Commentary: Pushing a New Classification Schema for Perpetrators of Maternal Filicide One Step Further

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J Am Acad Psychiatry Law 30:352–4, 2002

In their paper, "Maternal Filicide in Québec," Drs. Bourget and Gagné[1] introduce a new schema for classifying mothers who kill their children. The authors reviewed eight years (1991 to 1998) of coroners' files in Québec, Canada, as a basis for examining and classifying the filicide cases during those years. They propose a system that is "flexible and easy to use," as a step toward standardizing a tool for clinicians. Specifically, 34 cases were identified, with 27 individual mothers represented. The cases included several multiple sibling homicides. The authors posit five classification groupings that include mentally ill filicide, fatal abuse filicide, retaliating filicide, mercy filicide, and other/unknown filicide. They further specify the presence of intent, suicide, substance use, and predictability as factors useful for classifying the mothers within each of the categories.

How large a group the sample represents among the total number of coroners' cases for those years we are not told. Thus, the frequency of the event, a relevant variable when producing a coding schema from a small sample, is impossible to ascertain. Other sources of data in the article suggest that as many as 15 percent of the homicide victims in a given year in Canada are minors less than 18 years of age. The authors did not ferret out how many of those are young children versus adolescents, which may or may not be relevant to the classification schema. They were able to attribute most of the murders to family members. There is enough information to concur that maternal filicide specifically, and paternal filicide and infanticide, more generally, combine to represent a serious psychiatric and public health concern. Regardless of the actual incidence, the capacity to kill one's own child arouses alarm at our deepest level of humanity. It is incumbent on mental health professionals to establish careful definition and understanding of persons who commit such crimes under various clinical circumstances. The occurrence of such acts in first world countries around the globe marks it as a problem for further inquiry and scrutiny.

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The Classification System as Proposed

The authors begin by citing the need for a new classification schema to refine prior classification attempts based on such criteria as motive for the killing, source of the impulse to commit filicide, and clinical situation. Bourget and Gagné indicate that these prior attempts have been insufficient, as the earlier work does not accurately represent the "multifactorial nature of filicide." The factors identified by Bourget and Gagné as needing more attention include the role of psychiatric illness, perpetrator gender differences, sources of impulsivity, and neurotransmitter activity. For some unexplained reason, they then present their study and classification schema, but never again address gender differences or neurotransmitter activity, and the impulsivity connection is implied, but not explicitly stated. Thus, their classification schema may perhaps offer a step forward in a simple way of identifying relevant subgroups of perpetrators of filicide, but they leave some troubling gaps between stating what is needed and

offering a solution. The "clinical science" of their classification is a long day's journey away from being an acceptable schema for purposes of enabling clinicians to assess more accurately and predict those at risk.

The first category Bourget and Gagné present is mentally ill filicide, pertaining to any Axis I illness. Prior researchers reviewed in the article found increased risk for psychiatric illness among maternal perpetrators, with major depression with psychotic features most common. Postpartum depression was identified as common in one study, and several other studies reported that suicide attempts and completions often accompany the homicide. From this, it seems that a subtyping of depression with and without psychotic features, distinguished from other psychosis, would be critical. For example, the question arises of whether a psychotic process is a necessary component for the event to occur. Does the presence of depression accompanied by psychotic features strongly augment the likelihood of such events occurring? Most of the mothers (18/23) in this study were depressed, compared with only a few mothers with schizophrenia or other psychosis. It is not clear from the report how many of the depressive disorders were accompanied by psychotic features. It is not clear how these findings vary from or clarify prior research. Further study with larger samples is obviously needed. Better classifications will follow from a clearer distinction among Axis I disorders, such as major depression (with and without psychosis) and other psychotic disorders.

The two types of disorders have different kinds of clinical sequelae with regard to parenting. Depressive and psychotic mothers are distinct in their capacities and limitations as parents. In particular, the research literature on child development has long been focused on the effects of depression on parental judgment and potential for abuse and neglect. Thus, differentiating the parents psychiatrically may enable clinicians and/or creative researchers to draw on such scholarship when determining the clinical relevance of a classification schema. One function of classification models early on in their derivation is to provide criterion reference points for establishing identifiable subgroups, thereby facilitating research and, with further refinement, enhancing clinical prediction. For all these reasons, it is important from the beginning to distinguish depression and psychosis subgroups. Collapsing the categories may prove useful later, but doing so too early may obscure important group differences.

Similarly, within the mentally ill category, the authors discuss filicide and infanticide as collapsible subgroups. The postpartum depression that often precedes infanticide is a distinct, transitory illness that should be designated as such. Identifying mothers with postpartum depression who commit infanticide may not be easy (another factor the authors specify), but the possibility of early intervention and the potential role for hospitals and pediatricians to play in screening and intervention, render these mothers an important subgroup to identify.

In addition to the primary classification groupings, the authors further delineate four "specifiers" for each case: intent, suicide, substance use, and predictability. It is a bit confusing why "intent" is to be specified within the major classification groupings. The factor is necessary to specify only for the mentally ill and fatal abuse groups. Mercy filicide is "committed with specific intent to harm" as is retaliating filicide. These groups require intent as part of their definitions. Therefore, intent need not be a separate specified factor except for the two groups in which such intent may or may not be present.

Although the authors desire to provide a simple schema that is easy to use accurately, such simplicity may detract from the schema's usefulness in certain areas. Of note, the foregoing discussion indicates complicated aspects of the mentally ill category and raises question about its usefulness without further delineations that are clinically relevant. In fact, the authors point out that aggression, impulsivity, and suicidality are important elements to specify within a mentally ill classification. Yet, they do not account for those factors, except suicide, in their specifications and introduce other factors. Some more trial classification from a much larger sample will help clarify which of these specifiers and subgroups require their own delineation.

Finally, the other/unknown category lacks specificity. It includes those cases with insufficient information to facilitate categorization, plus those with multiple factors. It would be a distinct contribution if a standardized system for classification took into account information needed about any child homicide, so that it provided guidance about the kinds of information to be collected routinely in these kinds of homicide cases. Missing information would sub-

sequently rarely occur, and more cases could be categorized.

With regard to cases with multiple factors, these elements might be tallied separately, using additional specifiers, with the hope that statistical analysis will provide clues as to the hierarchy of factors and their relative significance as predictor variables.

Other Considerations for a Classification Schema

Although the schema being discussed is in its own infancy, and it is easy to point out what else ought to be included, this is the point in development where it is useful to consider other factors or specifiers so that their usefulness and inclusiveness can be tested in research. Toward that end, some additional considerations for classifying filicide perpetrators are suggested. The value of a classification system about maternal filicide would be greatly enhanced if some of the social and systemic forces that surround such homicides also are tracked and incorporated into a more complex schema. Given that most of the child victims were less than 10 years of age, with a substantial group of them under 1 year, a delineation of infant versus young child victim is critical. It may be that certain age groups are more or less likely to experience certain kinds of deaths at the hands of perpetrators with certain characteristics, leading us to identify better and understand related risk factors. Creating detailed pictures of risk factors is a first step in developing prevention and treatment efforts.

The presence of the father and other family members, supportive or otherwise, would also enable a more accurate clinical predictive model. It would be interesting to compare paternal filicide, no longer a distant second to maternal filicide in prevalence, to determine the differences in classifications. This factor might prove especially relevant in accord with child age and life stage. Statistics from the decades and generations past have shown that fathers are less likely to abuse their children to the point of homicide. Perhaps the changes in data reflecting more parity between mothers and fathers in this regard stem from the greater involvement of fathers in child care and child-rearing during the past few decades. Child care does not come without attendant risks for vulnerable children and struggling parents.

This disturbing possibility raises the spectacle of a significant and ever-present public health concern. In cases in which the State (e.g., child protection agencies) raises questions about a parent's ability to raise his or her child when that parent has serious psychiatric vulnerabilities and personality disorders, more often than not, the parent is supported in his or her right to raise the child without State interference. Respect for the rights of parents to conduct their family lives with privacy, coupled with overcrowded court dockets, results in a hands-off policy supporting the rights of parents for keeping the lives of their children in their own hands. Most parents with vulnerabilities provide their children with sufficient care and positive experiences in life and should be left alone. However, in an era when an increasing number of children are experiencing profound suffering at the hands of their own families, it becomes of parallel importance that we take measures to identify children who need protection from parents who cannot manage their aggressive impulses.

Any classification system of homicide offenders, when the victims are young children, must somehow include the constellation of caregivers, and their situations, if we are to understand the actual roles that illness, substance use, and retribution play in the homicide. For such acts cannot occur in a vacuum. Someone else must be absent or looking the other way at the wrong time for these deaths to occur.

With more detailed classifications, we can begin to draw a clearer analysis of perpetrators of filicide. At the same time, we must strike a balance between including enough relevant factors and including too many. Having too many factors in a schema of complex behaviors of relatively infrequent occurrence can create categories too specific to provide much usefulness in early screening and warning systems. The schema presented by Bourget and Gagné is a first, crucial step toward exploring the behavior and attempting to strike a useful balance. We have much to learn from their schema, and much to figure out about the subgroups of parental offenders who are in such pain that they must take the lives of their children and then often their own, before we learn where we might have helped along the way.

Reference

1. Bourget D, Gagné P: Maternal filicide in Québec. J Am Acad Psychiatry Law 30:345–51, 2002