Editor:

Sandberg *et al.*[1] provide an important step toward formulation of evidence-based options to deal with stalking, threats, and harassing behavior (STHB). The authors suggest further studies to determine whether their findings are generalizable. Additional studies are likely to find that STHBs are not rare and correlate with an alarming number of homicides, rapes, and serious injury (bad outcomes) suffered by outpatient clinicians.[2,3] Concern for the safety of clinicians has too often been neglected, primarily because of individual and institutional denial.

One-half of the responders in the study by Sandberg *et al.* did not agree to an interview. The authors speculate that bad outcomes may be the reason. Experience with victimization and self-defense surveys suggests other possibilities.[4] Interviews may be declined because of political correctness or legal concern. This would be true if the options used included self-defense or weapons training. One could also speculate that such options are emotionally empowering and that a feeling of safety mitigates against psychic trauma.

At clinician safety courses and workshops I held at American Psychiatric Association meetings and elsewhere, there were invariably those who reported obtaining pepper spray or a firearm during or after an assault or stalking episode. One may assume that some psychiatrists privately advise staff to use these options when needed.

The role of self-defense and weapons training should be studied as a lifesaving and injury prevention option in dealing with STHB. These modalities provide a sense of safety and competence. They may lessen psychic trauma and also allow the clinician to respond more objectively. This has been the case in inpatient settings.[5] There, even nonviolent self-defense training reduces assaults and improves staff-patient interaction. This benefit may be transferable to managing STHB.

Bad outcomes of STHB include homicide, rape, and severe injury. Contrary to beliefs widely held in the medical community, self-defense training and weapons training are the safest option in the gravest extreme.[6]

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**References**

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Editor:

Bourget and Gagné have proposed a new classification schema for maternal filicide inspired by their view that existing classifications of that form of child-killing behavior "fall short of clearly representing the multifactorial nature of filicide."[1] However, we agree with Dr. Pruett's critique,[2] in that the proposed classification lacks contextual complexity at the organismal as well as the ecological level of organization. Although Bourget and Gagné and Pruett do not mention our model for developing classifications of child-killing behavior in their articles, we have in fact previously proposed a biopsychosociocultural approach to help maximize inclusion of many of the relevant factors discussed by them.[3] Our proposal also facilitates data collection with less risk for premature elimination of factors germane to a given case. The biopsychosociocultural model flows logically from the biopsychosocial model and has already received widespread mainstream attention in the form of the cultural formulation first found in the appendix of the DSM IV, released in 1994.[4]

As recognized by Bourget and Gagné[1] and Pruett[2] the causes of child killing are multifactorial. Most

important, typological components tend to overlap and therefore are not mutually exclusive. Moreover, on the basis of insufficient empirical information, it is frequently problematic to declare child-killing behavior types as mutually exclusive of each other. It is because of this reason that we have proposed an approach that purposefully allows for typological dimensions involving child killing behavior to be simultaneously scored. It is our opinion that only by taking into account the overlapping nature of different typological constructs will we be able to arrive at empirically valid typologies for the relevant homicidal behavior.

Although we agree with Dr. Pruett's view that the nature of psychopathological complexity makes it difficult to conceptualize child killing types with a few limited constructs,[2] we posit that such complexity should take into account broader considerations of both Axis I and Axis II psychopatholgic diagnoses, especially during the early stages of typological construction. Moreover, the developmental factors either in the victims or the perpetrators also merit consideration, because both psychiatric and nonpsychiatric life-span factors are likely to be important.[3,5] This is a point that is clearly underemphasized in the classification of Bourget and Gagné.[1] In addition to Pruett's point that homicidal behavior must be explicable as a function of social context,[2] the ecological settings in which children are killed should be more specifically considered as a function of cultural, geographical, and even historical factors.[3] Biological factors may be taken into account in typologies of child-killing behavior but these should be explicitly articulated and incorporated. As for the question of intent, we have not explicitly recommended the use of motivational factors as part of a typology because of the significant likelihood of multifactorial motivational factor involvement in any child-killing type. However, motivational factors should probably be considered with each child-killing type of a given classification. In our view, intentionality, intent, and related constructs may involve more instances of psychotic thought processes than inferred by Bourget and Gagné, a position consistent with the intense and ongoing dialogue and controversy involving notions about criminal responsibility by psychiatric and legal experts and the public alike.

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