors and ideation in regards to simple suicide.

Fourth, I recommend that when information is collected about thoughts and behaviors in regards to mfs, additional epidemiological information is collected. Questions that should be included are type of treatment received, if any; the presence of a history of substance and/or child abuse, post-partum depression, and psychosis.

\textsuperscript{147} For instance, Haapasalo & Petaejae distinguish between filicide-suicide, impulsivity, fatal child abuse, post-partum depression, and psychosis.
abuse; prior attempts at simple suicide; aborted mfs attempts; communication about one’s intentions, including the presence of standby suicide notes, and the duration of the mfs ideation.

Fifth, I recommend that the efforts to collect information about mfs ideation include former dpsmyc who no longer have young children. Some of them might have experienced mfs ideation when their children were young. The rationale for this is that the former dpsmyc might experience fewer constraints in answering questions completely and truthfully than current dpsmyc who may have fears about involuntary hospitalization. In addition, questioning former dpsmyc may shed more light on the duration of mfs ideation and which episodes might be particularly severe. Finally, it would be important to know whether there are any lingering feelings of guilt or fears of having caused permanent damage to her children in the case of aborted attempts. If such feelings of guilt or fear still play a role, it would be important to know to what extent the former dpsmyc can discuss them with clinicians.

Finally, I recommend that studies are consulted on how taboo topics in general are dealt with in psychiatric treatment. Related to this would be studies on the role of masked pathology in treatment. A key question would be what the causes and symptoms of masked pathology can be, especially when not recognized by clinicians.


Emery, J. L. (1986). Families in which two or more cot deaths have occurred. *Lancet, 1*(8476), 313-315.


