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# Father Kills Mother

## Issues and Problems Encountered by a Child Psychiatric Team

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The child whose mother is killed by his or her father has to cope with the trauma of violence, the grief associated with the loss of both parents simultaneously, dislocation and insecurity regarding where and with whom they will live, stigma, secrecy, and often massive conflicts of loyalty. These issues and how they affected the 28 children of 14 families in which the father had killed the mother are examined. Recommendations for practice based on this clinical experience are proposed.

When their father kills their mother, children lose both parents suddenly and simultaneously. They are deprived not only of their mother by the catastrophe of her death, but also of their father, who is suddenly absent, in gaol, in a mental hospital, on the run, or perhaps even dead by his own hand. These children experience both the death of a mother as a victim of what is often an act of horrifying violence, and being the child of a murderer. For child psychiatric teams, these are difficult cases, and for individual workers, there will be little experience of working with such children, their families, etc.

There is no direct way of calculating the number of families each year where the father kills the mother, since there are no formal records kept on the children by the prison service, the probation service, or the Department of Health and Social Security (DHSS), and the records that exist are not coded in a way that enables identification retrospectively. Death records of individuals contain no information about their children. We estimate 40–50 families affected per year, on the basis that in England and Wales there are on average 500–600 cases of homicide per year, and of these 20% will be of a man killing his wife or cohabitee; 40% of these women will be in their child-bearing years (Home Office, 1984). In the USA, the homicide rate and the proportion of homicides that are 'wife murder' are both higher than here (Pynoos & Eth, 1985); even there, the information available is rather scanty. Only Schetky (1978), describing work with two pairs of siblings, and Pruett (1979), with one pair, appear to have reported on this subject. Pynoos & Eth (1985) and Malmquist (1986) have written on their work with children who have witnessed extreme violence, including those who had seen their father kill their mother.

We reviewed 14 such cases, involving 28 children in all, referred to us and other colleagues. These form a heterogeneous group (see Table I). The 28 children comprised 16 girls and 12 boys, ranging in age from 1 year 6 months to 14 years. The time of referral after the killing ranged from 2 weeks to 11 years, which reflects the differing reasons for referral. Most referrals came from social workers; one came from a general practitioner, and one from a school nurse. Because of the heterogeneity and the relatively small number of the sample, generalisations should be made with caution. We do not here discuss technical difficulties in or theoretical aspects of psychotherapy, nor the issues involved if these children have to make statements to the police or give evidence in court as witnesses to a homicide. The latter is well dealt with by Pynoos & Eth (1984). We described only those issues and problems that influenced our tentative recommendations for practice.

### Issues and problems in practice

#### Crisis intervention

From the work of Ayalon (1983), Pynoos (1986), and Pynoos & Eth (1986), it seems that crisis intervention can limit the severity of post-traumatic stress disorder (PTSD, DSM-III, American Psychiatric Association, 1980), which is likely to occur in these children, especially if they were present at the time of the killing. The most comprehensive and systematic description of PTSD exposed to violence was given by Pynoos *et al* (1985), and includes such symptoms as intrusive thoughts, images, sounds, and nightmares, a feeling of emotional detachment coupled with anxious attachment, a wish to avoid all feelings, a fear of recurrence and avoidance of reminders, increased arousal, and poor concentration with poor performance at school.

That these children are extremely stressed is not surprising given the violence they are exposed to. Consider examples from the 14 families studied:

> (Family 3). Emily (aged 4) and her brother (aged 11) were with their mother in the kitchen, when their

TABLE I
*Demographic data*

| *Family* | *Child* | *Age at time of murder (years)* | *Sex* | *Time elapsing after murder before referral* | *Source of referral* | *Reason for referral* |
|---|---|---|---|---|---|---|
| 1 | A | 7 | F | 24 months | Social worker (SW) | Advice *re* placement |
| 2 | B | 5 | F | 1 month | SW | Advice *re* placement |
| | C | 9 | M | | | Assessment for therapy (bereavement) |
| | D | 12 | M | | | |
| 3 | E | 4 | F | 3 months | SW | Advice *re* placement and therapy (bereavement) |
| | F | 11 | M | | | |
| 4 | G | 6 | F | 18 months | SW | Advice *re* placement |
| | H | 9 | F | | | Assessment for therapy (G, sexually precocious; H, withdrawn) |
| | I | 14 | M | | | |
| 5 | J | 4 | F | 1 month | SW | Advice *re* telling the children circumstances of mother's death |
| | K | 6 | F | | | |
| 6 | L | 4 | M | 2 months | SW | Advice *re* placement |
| | M | 5 | | | | |
| 7 | N | 9 | F | 12 months | SW | Advice *re* placement and therapy |
| | O | 0 | | | | (M, aggressive and antisocial) |
| 8 | P | 12 | M | 24 months | SW | Advice *re* access |
| | Q | 14 | | | | |
| 9 | R | 12 | M | 36 months | SW | Advice *re* access |
| | S | 14 | | | | |
| 10 | T | 1½ | F | 1 month | General practitioner | Assessment for therapy (complications for maternal grandmother as adoptive mother) |
| 11 | U | 4 | M | 2 weeks | SW | Therapy (post-traumatic stress disorder, bereavement) |
| | V | 5 | F | | | |
| | W | 6 | M | | | |
| | X | 7 | F | | | |
| 12 | Y | 3 | F | 11 years | SWs | Therapy (Y, antisocial, acting out, and taking overdose; Z, ? unresolved grief). Placement (Y) |
| | Z | 5 | F | | | |
| 13 | AA | | F | | School nurse | Therapy (psychosomatic symptoms) |
| 14 | BB | 8 | F | 10 years | SW | Therapy prior to father's release from prison, coinciding with end of statutory care |

father, from whom their mother had separated 3 years earlier, but who remained pathologically jealous, returned, entering by the back door. He shouted abuse at his wife, and then pulled out a shotgun and aimed it at her. Emily ran to her mother. Her father pulled the trigger. The first shot blew off his wife's face, the second hit her in the abdomen. The little girl stood in the middle of the room covered in her mother's blood and guts. Her brother ran for help, leaving her with their father and the dead and disfigured body of their mother.

(Family 11). There were four children in this family, two girls and two boys, each a year apart in age from another, ranging from 7 to 4 years. They were members of an immigrant family and led an isolated existence, developing their own private language, and did not attend schools. The family was under

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increasing pressure because of debt, and had recently been evicted. The father was unemployed and desperately seeking work. He returned one night after a frustrating day of job hunting to find that his wife had not prepared food for him. He flew into a rage, attacked her, beat her to the ground, jumped up and down on her and dragged her screaming into the bedroom. There was more scuffling and screaming, and then all went quiet. The children waited. Then father called them into the bedroom. He told them their mother was asleep. What they saw was their mother lying on the bed, tied up, with a blue face and protruding tongue. He ordered them into bed with her. Then he locked the door behind him and left the house. They stayed there until the next morning, when they were found by neighbours.

Pynoos (1986) and Pynoos & Eth (1986) describe the benefits of the crisis intervention approach they have developed, which in essence helps children to recount the traumatic events and their feelings in relation to it in as comprehensive a way as possible, using a semi-structured interview. The authors emphasise the need to intervene swiftly, in the first 24 hours if possible, since memories of the events are rapidly and progressively lost to recall and maladaptive responses may become entrenched. However, crisis intervention does not preclude the need, in the longer term, for bereavement counselling, and perhaps psychotherapy also.

This method of crisis intervention was not used in any of the cases in our series of families, as all were referred to us too late. However, some form of early intervention was made by a social worker in cases 2, 3, 4, and by a social worker and psychiatrist in case 11. No information regarding early intervention was available for cases 6, 7, 8, 9, and 12. In cases 5 and 10, early counselling was offered, but turned down by the care-takers. In both these cases the care-takers were kin (maternal aunt and uncle in family 5 and maternal grandmother in family 10).

### Bereavement

We recommend that all children whose fathers kill their mothers should be seen by a professional person skilled in bereavement counselling, in accordance with the views of Black & Urbanowicz (1984), especially where they are suffering from a pathological grief reaction, to which children are more prone than adults (Bowlby, 1980; Raphael, 1983). This reaction is particularly likely when their father has killed their mother, since their losses are multiple, simultaneous, and sudden. In addition, the grief reaction in these children is often complicated by a PTSD that inhibits the development of normal mourning. Moreover, because the child may be stigmatised as the child of a killer, and because his or her story is painful to listen to, provoking in the listener intense feelings of horror, rage, sadness, and shame, the child may feel compelled to remain silent. This suppression further increases the likelihood of a pathological grief reaction occurring. The children may be particularly inhibited if their foster family are kin, since its members will be more emotionally affected by the children's harrowing accounts.

Furthermore, it is our impression that relatives (as opposed to non-related carers) will often decide not to tell the children of the true nature of their mother's death, or disguise or distort the truth. We believe that the children should be told the truth about their mother's death, to enable them to make sense of their changed circumstances and the reactions of those around them, and to be able to mourn their losses effectively. What to tell the children will depend on their age and understanding.

In family 5, the maternal aunt and uncle who took care of the children were adamant that they would not reveal the truth of the events of their mother's death, in spite of the wide coverage of the murder in the local media, to which the children were inevitably exposed. Soon after, they moved some great distance to protect the children from the truth.

In family 12, after their mother's death, the children were placed with their father's brother and his family, and then later returned to their father on his release. At the time of their placement, they were not told of the true nature of their mother's death, nor of their father's real whereabouts. Many years later, her father confessed to Zandra (16), but swore her to secrecy. Just before referral to us, the children had been taken into care because of their father's violence. In the children's home, the younger sister, Yolande (14), discovered the truth of her mother's death inadvertently. When given this new information about the nature of her mother's death 11 years later, she began to grieve again; this was manifested initially as self-destructive acting-out. Zandra, given licence to talk openly about her family, also felt the need to grieve again, and expressed bitterness and shame at having been her father's confidante.

Another complication contributing to bereavement difficulties may be the paucity of objective information. With their mother dead and their father absent, the children may be the only source of information regarding their history, family, and social network, and may be too young or too shocked, especially early on, to give any, or at least any useful, account. In cases 3, 6, and 11, the social workers having to take care of the children immediately after the homicide could ascertain little about the children or about other family members or family friends. This exaggerated for these children their sense of dislocation. In fact, these families had long before lost contact with their wider family networks, and after the loss of their parents, the children felt a profound sense of rootlessness. In case 3, the child psychiatrist and social worker constructed a 'life-story book' (Ryan & Walker, 1985) for the children, and this and visits to their old home and neighbourhood proved very useful to them in relieving this sense of rootlessness and alienation. As to the particular psychological mechanisms involved in the mourning, we hypothesise that

TABLE II
*Placements and legal status*

| *Family* | *Child* | *Immediate placement after murder* | *Legal status* | *Intermediate placement* | *Legal status* | *Long-term or permanent placement* | *Legal status* |
|---|---|---|---|---|---|---|---|
| 1 | A | Already living with foster parents (FP) | Care order (CO) | Foster parents (FP) | CO | Adopted by FPs | Adopted |
| 2 | B,C | Paternal aunt and uncle | Father's custody | Paternal aunt and uncle approved as FPs | Voluntary care | Returned to father on his release | Father's custody |
| | D | | Father's custody | Children's home (maternal grand-parents involved) | CO | Children's home | Care order until 18 |
| 3 | E,F | Foster parents | CO | Short-term foster parents | CO | Long-term fostering with view to adoption | CO |
| 4 | G,H | Foster parents | CO | Foster parents | CO | Adoption by FPs in process | |
| | I | Aunt | Father's custody | Maternal aunt | Father's custody | Maternal aunt | |
| 5 | J,K | Neighbours | Not known (NK) | Maternal aunt and uncle | NK | Maternal aunt and uncle | Adopted |
| 6 | L,M | Not known | Not known | Children's home | CO | Adopted | Adopted |
| 7 | N | Short-term FPs | CO | Assessment centre | CO | Awaiting decision *re* placement | |
| | O | Short-term FPs | | Childrens home – secure unit<br>Assessment centre – children's home | | | |
| 8 | P,Q | NK | CO | FPs | CO | Adoption by FPs in process | |
| 9 | R,S | NK | CO | FPs | CO | Adoption by FPs in process | |
| 10 | T | Maternal grandmother | | MGM | CO | MGM | |
| 11 | U,V<br>W,X | Children's home | Voluntary care | Children's home | CO | As yet unplanned | |
| 12 | Y | Paternal uncle and aunt | Voluntary care | Paternal uncle and aunt | Voluntary care | Y returned to father on release; 6 years later, children's home and then FPs. Z as above, but to children's home 8 years after father's release remaining there | Care order |
| | Z | Paternal uncle and aunt | Voluntary care | Paternal uncle and aunt | Voluntary care | | Voluntary care |
| 13 | AA | Maternal aunt | Aunt legal guardian | Maternal aunt | | Maternal aunt | Aunt legal guardian |
| 14 | BB | Parent's landlady | CO | Parent's landlady | CO | Parent's landlady | CO |

two types may be common. Firstly, because of the catastrophic nature of the loss, the child may use denial, or splitting off of affect, resulting in failure to mourn. This may be evident as detachment and a difficulty in allowing a caring relationship to develop with the foster parents, leading to potential fostering breakdown. This was so in the following case:

> (Family 4) Gwen, aged 6, the youngest of three children, was placed with her 9-year-old sister with short-term foster parents after her father murdered her mother. Gwen never made a relationship with the foster mother, who had a hereditary disease which barred her from long-term fostering, although the children had been there 18 months when we saw them. It was only when, in individual therapy, she was provoked to grieve for her mother by the technique of forced mourning that she began to open up and allow her foster mother to care for her. This enabled the latter to make a commitment to her, and fight for the right to adopt her, in spite of her own illness.

Also, because of the intense conflict inherent in their loss – because they lose two care-givers simultaneously, not through a shared fate (e.g. a plane crash), which would unite them in death), but because one deliberately killed the other, the children may cope with their loss by splitting the parents into one all-good parent and one all-bad parent. This may involve only one child in the family, as was the case in family 3, where the elder child, Franz (11) 'identified with the aggressor' (his father) and idealised him, denigrating his mother, with consequent guilt later. Or the split may be expressed within the sibship, with one child idealising one parent, and the other (or others) idealising the other parent, leading to further family breakdown. This was the case in family 2:

> Darren (12) who had been the one closest to the mother, and the messenger to her lover, rejected his father completely after his father killed his mother, and then made his placement in the home of his father's sister untenable, although his younger siblings remained there, formed an attachment to their aunt, and believed her statement that their mother had been at fault, and had brought her death upon herself by her unreasonable and provocative behaviour. Darren was moved to a children's home where he was encouraged in his hatred of his father by his mother's elderly parents. Family therapy aimed at reuniting the children was unsuccessful. (The children were seen alone and together for bereavement counselling and individual psychotherapy over the next 2 years.)

Four out of twelve of the families in our series were referred for bereavement counselling (families 2, 4, 11, and 12) because of complicated grief reactions. In several other cases, referral was made for advice on placement (see below), but bereavement counselling was recommended and instituted (see Table II).

**Care, custody and access**

Advice on placement of these children was the most common reason for referral in our series, being the primary reason for referral in 7 of 14 families (families 1, 2, 3, 4, 6, 7, and 12).

In 6 of the 14 families, the children were placed with relatives, in two (families 2 and 12), with father's kin, and in four [families 4 (third child), 5, 10, and 14], with mother's kin. This may underrepresent kin placements, as both the DHSS and the Law Society's College of Law (personal communications) believed that they were the most common in these circumstances. Such placements may be complicated and put the children in a difficult position, given the loyalties involved in these fraught situations. The advantages of the availability of relatives as familiar figures after such a traumatic separation from their parents need to be weighed against the disadvantages. We do not think that such placements should be the *automatic* first choice, or that *ad hoc* arrangements with relatives should become permanent without careful consideration and planning.

There may be a presumption that because of their familiarity, relatives are most able to be supportive to these children at this time. However, it needs to be recognised that relatives are usually preoccupied with their own emotional responses to the killing of someone very close to them, and so may be emotionally unavailable to the children. If children are placed with their mother's relatives, the latter may be so hostile to the father that they discourage or deny reasonable access of the children to him, as happened in our case 5. If the children are placed with father's kin, these relatives may seek to protect the character of the father and do so at the expense of the character of the children's mother (e.g. she may be blamed for provoking the father's assault), as was the case in families 2 and 12. Furthermore, especially if the father receives a short sentence, his relatives, if they have care and control of the children, might wish to keep the child for him until he is released, and not encourage as wholehearted an attachment as the child might form and benefit from with an adoptive parent. This may be deleterious to the child (Harris, 1985). We encountered this in relation to families 2 and 12. In both these cases, in which the children were returned to their father's care on his release, serious problems arose.

> (Family 2) Bonny (aged 5) and Carl (aged 9) had found a place in their aunt and uncle's family. Bonny especially was very attached to her aunt and referred to her as 'mother'. In anticipation of their father's release, the aunt and uncle had built on an extra room to accommodate him so that they could all live together and not disrupt the bonds in the 'new' family. One week after release, the father quarrelled violently with his sister over her way of bringing up his children, took both children, and went to live independently, with apparent disregard for the bonds which had been formed. The children were made to suffer yet another traumatic loss. The father refused all contact, and the family were lost to follow-up investigation.

### A note on the law in England and Wales

Where the child's parents (or guardians) are prevented by circumstances from properly caring for the child, the local authority (social services) is obliged to receive the child into care under Section 2 of the Child Care Act, 1980. This is voluntary care, and a father can remove the child from care if he so wishes. If the local authority wanted to prevent this (if in their judgement the arrangements the father planned for the child were not in the child's best interests) they would have to apply for full parental rights under Section 3 of the above act, and would have to satisfy its stringent statutory criteria. If these could not be satisfied, wardship could be applied for. Similarly, if an application for compulsory care under Section 1 of the Children and Young Person's Act of 1969 were to fail, wardship of the children might be granted, to allow independent evaluation of their needs. If the child is made a ward of court, all matters relating to the child's welfare have to be argued before a judge of the Family Division of the High Court, and the child's needs are regarded as paramount. At present, there is no consistency of practice regarding care proceedings for those children whose fathers have killed their mothers.

In families 1 and 3, a decision was taken to free the children for adoption (Adcock & White, 1984) against the father's will. In case 1, the child was fostered by foster parents of a different ethnic background for 3 years prior to their father murdering their mother. The father opposed the application for adoption on racial grounds, and the referral was made for an opinion about where the child's best interests lay. In view of the child's firm attachment to her foster parents and the length of the father's sentence a 'freeing for adoption' recommendation was made. In family 3, the decision to free for adoption was taken because there had been little contact between the children and their father in the 3 years preceding the murder of their mother, their mother and father having separated.

### Access

This was an issue in 5 out of the 14 cases (2, 3, 8, 9, and 11). It was the reason for consultation in cases 8 and 9. In these cases, as well as in 2 and 3, the father had requested access to his children. In each case, these children were adamant that they did not wish to see their father. They had a clear understanding of the events that led to their mother's death and their father's imprisonment, and they could explain their refusal to see their respective fathers. The children's wishes were therefore respected. The principle was applied that access was the right of the child, and the child's wishes should be taken into account, giving due consideration to his age and understanding.

In certain circumstances, planned and supervised access might be beneficial. For example, if the children were worried that their father was dead, or regarded the absent father as a terrifying and vengeful figure, access might turn the father back into an actual human being, comprehensible to the child. Of course, in these cases, if children are encouraged to see their father, their fears need to be considered prior to such a meeting.

In some older children, a pre-existing bond with their father is not threatened by the death of their mother, which may have occurred as an almost accidental escalation of the habitual marital violence which the children had grown to accept. In some cases, the children might benefit by regular access to their father, who may successfully resume custody after serving a short sentence.

## Recommendations for practice

### Intervention of the child psychiatry team

All children who are deprived of two parents suddenly by one killing the other should be seen in a child psychiatric department for crisis intervention to minimise post-traumatic stress, and for bereavement counselling by experienced and expert professionals. This work should be done in association with the social worker, who can help to construct a life-story book and help them by revisiting their home, school, mother's grave, etc. We believe a child psychiatric team should be involved in every case – the rarity and complexity of these events requires the most expert advice and intervention available.

### Care and control

In every case, wardship or full care orders should be sought until arrangements for permanent placement are completed.

### Placement

Children should not be placed automatically with relatives, and placement with relatives, made as an *ad hoc* arrangement, should become permanent not by default, but only after careful consideration and planning. Permanency planning should not necessarily be delayed pending the outcome of the father's trial, and the children should be freed for adoption if they would be grown up by the time father is released, or if they are too young to have a memory of, and relationship with, their father, or for other reasons, such as his likely incapacity to care for them after release.

### Access

Access is the right of the child. This should be the guiding principle. In some cases, visiting the father in prison may be therapeutic.

### Central information sources

Because these events are rare and complicated, we believe that a central information source should be

established, which may be national or regional: to provide advice so that cases can be dealt with optimally; and to collect and collate information systematically, to expand knowledge, evaluate practice, improve intervention and management, and put decision-making on a firmer footing.

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