Maternal filicide-suicide from a suicide perspective
Assessing Ideation

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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)

Depressed and potentially suicidal mothers of young children may be at risk of having thoughts about not only killing themselves but also their children. While the risk of actual attempts is extremely low, the risk of having these thoughts may be much higher than treating psychotherapists think it is. Estimates on the prevalence of such thoughts are provided in this study. The type of mothers who are most vulnerable for having these thoughts is discussed as well as circumstances that might trigger them. It is argued that the principles and many of the findings of the study of simple suicide can be applied to the study of filicide-suicide. Implications for the impact on psychotherapy and the need to intervene are also addressed.

There is little information about ideation preceding maternal filicide-suicide (mfs). There are no studies on it. Studies of mothers who made a fatal or nonfatal suicide attempt after having killed one or more of their children (mfs mothers) do not directly address the presence of ideation. However, careful analysis of these studies and case descriptions included in them often reveals events that strongly suggest that the mother had been thinking about filicide-suicide for months or years prior to an actual attempt.

A review of the maternal filicide-suicide aspect in studies on filicide as well as in studies on homicide-suicide shows that studies after 1990, especially outside the USA, have provided a more complete picture of mfs by including all filicide cases in a specific area during a specific period rather than selected samples consisting of hospital patients who by definition had not made a fatal suicide attempt. In addition, most of these recent filicide studies have a special category for filicide-suicide, and sometimes even subcategories for fatal and nonfatal suicide attempts.

This review also shows that there are many misconceptions about filicide-suicide in these studies, especially those published prior to 1990 and in the USA. I will first address these misconceptions, many of which still shape the thinking about maternal filicide-suicide and ideation about it. Secondly, I will provide some estimates of the prevalence of filicide-suicide and of ideation about filicide-suicide by mothers.

Thirdly, I will discuss possible indications of the presence and severity of ideation about mfs that may be helpful to a clinician who is working with clients who might be vulnerable, i.e. depressed and potentially suicidal mothers of young children. Finally, I will discuss strengths and limitations of the research.
Myths and Reality about Maternal Filicide-Suicide

Myth 1: Filicide-suicide by mothers is due to child abuse, A psychotic episode or revenge against the father

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/psychotic episode 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 used methods that were perceived as painless such as gas or drowning. For the suicide attempt they tended to use the same method as for the filicide. When that was not feasible, they often used methods that are violent such as guns or hanging. It appears that ideation preceded the attempt. The contents of the ideation often consisted of beliefs that a child would have the same kind of miserable life that the mother had had. Therefore, the mother considered it her maternal duty to rescue the children from this terrible future. The only rescue method left to the mother consisted of killing her children and herself.

Filicide due to child abuse is generally regarded as accidental and not planned as mfs is. Also, only one child tends to be killed, while the mfs mother tends to kill all her children.

Mothers who kill their children while experiencing a psychotic episode generally kill intentionally. Although there may have been thoughts preceding the filicide, the pattern of ideation and planning differs from that which is seen in filicide-suicide. Suicide attempts often are not made or when made are nonfatal for many mothers, while in the majority of such cases only one child is targeted.

Mothers who kill their children to spite their father do not make a suicide attempt or make one that is impulsive and mostly not fatal.

Myth 2: Mothers associated with mfs do not get therapeutic help.

Studies published after 1990 (Alder & Baker, 1997; Alder & Polk, 2001; Bourget & Gagne, 2002; Haapasalo & Petaejae, 1999; Meszaros & Fisher-Danzinger, 2000; Okumura & Kraus, 1996) show that 70 to 100% of mothers who made a fatal or nonfatal suicide attempt after filicide had been receiving psychotherapy during the year preceding the attempt. The last session sometimes happened only days prior to the attempt.

If ideation about filicide-suicide is much more prevalent than actual attempts, as I argue, then there is more than a remote possibility that depressed and potentially suicidal mothers of young children seen in outpatient psychotherapy are experiencing ideation about filicide-suicide. Therefore, it is important that clinicians are aware of indications of the possible presence of ideation about mfs. Clinicians who believe that maternal filicide-suicide is due to child abuse or a psychotic episode are at risk of overlooking these indications.
Myth 3: No information is available about mothers whose suicide attempt After filicide was fatal because they are dead.

Psychological autopsy studies, developed in the 1950's for better understanding cases of regular suicide, have been applied to cases, where the filicidal mother made a fatal suicide attempt, and provide much information. It appears that researchers using the psychological autopsy method generally had access to psychotherapy files.

Myth 4: Mothers whose suicide was nonfatal are similar to Those whose suicide was fatal.

The description of MFS mothers whose suicide attempt was fatal does apply to some mothers whose suicide attempt was nonfatal. Their attempt was well prepared, and there were similar personality features. Something unforeseen (and hard to foresee) may have happened with the method used that prevented the suicide attempt from becoming fatal. However, most mothers whose suicide attempt was nonfatal were not well prepared and acted impulsively. Their background had many features of schizophrenic mothers who killed a child without making a suicide attempt (Alder & Polk, 2001).

As to the suggestion that from a clinical perspective filicidal mothers whose suicide attempt was nonfatal are similar to those whose attempt was fatal (D’Orban, 1979; Nock & Marzuk, 1999), it is interesting that Maris (1992) argued that the findings of studies of persons making nonfatal (regular) suicide attempts cannot be generalized to persons whose suicide attempt was fatal.

Myth 5: Mfs mothers are suffering from insanity.

Most, if not all MFS mothers are suffering from one or more psychiatric disorders. However, these disorders usually do not include any of the thought disorders. Even the psychotic features contained in the DSM-IV diagnosis of “depression with psychotic features”, formerly known as “psychotic depression”, are described as cognitive distortions in the DSM-IV TR that are congruent with the theme of the depression.

There may be several reasons for this particular misconception. First, there is the fact that MFS mothers whose attempt was nonfatal were often suffering from a thought disorder. Therefore, studies that only include mothers hospitalized after a nonfatal suicide attempt may contribute to this misconception. Secondly, hospitalized mothers often were found “Not guilty by reason of insanity”. It might not have been made sufficiently clear that this use of the term insanity does not automatically imply the presence of a thought disorder. Finally, there may be a desire on the part of the medical/psychiatric community and certainly by society at large to attribute acts of MFS to insanity, because it is too painful to confront the possibility that a mother is not insane and might have been premeditating the killing of her children.
Older studies on regular suicide showed a comparable tendency to speak of mental illness, where this term implied the presence of a thought disorder, while recent studies speak of psychiatric disorders, or define mental illness as the presence of one or more psychiatric disorders.

**Myth 6: Most filicide deaths are due to fatal child abuse.**

Between 40 and 70% of deaths of children between the ages of 1 and 6 due to filicide are linked to the suicide of either parent. In the USA this percentage appears to be closer to 40% because of the high incidence of fatal child abuse. The prevalence of filicide-suicide by either parent appears to be similar between countries and stable over time, while fatal child abuse shows a great deal of variation. In a similar vein, Coid (1983) reported that the prevalence of homicide-suicide is similar between countries and stable over time, which he attributed to the similarity of the epidemiology of psychiatric disorders. The much larger variation of overall homicide rates was attributed by him to sociological factors.

Improved medical technology may have contributed to a decrease of the number of deaths due to child abuse, while such a decrease in filicide-suicide is less likely because the death was intentional. Also, campaigns against child abuse conducted in several countries may have contributed to a decrease of fatal child abuse, but would not have reached mothers who are contemplating filicide-suicide because reportedly they rarely abuse their children.

**Myth 7: It is not possible to identify risk factors for filicide, incl. filicide-suicide**

In studies on filicide often remarked that it is difficult to identify risk factors for filicide, including acts of filicide-suicide. Despite the fact that these studies often state that maternal filicide-suicide is primarily suicide rather than homicide, they do not employ the principles and findings of the study of suicide, suicidology, to identify risk factors for mfs. My dissertation is the first systematic attempt to do so and applies a variety of suicidology concepts to mfs, such as pathways from childhood to a serious suicide attempt, the role of aborted attempts, the contents and impact of ideation, the presence and content of suicide notes, the role of methods, aspects of opportunity, demographic features, the role of psychopathology, including depression, rejection sensitivity, and fears of an impending disaster, and various theories on suicide, most prominently the escape theory of suicide (Baumeister, 1990).

In fact, the thoughts and behaviors of mfs mothers prior to the act are in many respects similar to what is seen prior to cases of regular suicide that are not associated with any of the thought disorders. Most notably, they had been thinking about filicide-suicide for months or even years. Also, changes in the rate of maternal filicide-suicide in a country appear to mirror changes in the female suicide rate. Therefore, it appears that many of the phenomena that have been identified as risk factors in regular suicide by women may apply to maternal filicide-suicide, as we will see shortly.
The Prevalence of Maternal Filicide-Suicide and of Filicidal-Suicidal Ideation

The following data support the estimate that the chance that a depressed and potentially suicidal mother of young children is experiencing ideation about filicide-suicide is much higher than most treating clinicians think.

- The prevalence of mothers making fatal or nonfatal suicide attempts after having killed one or more of their children is similar between countries and stable over time, i.e. it moves in a narrow range from one mother per 2 to 8 million of the general population of a country (and between 3.5 and 6 million in recent studies). The number of children killed by either parent in conjunction with the parent’s suicide shows a range that is equally narrow: 0.3 to 0.9 child per million of the general population (and between 0.4. and 0.7 per million in recent studies). Rates that exceed this narrow range primarily occur when the social culture is relatively tolerant of mfs, as in Japan. 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, the prevalence for mfs tends to be in the high end of the range, i.e. close to one mother per 2 million of the general population.

- It is unlikely that availability of additional or more accurate data, as discussed in some detail in the dissertation, would significantly alter these estimates. At most, the narrow range would be a bit less narrow.

- Five % of mothers of young children who made a fatal suicide attempt took one or more of their children along. This percentage is likely to be much higher when only mothers are taken into account who are not involved in child or substance abuse, and who are not known to be suffering from one of the thought disorders or a terminal illness.

- The percentage of mothers with ideation about suicide who are also contemplating filicide-suicide could be close to the percentage of mothers with fatal suicide attempts who take one or more of their children along.

- Estimates of the prevalence of (regular) suicidal ideation among women in the age bracket typical of mothers associated with filicide-suicide vary widely based on the severity of the ideation but usually are at least 2% of the all women in that particular age bracket. It is noteworthy that of persons diagnosed with general social anxiety disorder, which may be widespread among mfs mothers because of the presence of rejection sensitivity 45% made a nonfatal (regular) suicide attempt and 77% were suffering from suicidal ideation. (Lecrubier et al., 2000)
Phenomena to which a clinician should pay attention when evaluating for the presence of maternal filicidal-suicidal ideation

Signposts of vulnerability vs. signposts of the actual presence of ideation

A clinician who is evaluating for the presence and severity of maternal filicidal-suicidal ideation might want to pay attention to signposts that are potential indicators. These signposts can be life events, personality features, behaviors, thoughts, and other phenomena that have been observed among mfs mothers. Most of these signposts are associated with increased vulnerability for mfs. Having stated this, it may be useful to note that most mothers described by these signposts probably are not experiencing mfs ideation. A second category of signposts specifically addresses the presence and severity of mfs ideation. A more detailed discussion of signposts is presented in my dissertation in the section of “Special Protocol for the Assessment of Ideation about Mfs”.

The signposts are primarily derived from studies on filicide and homicide-suicide. Whenever it appears that suicidology is relevant to a particular signpost or group of signposts I will include it in the discussion.

Signposts suggestive of Vulnerability

Personality Features and Psychopathology

The only two studies in the literature that were exclusively focused on mfs (Meszaros & Fisher-Danzinger, 2000; Okumura & Kraus, 1996) found that a configuration of personality features and psychopathology symptoms referred to by them as Typus Melancholicus Personality Structure was present in the majority of mfs mothers who were not suffering from schizophrenia. These features were performance anxiety and a concomitant fear of not being able to meet the standards one’s environment is believed to set, being overly responsible, obedient and orderly, and fear of having one’s shortcomings exposed and being stigmatized as a result. Consequently, there is a good deal of rejection sensitivity, and symptoms of mixed anxiety-depression. Often we also see a poorly defined sense of self and concomitant tendencies to over-identify with others and with social roles.

Okumura & Kraus (1996) state that mothers of young children with a Typus Melancholicus personality tend to see and treat their children as extensions of themselves and have problems seeing them as separate individuals. These mothers are at risk of seeing themselves as inadequate mothers (often associated with a lack of maternal nurturing in their own childhood), and they often show overconcern for the (future) well-being of their children. Because they see their children as an extension of themselves, they automatically assume that the children will have the same problems that they have had during their life. Seeing themselves as unable to change, they equally believe that improvement is not possible for their children. The mother tends to experience
pathological guilt about all this, which may be especially severe when the child is suffering from a disability. This process becomes a vicious cycle, when the mother's pessimism about her children's future makes her even more depressed and hopeless. Most significantly, perhaps, is the presence of fears about events that will make the predicament of the mother and her children intolerable and will leave her no other choice than to kill her children and herself.

These mothers tend to be high functioning. The absence of a thought disorder and the mothers' fear of being stigmatized make it likely that mfs ideation will only be disclosed partially by the mother, if at all. The same may be true for detection by the clinician.

The process that may lead these Typus Melancholicus mothers to mfs attempts seems to be well described by the Escape Theory of [regular] Suicide (Baumeister, 1990). This theory describes how a person's perception of not meeting the standards of performance that apply to him or her respectively can lead to self-blame, negative self-awareness, depression, shutting out of all awareness and, finally, a fatal or nonfatal suicide attempt, when it is no longer possible to continue shutting out all awareness. The state of shutting out awareness is referred to as a deconstructed state by Baumeister, and is characterized by an over-focus on concrete tasks, numbing of all emotions, passivity and going through the motions. When events occur that make it impossible to continue with this form of passivity, some persons react by making a suicide attempt. This theory which does not distinguish between fatal and nonfatal suicide attempts and, more or less, assumes rationality or at least appears to assume that there is no thought disorder, may have to offer much in terms of understanding the behavior of mfs mothers with a Typus Melancholicus Personality.

Another aspect of suicidology that lends support to the role of Typus Melancholicus in mfs is the finding that DSM-IV TR disorders, where rejection sensitivity is an important component, are associated with an exceptionally high degree of suicidality. As mentioned earlier, 45% of persons diagnosed with General Social Anxiety Disorder had made a nonfatal suicide attempt during their lifetime, and 77% reported to have experienced suicidal ideation.

Many of the signposts to be described shortly are easier to understand against the background of the presence of a Typus Melancholicus Personality Structure. It is important to point out that several other studies (Alder & Baker, 1997; Alder & Polk, 2001; Haapasalo & Petaejae, 1999) describe similar configurations of personality features and symptoms without labeling it typus Melancholicus.

Additional Signposts associated with personality features and psychopathology

- The overconcern, feelings of inadequacy, pathological guilt, and merger with her children sometimes lead to extended rejection sensitivity (or rejection sensitivity by proxy), where the mother observes the rejection of her children by their peers, while this may not be happening, and where she fears for their rejection by peers in the future.

- Fantasies as an important defense mechanism, especially fantasies about being rescued from one's current predicament and having a better life (to be distinguished from rescue fantasies, where the mother kills herself and the children to spare them a bad future).
Fantasies are the most important defense mechanism found in Avoidant Personality Disorder, where rejection sensitivity is a key symptom (Millon & Davis, 1996)

- Fear of an impending disaster not grounded in reality, which is one of the symptoms seen in persons in the year prior to a fatal suicide attempt (Fawcett, Clark, & Busch, 1993). Susceptibility to such fears, such as being superstitious, could also be a signpost. The fear of an impending disaster could also be considered as a sense of a foreshortened future, one of the symptoms of PTSD, which is a disorder that also has been associated with an elevated risk of suicidal behavior.

- Reduced ability to cope with stress and transitions, which was also demonstrated for regular suicide by Shneidman (1999).

Events in mother's history:

- Psychological and sometimes sexual abuse in childhood and their impact in adulthood, which also is a prominent risk factor in regular suicide (Van der Kolk, Perry & Herman, 1991)

- Long-term emotional problems dating back to adolescence and sometimes to childhood. In terms of the applicability of suicidology one can point to Maris (1981), whose research showed pathways from one's childhood to a serious fatal or nonfatal suicide attempt in regular suicide.

- First or second-generation immigrant, which is also a known risk factor in regular suicide (Chandler, 1994; Lester, 1997).

- A mother whose parents have experienced severe trauma, e.g. Holocaust survivors. This is also seen in simple suicide. This issue may be compounded by immigration issues.

Demographic Features

- Age of mother 27-35, while fatal child abuse is associated with late teens and early twenties.

- Age of children. Mostly older than 12 months. Oldest child in family not older than 7, while the victims of fatal child abuse mostly are two or younger and the victims of post-partum filicide, by definition, are younger than 12 months.

- Most mothers have one or two children, some have three. Indications of lower risk when a mother has more than three children. This would be an example where risk factors associated with regular suicide would suggest a reduced risk, and might falsely reassure a clinician.
• Some indications that mothers with only daughters are at higher risk

• Employed prior to becoming stay-at-home-mother. This is seen in a number of descriptions of mfs cases. There are studies in regular suicide that suggest a similar trend, while other studies contradict this.

• Not African-American. African-American women are known for their low suicide rate.

• Not lower economic status. There are conflicting reports about social class and regular suicide. However, there are indications that outpatient psychotherapy, especially ongoing therapy, could be a reflection of middle class values. Therefore, it can be no surprise that most mfs mothers were middle class.

Current stressors

• Abandonment and increased fear of being abandoned, e.g. by significant other, due to death or (the prospect of) loosing custody of children.

• Poor marital relationship. Simultaneous problems with the husband and both parents could be particular dangerous, especially for a person suffering from social anxiety who is very dependent on family relations, and has a perception of being alone and socially unattractive.

• Events causing reactivation of childhood trauma

• Stress resulting from the various mental health issues, incl. belief that one is “damaged goods”, and that defects may be genetic and are being passed on to children

• Presence of a sickly or disabled child 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

• Fear of exposure of secrets or behaviors perceived as shameful. Also, fear of bringing shame to (extended) family.

• Experience of alienation, isolation, discrimination or a breach of continuity due to cultural factors or events associated with PTSD

• Vulnerability to organic, medical and medication related symptoms, such as PMS that can exacerbate the mother’s distress

• Feelings of being overburdened, and being trapped. The feeling of being trapped can be especially dangerous for someone whose lifelong coping style has consisted of running
away from problems and no longer can resort to that, which is referred to as Arrested Flight by some authors.

Phenomena associated with a suicidal/filicidal-suicidal process:

- Most risk factors seen in regular suicide by women with some obvious exceptions, e.g. having children is generally a protective factor against suicide.

- Family history of depression and suicidal behavior

- Ideation about regular suicide: how severe currently and at worst point ever? Beck et al (1999) found that suicidal ideation at its worst point is a better predictor of an eventual fatal suicide attempt than the level of suicidal ideation a person may exhibit shortly before such an attempt.

- Prior attempts at regular suicide, including those prior to becoming a mother. Maris (1981) reports that for 50% of women under the age of 40 the first attempt at regular suicide is fatal. It is remarkable that approximately 50% of mfs mothers who made a fatal or nonfatal suicide attempt after their filicide had made a prior nonfatal attempt at regular suicide. (Alder & Polk, 2001; Bourget & Gagne, 2002)

- View of suicide and/or filicide-suicide in culture. For immigrants this also includes the culture of origin. In Japan suicide by a mother without taking her children along is more frowned upon than mfs.

- Symptoms suggesting the presence of a deconstructed state during the end phase: passive, tuning out emotions, going through the motions, uncharacteristic focus on concrete activities. Comparable to the deceptive calm before a storm. The concept of a deconstructed state has been described by Baumeister (1990) as the period that precedes a serious fatal or nonfatal attempt at regular suicide.

Phenomena associated with past and current treatment and with evaluation

- Frequent interruptions of therapy, often restarting treatment, and premature terminations, possibly resulting in a disillusion with all treatment. Paris (2002) reported that women with Borderline Personality Disorder who are in their early 30's are at an increased risk for making a serious suicide attempt, while they only made nonfatal, and presumably less serious attempts in their 20's. Paris attributes this to, among other things, disillusion with what can be accomplished with psychotherapy. Considering that many of the mfs mothers had features of a Borderline Personality Disorder, if not a regular diagnosis, Paris' observations might be helpful to the clinician evaluating for mfs ideation.
• Prior psychiatric hospitalization and fear of re-hospitalization.

• Experiencing hospitalization as stigmatizing, possibly resulting in fear of involuntary hospitalization as well as past rejection of clinicians' suggestions for voluntary hospitalization.

• Easily overlooked fears related to hospitalization, such as the fear that secrets shared with a few persons will become public knowledge, once the holders of the secret learn that the mother has been committed to a psychiatric hospital and think of her as "crazy".

• Ambivalence about treatment, incl. medication: wanting treatment, but fearing the associated stigma.

• Simultaneous contacts with several clinicians, which may represent an effort to keep any one clinician from having a complete picture that could lead to involuntary hospitalization.

• Ability to keep treating clinician from hospitalizing her or otherwise breaking confidentiality, and a concomitant fear that a new clinician might not be so easily persuaded/manipulated.

• Willingness to give clinician permission to contact family and other clinicians (previous or current)

• Possibility that clinicians' ability to assess ideation about filicide-suicide is limited by the misleading effect of the mothers' high functioning and issues of countertransference, such as unimaginability of mfs occurring.

Factors associated with presence and severity of ideation

“Delusions of rescuing”; notion of altruism

• Worsening of extended rejection sensitivity and/or increased fear of impending disaster could lead to concomitant rescue fantasies, i.e. including one’s children in a suicide attempt so they will not have to suffer from rejection or disaster. Often such rescue fantasies are referred to in the literature as delusions, especially delusions of altruism.

• Belief that all children (and not just one child) will suffer rejection and have a miserable future regardless of loss of mother and siblings.

• Rescuing surviving family members of burden of having to deal with a mentally sick person.

Phenomena associated with a suicidal/filicidal-suicidal process and the evaluation process.
• Prior attempts at regular suicide, especially after having become a mother

• Aborted attempts at mfs. Asking a mother about aborted attempts might reveal how serious she is about mfs and how far advanced she is in preparations. Studies about regular suicide have shown that persons who had aborted a suicide attempt were more likely to make a subsequent serious attempt than persons who had no history of aborted attempts. An example of an aborted attempt would be a person holding a loaded gun to their head and then deciding not to fire it. Aborted attempts might be more relevant for mothers with mfs ideation because non-fatal and non-serious attempts, which reportedly are quite common in regular suicide, would require the mfs mother to involve her children, and to start with them in attempts that do not involve methods that are simultaneous in nature, such as gassing or jumping from a building. Therefore, the mfs mother, when dealing with an urge to become (filicidal)-suicidal, may be more likely to start preparing for an mfs attempt, which subsequently is aborted. While a mother may disclose thoughts about mfs to clinicians, she may be less forthcoming about aborted attempts because of the increased risk of involuntary hospitalization. This implies that a clinician has to take into account the possibility of aborted attempts and might want to employ strategies to facilitate sharing information about them. The quote at the beginning of this study refers to a mother communicating about such an aborted attempt to a friend.

• Extent of preparation: Asking mothers questions about the details of her plans may reveal how serious and premeditated she is and how far advanced her preparations are. Shea (1999) advocates a similar approach when discussing ideation about regular suicide. Clarke & Lester (1989) discussed how the operational aspects of certain methods (ease of use) and the availability of certain means impact the decision-making of persons contemplating suicide and, by extension, the suicide rate. Chew & McCleary (1994) discussed additional aspects of opportunity, such as the number of persons in the household and issues of timing. Aspects that a clinician might want to evaluate for include the following.

  o Knowledge of various methods, incl. a plan “B”, if method chosen for filicide fails. Of particular importance is the question whether a simultaneous or sequential method is considered.
  o What done in terms of rehearsing? Any aborted attempt?
  o Plan to include all children and plans about with which child to start.
  o Thoughts about the best time and the best location
  o Method for suicide, if different from filicide. Plan B if this chosen method fails.

• Impact of ideation and any aborted attempts on mother’s self-image, functioning, and therapy. Several studies on regular suicide report a sensitization effect, where ideation once begun is triggered more easily thereafter. Attention is also given to the fact that some persons with suicidal ideation tend to isolate themselves, which may further increase depressive feelings and resulting ideation.
• Communication to family and/or friends about current intentions as well as prior suicidal behavior. Many studies about regular suicide report that persons who had made a fatal suicide attempt had communicated about it with friends and family members, sometimes in very clear terms and sometimes in terms that only became clear in hindsight.

• Suicide notes, sometimes written prior to mfs attempt as a standby note or included as part of a diary or journal. In regular suicide a link is suggested between the degree of premeditation and the presence of a suicide note, especially for women.

• Communication with clinicians that is limited due to shame or fear of hospitalization, as Shea (1999) claims happens in regards to regular suicide. Does mother raise clinician’s concern about the possibility of filicide-suicide and does she subsequently take it away?

Factors associated with a rapid worsening of the severity of mfs ideation.

Most recent studies on mfs conclude that mfs attempts, just like attempts at regular suicide, are the result of a convergence of personality features, psychopathology, and life events, and not only one factor such as mental illness. In suicidology it is pointed out that triggers might not be major events, just the proverbial straw breaking the camel’s back. Nevertheless, certain events are mentioned in many mfs case studies as triggers. These usually include

• Abandonment and increased fear of abandonment

• Recent events causing reactivation of childhood trauma

• Scenarios of doomsday events that are quite specific, such as a date suggested in a horoscope. Likewise, fear of exposure of behavior perceived as shameful leading to being ostracized, especially when linked to a specific date that looms as a deadline, e.g. a medical appointment expected to lead to involuntary hospitalization.

• Vulnerability to organic, medical and medication related symptoms, such as PMS that can exacerbate the mother’s distress

• “Contagion”/”Copy-cat” effect due to publication of mfs cases in media

In addition, I believe that expected interruptions of the deconstructed state can play a major role. For instance, children going back to school after summer vacation might cause a flare-up of fears about the rejection they will suffer at the hands of their peers.
Information about the Nature and Quality of the Research

Strengths of the research

This dissertation represents a first in several areas. It is the first review study of maternal filicide-suicide. While recent review studies of filicide generally mention filicide-suicide, it is not treated in the same depth as other forms of filicide.

It is also the first time that suicidology has been applied to the study of mfs, and the first time that a comparison of prevalence of mfs over time and between countries/localities has been made, although there are meta-studies of the prevalence of overall homicide-suicide. It is interesting that the narrow range reported in these meta-studies is even narrower for mfs.

In this study I have given much attention to differences between mfs mothers making fatal suicide attempts vs. those making nonfatal attempts, and the impact this has on the conclusions reached in studies where maternal filicide-suicide is addressed. More particularly, I am talking about the practice of generalizing the finds of hospital studies of mfs mothers who made nonfatal suicide attempts to all mfs mothers.

Most of all, this dissertation is a first in addressing ideation about mfs, and in proposing phenomena clinicians should pay attention to when evaluating depressed and potentially suicidal mothers of young children for the presence of ideation about mfs.

Limitations of the Research

This is a theoretical dissertation designed to generate hypotheses for empirical research. The manner in which the information was gathered and interpreted, by definition, has a somewhat speculative character (less so for the data on prevalence).

A specific limitation is that the prominence that I have assigned to the Typus Melancholicus personality structure is based on only two studies, both of which only included mothers who had survived their suicide attempt. However, I do believe that those mothers in the two studies who met the criteria for a Typus Melancholicus personality structure (about half of the mothers in either study) were quite similar to filicidal mothers whose suicide attempt had been fatal.

An aspect that could be both strength and a limitation is the fact that many of the variables on which I gathered information initially had been suggested to me as a result of my research of the mfs of my late wife. This may have made me more aware of potentially relevant variables, while at the same time my personal experience may have represented a bias.

Recommendations for further Research

- Conducting a psychological autopsy type study of past mfs attempts where the suicide attempt was fatal because the information provided in the case descriptions is limited, and often primarily based on reports by the police or the Coroner.
• Revisiting studies on filicide, reanalyzing their results and ferreting out which of the results applied to cases of filicide followed by a suicide attempt.

• Conducting a study among depressed and potentially suicidal mothers of young children who are currently in outpatient psychotherapy about various aspects of their suicidal and mfs behavior and ideation. This study could be extended to women whose children are no longer young and who were in therapy when the children were young. Women in this last category might be more open about their experiences that they had when they were younger. Their replies might also provide information about the length of the period during which ideation about mfs might play a role.

• A critical review of studies about taboo topics and possibly applying some of the findings to the study of mfs and mfs ideation.