

A Review of Maternal and Paternal Filicide

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Filicide, the murder of a child by a parent, is a multifaceted phenomenon with various causes and characteristics. This review of the existing literature delineates the present state of knowledge regarding filicide and illustrates similarities and differences between offenses perpetrated by mothers and by fathers. The importance of numerous reports of an association between filicide and parental pre-existing psychiatric disorders is compounded by indications that a significant number of homicidal parents come to the attention of psychiatrists or other health professionals before the offense occurs. As prevention implies the recognition of causes involved in particular situations, a better understanding of potentially fatal parental/familial dynamics leading to filicide could facilitate the identification of risk and enable effective intervention strategies.

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The terms filicide, neonaticide, and infanticide have been used interchangeably in the literature on child homicide. Filicide is the murder of a child by a parent, while neonaticide specifies the killing of a child on the day of birth. Although infanticide is often used to refer to child homicide, the term has medicolegal implications and applies mainly to the killing of a child under the age of 12 months by a mother who has not fully recovered from the effects of pregnancy and lactation and suffers some degree of mental disturbance.^{1–3}

Filicide is a relatively rare event. In Canada in 2004, 27 children were killed by their parents.⁴ Mothers and fathers (including stepparents) were equally responsible for killing their children. The parent subsequently committed suicide in over one-fifth (22%) of these incidents.

We reviewed the existing literature to delineate the present state of knowledge regarding filicide perpetrated by either the mother or father. A better understanding of potentially fatal parental/familial dynamics leading to filicide could facilitate the identification of risk and enable effective intervention strategies.

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Classifying Filicide

In attempts to determine reasons for child murder by parents, several authors have proposed general classification systems that categorize cases based mostly on perceived motive or on the source of the impulse for the parent's homicidal act.^{5–9} Resnick⁵ was the first to propose a classification based on motive: altruism, acute psychosis, unwanted child, accident, and spousal revenge. In this model, altruistic filicide is characterized by the motive of relieving the child of real or imagined suffering and includes murder associated with suicide. Acutely psychotic filicide involves parents who kill under the influence of severe mental illness. In unwanted-child filicide, the victim was never or is no longer desired by the parents. These filicides are usually committed due to illegitimacy or uncertain paternity. Accidental filicide is unintentional death due to child abuse, generally following battered child syndrome, and spousal revenge filicide describes children who are killed to retaliate against or punish the parent's mate.

Subsequent models proposed by Scott⁶ and d'Orban⁷ focused on categorizing filicidal women with regard to the source of the impulse (parent, child, or situation) to kill the child. D'Orban modified Scott's classification of maternal filicide by adding neonaticide to the categories of battering mothers, mentally ill mothers, retaliating women, unwanted children, and mercy killing. According to d'Orban's model, battering mothers kill their child

in an impulsive act stemming from the victim's behavior, whereas retaliating women displace aggression from the mate onto the child. The category of mentally ill mothers incorporates all filicides committed in the context of psychotic illness or depression. Unwanted children are killed by the mother's passive neglect or active aggression, and mercy killing involves cases in which there was true suffering by the child, without apparent secondary gain by the mother.⁷

Guileyrardo *et al.*⁸ suggested a classification of filicides into 16 subtypes, based on selection of the primary motive or cause. In an attempt to incorporate clinical situation and motive, Bourget and Bradford⁹ proposed five major categories: pathological filicide, accidental filicide, retaliating filicide, neonaticide, and paternal filicide. In this model, pathological filicide refers to cases in which the perpetrator most likely has a major psychiatric illness. The filicide probably has psychotic or altruistic motives, and includes extended homicide-suicide. Accidental filicide includes death due to various forms of child abuse, including battered-child syndrome and Munchausen syndrome by proxy.^{10,11} Retaliating filicide is the murder of a child to punish a spouse, while neonaticide is usually the result of an unwanted pregnancy. By including the classification of paternal filicide, Bourget and Bradford⁹ were the first to recognize the importance of gender as a category in and of itself.

Although these classifications have been useful in identifying and describing filicide, various problems limiting a clear analysis of causes have become evident over time. One problem has been the difficulty in accurately assigning one case to a specific group, due to considerable overlap between categories. Another limitation is that, to date, paternal filicide has attracted only limited research. As such, relevant factors such as the role of perpetrator gender differences have been excluded in analyses of filicide. In addition, the influence of perpetrator psychiatric illness has not been fully considered. In light of these shortcomings, Bourget and Gagné¹² developed a classification system that takes into account several characteristics of filicide and associated circumstances, including parental motive, intent, and psychiatric illness. All types of filicide (i.e., mentally ill, fatal abuse, retaliation, mercy, and other/unknown) are specified as being either with or without intent, the conscious desire to kill. Mentally ill filicide refers to cases in

which the offense is associated with a DSM-IV¹³ major Axis I mental illness active at the time of the filicide. The presence or absence of psychosis as a determinant is documented in this category, as are cases of infanticide, a term used only to account for postpartum phenomena, hormonal influences, and other nonspecific mental disturbances in mothers who gave birth within the year. Fatal abuse filicide includes cases of child neglect and battered-child and shaken-baby syndromes. This type of filicide is committed without specific intent, and the event cannot meet the criteria for mentally ill filicide. In contrast, retaliating filicide is associated with specific intent to commit murder and can be the result of anger or revenge. Mercy filicide is also committed with specific intent to kill and occurs when the child has a severe, debilitating illness. The parent does not have psychosis, and the event is not better accounted for by any other category. The category of other/unknown is used only when information is insufficient to allow for an accurate classification and can include cases with multiple factors. This classification system also allows the inclusion of more specific information related to each case as needed, on the basis of actual case evidence. Cases of filicide can be specified according to whether they are associated with suicide/attempted suicide and substance use. Each case can also be identified as predictable or unpredictable, with the aim of assisting in future prevention.¹²

General Characteristics of Filicide

Filicide is associated with various victim and perpetrator characteristics. The first year of life appears to represent a critical period, with the risk greatest on the first day of life.¹⁴⁻¹⁹ Neonaticides are almost always committed by mothers,²⁰ as are homicides during the first week of life.²¹⁻²³ While mothers are overrepresented in cases of infanticide,²⁴ filicides that occur after the first week of life are often committed by the father or stepfather, with fathers being the most frequent perpetrators of filicide in later childhood.^{17,23,25-28}

Although some studies have noted that mothers commit filicide more often than fathers,^{5,9,21,29-32} other research has shown that paternal filicide is as common or more common than maternal filicide.^{12,17,27,33-39} Reports of a higher proportion of maternal filicides most likely reflect the inclusion of neonaticides in some studies.¹⁷

Neonaticides involve an equal number of male and female victims.^{27,40} Some studies have found that boys are overrepresented in victims between the ages of 4 and 15 years of age,^{23,27,38,41–43} but others have reported equal numbers of male and female filicide victims.^{18,25,26,44} Differences in sample size may in part account for these inconsistent findings. Mothers may be more likely to kill girls and fathers to kill boys,^{2,45} particularly boys over the age of 15 years.^{23,46} Younger victims may be more likely to have been physically abused by the parent.²⁷ Several studies have reported that victims of filicide are more often the first born.^{27,29,47–49}

Results of numerous studies indicate an association between filicide and parental psychiatric illness, with major depression with psychotic features most common.^{2,5,9,12,28–30,50–56} Bourget and Bradford⁹ noted that 31 percent of parents who committed filicide had a diagnosis of major depression, compared with none of the perpetrators of nonparental homicide. In a review of 131 case reports of filicide, Resnick⁵ found that 75 percent of the parents displayed psychiatric symptoms, including major depression and schizophrenia, before the offense. A recent review of 85 filicide cases in Turkey⁵⁷ showed that nearly half of the perpetrators had diagnosed psychiatric disturbances, including schizophrenia (61%) and major depression (22%). In reviews of maternal and paternal filicide cases in Quebec between 1991 and 2001, Bourget and Gagné^{12,28} found that 85 percent of mothers and 56 percent of fathers had diagnoses of major depressive disorder or schizophrenia/other psychosis.

Homicidal parents have high rates of suicide attempts, which are often serious and successful.^{2,12,28–30,38,50,58–60} Parents are more likely to commit suicide after killing older children.^{27,38,61,62} In Canada between 1993 and 2002, a parent committed suicide after murdering an infant in 4 percent of instances, while 60 percent of homicides against children aged 12 to 17 years ended in the suicide of the accused parent.⁶² The increase in filicide-suicide events with the child's age may be related to differences in motives for filicides involving older versus younger children. Parental suicide attempts are not characteristic of neonaticide, unwanted child filicide, retaliating filicide, and fatal abuse filicide.^{7,12,26,41} Fatal abuse filicide is generally regarded as accidental and not premeditated; thus the ultimate "accidental" death of the child is not the motive for the abuse.²⁸

While the term "fatal abuse" is not age specific, victims of fatal abuse filicide are often young, unwanted children.^{5,7} Mental illness, and in particular depression, is a significant finding in homicide-suicide cases, including filicide-suicide.^{12,28,38,61,63–65} Although results of some earlier studies indicate that mothers who kill their children are more likely than fathers to commit suicide after the act,^{2,30,50} more recent studies have found that fathers are more often perpetrators of filicide-suicide.^{16,17,46,61,63–68} Recent investigations note the importance of further research on filicide-suicide,^{61,69} given that parents who commit suicide after killing their child represent a significant proportion of filicidal mothers (16%–55%)^{12,38,46,68} and fathers (40%–60%).^{2,28,43,68,70}

Maternal Filicide

Women who commit neonaticide are typically younger, are often unmarried, often deny and/or conceal their pregnancies, have a lack of prenatal care, and have no plans for the care of the child.^{20,41,71–73} Overpeck *et al.*⁷⁴ found that a marked risk factor for infant homicide was a second child born to a mother under the age of 20. Although fear has been noted as an important factor in the motivation for neonaticide,⁷⁰ the main motivator may be the undesirability of the child.^{20,72} Women who commit neonaticide evidence less depression, psychotic illness, or suicidal attempts than do mothers who have killed an older child^{7,41,75,76} and are less likely to be hospitalized than are those who commit filicide.⁷¹ Prevention is seriously compromised by the fact that women who commit neonaticide rarely seek any help.^{5,77}

Mothers who commit filicide tend to be married and to report high levels of stress and a lack of support and resources at the time of the offense.^{5,7,9,76,78} Multiple psychosocial stressors as motivating factors for maternal filicide have been identified, including being the primary caregiver for at least one child, unemployment/financial problems, ongoing abusive adult relationships, conflict with family members, and limited social support.^{7,9,12,78,79} Social isolation has also been noted as a factor common in women who killed their children,⁸⁰ as has a history of childhood abuse.⁷⁶

Depression or psychotic illness typifies mothers who killed older children.^{7,75,76,78,81,82} In a recent study comparing characteristics of filicidal women with and without psychosis at the time of the offense,

Lewis and Bunce⁷⁹ reported that the psychotic women tended to be older and more educated than the nonpsychotic women and were more often divorced or separated but less commonly employed. The psychotic women were also more likely to have a history of substance abuse, psychiatric hospitalization, ongoing psychiatric treatment, and suicide attempts.

Psychosis and suicide attempts are not characteristic of women who fatally abuse their children.^{12,79,83} Personality disorders and intense psychosocial stress at the time of the fatal abuse are common.^{6,7,75,76,84} Parental separation in childhood and marital violence have been identified as cofactors in fatal child abuse by mothers, and many perpetrators of fatal abuse have a history of abuse in their childhood.²⁶ Although fatal-abuse filicide can be the result of an isolated event, it often occurs following recurrent abuse.^{35,43,79,85,86} Population studies have found that one in two fatally abused children have been victims of prior abuse.^{26,43,86}

Retaliating maternal filicide is rare.^{5-7,9,12,78,79} Women who commit retaliating filicide typically have personality disorders and a high incidence of suicide attempts.^{6,9} Marleau and Laporte⁸⁷ noted the possibility of a relationship between maternal motivation for filicide and victim gender. These authors speculated that daughters are at increased risk in altruistic situations, while sons are more at risk in retaliatory situations. Loomis⁸⁸ also reported that mothers kill their sons to seek revenge on their mates.

Mental Illness in Maternal Filicide

The prevalence of serious mental disorders has been noted often in studies of maternal filicide, with depression and psychosis reported most often.^{5-7,9,12,29,38,40,60,61,76,78,79,83,89,90} Resnick⁵ found that 67 percent of the 88 filicidal mothers were psychotic and that major depression and schizophrenia/psychosis were more common in mothers than in fathers. McKee and Shea⁷⁸ noted that of the 20 women in their sample, 40 percent had diagnosed psychotic or paranoid disorders and 25 percent had major depression at the time of the offense. In the study by Bourget and Gagné,¹² 67 percent of the 27 filicidal mothers had a diagnosis of major depressive disorder and 15 percent had diagnosed schizophrenia. Lewis and Bunce⁷⁹ reported that the most common diagnoses of the 55 filicidal women in their sample were schizophrenia (48%), major depressive

disorder with psychotic features (34.5%), and personality disorder (67%). In a review of the psychiatric history of 10 mothers who had committed filicide-suicide, Hatters Friedman *et al.*⁶¹ found evidence of depression or depressive symptoms in 70 percent of the women and of psychosis in 30 percent.

Few studies have specifically examined the influence of mental illness in filicide.^{79,89,91} Lewis and Bunce⁷⁹ found that, compared with nonpsychotic women who have killed their children, psychotic women were more likely to kill multiple victims and to attempt suicide at the time of the filicide. This study extended the authors' previous findings⁸⁹ that psychotic mothers were more likely than nonpsychotic mothers to use a weapon (knife or gun) to kill their children. Stanton *et al.*⁹¹ also noted that violent methods of killing characterize mentally ill filicidal mothers. They investigated six women who had DSM-IV¹³ diagnoses that included major depressive disorder, schizophrenia, and schizoaffective disorder (either manic or depressed phases before the filicide). All the women used violent methods of killing and killed older children, with more than one child killed in several cases. The authors found that the women who were manic before the filicide had displayed a lack of premeditation and had developed delusions within a day before the offense. In contrast, the depressed women reported thinking about their own and their children's deaths days or weeks beforehand. The authors suggested that relevant features of maternal filicide in the context of major mental illness may be disorganized thinking and unstable mental state.⁹¹

Paternal Filicide

Despite findings that men commit filicide as often as or more often than women,^{17,27,33-39,92} paternal filicide has attracted limited research. Few of the studies investigating paternal filicide^{2,5,6,36,46,93,94} employed large samples of fathers, limiting the generalizability of results. Bourget and Gagné²⁸ reviewed data from 77 cases of paternal filicide in Quebec over a 10-year period and previous reports of child homicide by fathers.^{2,5,26,27,43,57,66,95,96} The review revealed several factors regarding victims, method of killing, and filicidal motive that seem to be characteristic of paternal filicide (Table 1).

There is a high frequency of completed or attempted suicides by fathers after they have committed homicides.^{16,17,27,38,43,61,63,66,67} The likelihood

Table 1 Characteristics of Paternal Filicide Relative to Maternal Filicide

Method of Killing	Victim Characteristics	Filicidal Motive
More violent (firearm, knife, severe head trauma)	More often older children Higher proportion of males More often multiple victims	More fatal abuse More retaliation

of suicide may increase in instances involving multiple sibling victims^{28,43} and with older victims.²⁷ In a study of 32 cases of child homicide in the U.S. Air Force, Lucas *et al.*²⁷ found that the probability of homicide/suicide increased as the age of the victim increased; 13 percent of filicides involving younger children (between 1 and 4 years of age) ended in the perpetrator's suicide, while 50 percent of incidents involving older children (between 4 and 15 years of age) did.

Fathers are often perpetrators of fatal-abuse filicide, which is usually the result of battered-child syndrome and rarely involves a psychotic disorder or suicide attempt.^{5,6,9,26,28,97} Previous family violence is often a cofactor in cases of fatal abuse and in other paternal filicides.^{26-28,43,98} Perpetrators are likely to have a personal history of abuse in childhood, particularly in paternal filicides involving infants under one year of age.^{26,27,66,93}

The presence of significant life stressors has been reported by filicidal fathers, including financial difficulties, impending marital breakup, and fear of separation.^{27,66,99} Some paternal filicides reportedly have occurred in the aftermath of arguments concerning marital infidelity,^{66,96} and being separated at the time of the offense has been noted to be an important precipitating factor.^{27,66,67}

A high proportion of filicidal fathers have low socioeconomic status.^{57,66,93,96} Many filicidal fathers are unemployed and have below-average education levels.^{57,66,81,93} Social isolation and/or a lack of social support are also commonly reported in paternal filicide.^{66,93}

Motivational factors noted for paternal filicide include attempts to control the child's behavior, and misinterpretation of the child's behavior.^{5,66,93} In an investigation of five paternal filicides, Palermo¹⁰⁰ pointed out that all of the men felt a sense of personal inadequacy and had a lack of parenting skills and coping mechanisms. Several stud-

ies show a high incidence of related substance abuse/dependence.^{9,27,38,66,93}

Mental Illness in Paternal Filicide

In an investigation of coroners' files pertaining to 20 fathers who had committed filicide-suicide, Hatters Friedman *et al.*⁶¹ found evidence of a psychiatric history of psychosis in 25 percent and of depressive illness in 50 percent of the fathers. Bourget and Gagné²⁸ noted a similar rate of psychiatric illness in their examination of coroners' files pertaining to 60 filicidal men; the presence of psychosis was established in 30 percent of the fathers, and 52 percent of the men had major depressive disorders. Others have reported comparably higher frequencies of psychotic symptoms among filicidal fathers.^{5,66,93} In his review, Resnick⁵ classified 44 percent of the 43 filicidal men as psychotic and 33 percent as depressed with psychotic features. Campion *et al.*⁹³ noted that 11 of the 12 filicidal men in their sample had psychiatric disorders, with seven (64%) of the men suffering either acute or chronic psychosis at the time of the offense. Marleau *et al.*⁶⁶ found that 7 of 10 homicidal fathers had, at the time of the offense, an Axis I disorder according to DSM-III-R¹⁰¹ criteria, including four with mood disorder, one with dysthymic disorder, one with schizophrenia, and one with psychosis. Four (57%) of the offenders were actively psychotic at the time of the offense. Eight of the men had personality disorders that have been associated with paternal filicide.^{6,12} Six of the men attempted suicide shortly after the offense.⁶⁶

Discussion

The literature is replete with statements regarding the need for further research to enable a better understanding of filicide. This review allows a comparison of filicides perpetrated by mothers and fathers. A significant proportion of both male and female perpetrators have depression and/or psychosis. Personality disorders, particularly borderline personality disorder, are also frequently seen in both men and women. Other similarities between men and women who commit filicide include (1) the presence of significant life stressors; (2) social isolation and lack of social support; and (3) a history of abuse in childhood. Table 1 outlines some of the factors that characterize paternal filicide. Additional factors that differentiate filicidal fathers from filicidal mothers are: (1) fathers rarely commit neonaticide; (2) filicidal

Table 2 Rates of Mental Illness and Parental Motives in Filicide and Filicide-Suicide: Comparison of Coroners' Studies

Study	Sample	% Mental illness	% Suicide	Filicidal Motive
Bourget and Gagné ¹² (Quebec, 1991–1998)	27 Mothers	67% Depression; 15% psychosis	56%	68% Mental illness; 9% fatal abuse
Bourget and Gagné ²⁸ (Quebec, 1991–2001)	60 Fathers	52% Depression; 10% psychosis	60%	66% Mental illness; 25% fatal abuse; 1% retaliation
Hatters Friedman <i>et al.</i> ⁶¹ (Ohio, 1958–2002)	10 Mothers	70% Depression; 30% psychosis	100%	90% Altruism; (10% psychotic altruism)
	20 Fathers	50% Depression; 25% psychosis	100%	60% Altruism (20% psychotic altruism); 10% acute psychosis

fathers are usually older; (3) filicidal fathers are more likely to have a history of violence toward their children; and (4) more fathers who commit filicide also commit suicide.

Several factors preclude a more in-depth analysis of maternal and paternal filicide. For instance, studies differ regarding inclusion criteria for the age of victims, limiting an examination of potentially relevant characteristics of filicide relative to the victim's age. Another concerns differences among studies that distinguish between neonaticide and filicide and those that refer to filicide as an overall category that could include neonaticide. Clearer guidelines for research in this area would allow for a more conclusive analysis of characteristics relevant to maternal and paternal filicide, particularly given that neonaticides are rarely committed by fathers. A third limitation concerns reports that indicate that more victims of filicide are first-born children. In the absence of data for comparative purposes, it is not clear whether first-born children are more likely to be victims proportionate to the percentage of first-borns. Clarification is further hampered by the fact that birth order of filicide victims is infrequently reported in the literature. Finally, few studies distinguish between filicides committed by biological parents and those committed by stepparents.

Some contradictory reports regarding rates of mental illness in filicidal offenders may be explained by differences in study type. Findings based on general population studies of coroners' files are likely to differ from those reported in studies of psychiatric populations or correctional populations. For instance, a study of paternal filicide with a prison sample is likely to show a high incidence of fatal child abuse and a lower incidence of psychosis, whereas research conducted in a psychiatric hospital would probably show a higher incidence of psychosis and

less fatal child abuse. Reviews of coroners' files, which examine every filicide that occurs in a given region over a period of time, could clarify the prevalence of mental illness in parents who have committed child homicide. However, few such studies have been conducted to date, and fewer still have reported rates of mental illness in filicide offenders. Table 2 displays results of three recent coroners' studies of parents who committed filicide and filicide-suicide.^{12,28,61}

Some researchers have noted a lower rate of mental illness in paternal offenders compared with maternal offenders, thought to correspond to a higher rate of fatal child abuse by fathers.^{5,38,97} The higher rate of fatal abuse by fathers may give the impression that few filicidal fathers are mentally ill. However, this view is changing in the face of recent studies.^{28,66} Marleau *et al.*⁶⁶ recorded no incident of fatal abuse filicide, and noted that all 10 men in their study had a psychiatric disorder at the time of the offense. Similarly, in a review of 77 paternal filicide cases, Bourget and Gagné²⁸ found a high proportion of mental illness (64%) and a comparatively lower number of fatal abuse cases (25%). Whether the findings of a higher proportion of mental illness in filicidal fathers are attributable to improved data collection and larger samples, refined diagnostic methods with use of standardized criteria, or changing values or a reflection of societal changes with fathers taking on increased responsibilities in child care remain interesting avenues to be explored.

The importance of the numerous reports of an association between filicide and pre-existing psychiatric disorders is compounded by indications that a significant number of homicidal parents come to the attention of psychiatrists or other health professionals before the offense.^{5,7,12,26–28,61,78,79,85,98} Results of two studies indicate that filicidal parents' most

frequent reason for contacting agencies was concern over their mental health.^{26,98} Perpetrators of filicide involving older children (aged 4–15 years) reported the highest frequency of prior mental health contact.²⁷ D'Orban⁷ found that 77 percent of maternal offenders were in contact with social workers or psychiatric services before the offense. Bourget and Gagné^{12,28} noted that almost half of the filicidal women and men in their samples had had previous contact with doctors, psychiatrists, and/or other professionals. Lewis and Bunce⁷⁹ reported that nearly all of the psychotic women in their study were in ongoing psychiatric treatment at the time of the offense, and that significantly more psychotic women compared with nonpsychotic women voiced concerns about their children to their family within two weeks before the offense.

As prevention implies the recognition of causes involved in each particular situation, a better understanding of potentially fatal parental or familial dynamics leading to filicide could facilitate the identification of risk and enable effective intervention strategies. To date, the most effective identification and prevention strategies still imply the need for a case-by-case approach. One cannot emphasize enough the importance of being vigilant, particularly in first-line psychosocial, medical, or legal service delivery, for those who work with parents undergoing a crisis. The first-line emergency physician, family doctor, or any professional trained in the medical and mental health fields should not hesitate and must even consider it a duty to evaluate carefully the mental status, including any thought of suicide, extended suicide, or homicide, of a depressed or psychotically ill parent.

Professionals who provide prenatal health care should be alert to the possible risk of neonaticide before the pregnancy comes to term. During prenatal and postnatal care, it would not be difficult for clinicians to ask a few questions that would probe a parent's attitude toward infants and children without incrimination. Given that up to one-quarter of child victims killed by their mothers are below the age of one (Bourget, unpublished data, 2006) and that mothers in the postpartum period often consult their physician in follow-up or bring the infant for postnatal care and vaccination, the family doctor or pediatrician may at times be the only medical contact with a depressed mother.

Key pieces of information that could indicate the presence of filicidal ideation can be obtained by questioning a parent about his or her mood and the presence of other depressive symptoms and how they are coping with their child. If a parent reveals that he or she is depressed or is showing distress or decompensation, clinicians should specifically inquire about the child, and if there is then reason for a higher index of suspicion, should ask about thoughts of suicide and of harming the child. The importance of gleaning this information is underscored by indications that mothers who have committed filicide-suicide had been thinking about the act for months or even years before an actual attempt.¹⁰²

Depressed parents with suicidal ideation should be asked directly their thoughts on the impact of their suicide on their child's future and should be provided with the necessary treatment and support. The clinician may consider calling on the other parent or any significant relative for collateral information on the psychosocial milieu and evaluate his or her potential for protective involvement. The preservation of integrity of the child takes precedence over any ethical concerns when the clinician has reasonable grounds to suspect that the child is likely to be harmed by the caregiving parent or by the parent's failure or neglect in caring for the child.

Several countries, including the United States and Canada, have enacted legislation to provide child protective agencies with powers to intervene when suspicions arise that the child is at risk. Whenever possible, consent must be sought from the parent to share information for the protection of the child; however, absence or refusal to give consent should not preclude the clinician's taking appropriate actions when mandated by law or otherwise dictated by his or her duty to care. In those cases in which there is no stated intent but evidence exists of serious risk factors that merit further exploration, a psychiatric hospitalization may be indicated to assess and monitor risk. The professional working in family law, separation, divorce, or child custody proceedings could also exercise vigilance in identifying those emotionally disturbed client parents who are involved in strained marital relationships and threatened or actual separations. Finally, given the present state of knowledge showing the high rates of psychopathology in parents who kill their children, forensic psychiatrists and other professionals in the forensic field should keep a high index of suspicion for the

presence of mental illness when they examine a filicide offender.

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