# Father Kills Mother: Post-Traumatic Stress Disorder in the Children

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## Introduction

Children whose father kills their mother are orphaned by this act. Not only are they deprived of their mother by the catastrophe of her death, but also their father is suddenly absent, taken away to jail, or in a mental hospital, on the run or dead by his own hand. These are the children of a woman who dies a violent death and the children of the killer.

For child psychiatry teams these are difficult cases, and few individuals will have experience of working with more than one or two such families in a professional lifetime. As a result of the senior author's (DB's) interest in bereaved children, many were referred in the first place for help with bereavement issues and we found ourselves with a uniquely large series of cases. We published our first paper in 1988[1] and consequently were referred many more. To date we have seen personally 76 children and their caretakers, occasionally their jailed fathers, plus social workers, probation officers, grandparents etc. We have also seen four children whose mothers killed their fathers. We have information on 41 more cases whom we have not seen.

We estimate that in England and Wales, there are likely to be about 50 families a year, involving between 100 and 150 children who are affected. The plight of these children cannot be exaggerated. They are often witness to the killing, may be left alone with the dead body of their mother, may have to summon help or attempt to defend her. They may witness their father's subsequent suicide or defection, may be the only source of information for the police and social services who have to find relatives to care for them. They may have to give statements to the police about what happened and later act as witnesses in court. They often lose, at one blow, their parents, their home, their toys, clothes and possessions, their friends, their school, their neighbours and even their siblings if, as is often the case with large families, different relatives each take one or two of the children.

What is even more important is that they lose their self-esteem. To be the child of a killer is not an enviable role. It cannot long be hidden, although the children we have seen, if they were not present at the killing (and sometimes even if they were), are the last to be told what happened to their parents. They and their carers may need professional advice and help with mourning and with the psychiatric sequelae that commonly develop. Where children should live and with whom, whether they should attend the funeral, see their father in prison, see the dead body of their mother are questions which require consideration and discussion. Some case examples may help to illustrate these points.

### Case 1

Diana, aged six, was the only child of separated, middle-class parents. After an access visit, father shot mother at point-blank range and then rushed out of the house and committed suicide by crashing his car. Diana was left alone with the dead body of her mother. She tried to telephone the police, using the emergency number she had learned. Unfortunately she could not get through. At some time she must have fallen asleep and in the morning she tried again with success. The police came and were able to find a neighbour to look after her. No one in the neighbourhood knew where relatives lived but after a few days they were located in a city two hundred miles away. The elderly paternal grandparents took Diana to their home but found her too much of a handful. Mother's parents were also elderly and could not have her. DB was consulted by the grandparents one week after the death. Diana was seemingly unconcerned about recent events until invited to draw a picture.

She drew a man holding a gun, larger than the father himself, and the dead mother. Diana said when drawing her, 'I can only draw a sad face, I can't draw a happy one'. Then she depicted the car crash of father. She said she had poured lemonade on mother to revive her and at this point began to sob uncontrollably, the first tears that her grandparents had seen since the death. They had, like most caretakers, avoided reminders of the parents and the tragedy and had given the child no opportunity to tell the story or to try to make sense of what had happened. This is a common finding.

### Case 2

Maria was four when her father stabbed her mother who had announced her intention to leave him. Father then left the house and threw himself under a bus but survived, badly hurt. Maria was alone all night with the body. When seen by us a few days later she was living with mother's parents who found her difficult to manage and had not yet discussed the death with her. Maria could only talk about 'red water', presumably a reference to the blood she had seen. The grandparents and social worker asked us to help find out what Maria had experienced and to help explain what had happened. Using large dolls, we helped her aunt and grandparents tell her that her parents had had a big fight, and that daddy had hurt mummy with a knife. She had had to go to hospital but the doctors had not been able to make her better and she had died. We helped them to talk about what it meant for someone to die. That it was irreversible and that people looked different and could not talk or move, or eat any more. We arranged for her to see her dead mother with her aunt and our child psychiatric nurse, and to attend the funeral. We have seen her regularly since and have advised on placement. She has begun to talk about her knowledge of the knife hidden in the parents' room, her guilt at having told father about mother's lover and her desire for father to say he is sorry for what happened. She has visited her jailed father.

### Case 3

Harry, aged six, was referred with his two older sisters by social services for advice about access to father. Harry was invited to draw a picture. We were told by his uncle, with whom he had lived since his mother was killed by his father, that Harry did not know how mother died or where father was. Harry's picture indicates that he knew and may have witnessed the events, as what he depicts was the truth. He shows the three children asleep in bed when his father hit his mother with an axe. Then his mother falls dead with blood around her shoulders. It also shows his reluctance to leave his own house for his uncle's (he has no legs and no face in the drawing) and it indicates that he has thought about visiting his father in jail.

There are many issues that arise in dealing with these cases of personal, as opposed to mass, disaster, some of which we have dealt with elsewhere[2]. In this paper we concentrate on two main issues, post-traumatic stress disorder (PTSD), and immediate manage-

ment with consideration of preventive interventions.

**Post-Traumatic Stress Disorder**

There has been much controversy about this concept in adults and even more in children. Garmezey and Rutter[3], summarising published studies on children and disaster concluded that in the majority of children exposed to severe stress, disturbances are short lived and a specific diagnostic category of PTSD is not needed for children. However, the literature surveyed did not include children experiencing a major disaster and Yule and Williams's[4] study of the child survivors of the ferry disaster in the English Channel led them to conclude that children do show intense and long-lasting behavioural disturbances in major disaster and that amnesia, intrusive thoughts and flashbacks can occur in quite young children. Terr[5], when she described at a conference her findings in the children kidnapped in the Chowchilla bus, was ridiculed and denigrated. Benedek[6], describing this scene, concluded that 'the audience's response of disbelief, in the face of carefully collected documentation, might have been so intense because it was difficult for professionals to accept that traumatic events caused by fellow humans in the lives of children might colour and shape their lives for years to come'. Sugar[7] in his review concludes that most children have psychopathological reactions to disasters and these conclusions are echoed by Yule and by Parry-Jones (unpublished data) in his study of the child survivors of Lockerbie. The change has come when the children themselves have been examined by child experts, rather than relying on adults', especially parents' reports. It is probable that the massive scale of the trauma and loss for the children overwhelms adults and makes them employ denial to protect the children and themselves. Terr[8] provides a comprehensive overview which indicates generally increased acceptance of this diagnostic concept.

We find that, in the cases we are describing, a mechanism of being appalled at the scale of the trauma to the children is active not only in the relatives but in the professionals who previously may not have come across such an event. An assessment of the presence and severity of PTSD needs to be made in every case, since, given the violence these children witness, it is likely that many will develop the syndrome. In our sample, nearly half the children had been present at the killing. Most of those present had symptoms of PTSD, whereas it was not found in those who were absent from home at the time of the killing. PTSD in children is discussed by Pynoos et al[9]. They define PTSD in children following DSM III[10], as follows:

- occurrence of a distressing, traumatic event
- repetitive re-experiencing of the event in play, dreams, instrusive images and sounds
- psychic numbing or affective constriction
- incident-specific phenomena that were previously not present (startle reactions, avoidant behaviour, sleep disturbances, etc).

DSM III R[11] substantially is similar but allows formal diagnosis of PTSD only after one month subsequent to the traumatic event.

In those children who are traumatised by witnessing the killing, normal grieving may be inhibited[12] and other factors may also inhibit this process. The child may feel compelled to remain silent because of shame or because he may wish to protect others from the intense feelings of horror, rage, sadness and powerlessness which his story may provoke. This suppression is particularly likely if his carers are kin, since they will be more emotionally affected by the child's account. The child may learn from the carers that it is wrong to talk about what he knows or that it is in some way dangerous. We know that mourning cannot begin until death is made real. Part of the assessment must be to ascertain what the child has been told, and what he knows (which may be quite different), and at what stage of understanding about the permanence of death he has reached. We know from the work of Lansdown and Benjamin[13], amongst others, that even young children can have a good understanding of the main components of the concept of death.

Relatives are more likely than unrelated carers to decide not to tell the children the true nature of their parent's death. Of the children who were not told, 70 per cent were living with kin. Without this knowledge the children will have difficulty in understanding their changed circumstances and the reactions of those around them and may not be able to effectively mourn their losses.

**Identifying psychiatric disorder**

Other disorders are common. Excluding PTSD, we found over half the children had one or more other psychiatric problems, and only 10 per cent had no problems at all.

**Placement, custody and access**

Placement after the death is very problematic. Half the children went to kin but many of these placements broke down, because of the grief of the relatives, or because of the pressures heaped upon the children by the relatives' antagonism for the other side. If the children go to maternal relatives they rarely see their father and their fantasies about his power and capacity for evil may become very frightening. If they go to father's relatives, the relatives see it as their duty to justify father's actions. The mother is often reviled and denigrated. The implication often is that she brought her killing on herself. Paternal relatives may also keep the child for father on his release, consequently making it difficult for him or her to form a permanent attachment. Brinich[14] has suggested that when relatives become parents by default the dynamics of the relationship often are different from voluntary assumption of parenthood. Involuntary parents both over-protect and subtly reject their foster-child.

**Management and treatment**

Clinical experience has shown that crisis intervention limits the severity of post-traumatic stress symptoms[1, 8, 15-17] although this needs confirmation by controlled trials. This approach depends on helping the child to recount the traumatic events and his feelings and integrate them in as comprehensive a way as possible. When we see the children soon after the killing, in addition to individual assessment, we involve the child or children in sibling/group therapy. This is a modified form of family therapy, in which the caretaker may be included or may have separate counselling depending on the relationship and the issues identified at assessment. Unrelated foster-parents appreciate help with management. Maternal relatives may need, in addition, help with their own mourning, and work on their anger and resentment. Their own children may have to make many adaptations to accommodate the needy bereaved children and some family therapy is useful. Much of our therapeutic work is at a cognitive level, helping the child to understand what has been experienced.

This work is very difficult and can be exhausting. In our experience, prevention or amelioration of post-traumatic stress symptoms is possible if the children are seen early. We have found that children are very willing to tell us what happend and indeed are relieved that someone wishes to know. Often this leads to a compulsive repetition of the events which caretakers find embarrassing. It may be neces-

sary to repeat this work over time, according to each child's age and understanding, an additional burden for adult carers who must work through their own grief.

### Case 4

Two girls aged three and five were present at their mother's killing. The older one developed asthma subsequently, which dramatically came on when painting a picture of a rainbow at the seventh therapeutic session. The therapist recognised that the asthma which accompanied her attempts was the sound the girl had heard as her mother attempted to take in air with a cut throat. The child's symptoms were relieved by interpretation.

### Case 5

Larry, aged five had night terrors every night following the death of his father at his mother's hands when both were drunk. He had witnessed the killing and had stayed all night with mother and the body of his father until mother, sober the next morning, gave herself up to the police after taking Larry to her sister's. Using the technique described by Lask[18] of waking the child just before the night terror usually began, he was cured within a few days. He is having psychotherapy to help him with his grief and other symptoms, and the maternal aunt values the help given. Thus, timely interpretation and relevant behavioural techniques can relieve symptoms and facilitate longer term interventions. Early intervention is economic and effective.

### Principles for practice

As a result of our experience with these troubled children we have formulated the following recommendations.

### Immediately after the killing

1. Placement should be with familiar people, who will need immediate advice and support.
2. Custody decisions are required at once. Preferably the State should act as parent while plans are formulated. The children may require independent legal representation and advocacy.
3. Primary health care services should be alerted about the children and early consultations sought from child mental health services with particular reference to assessment of PTSD and the need for crisis intervention or other treatment. Expert advice should be sought regarding the planning of access to father and key relatives, the desirability of seeing the body and of attending the funeral.

### In the longer term

1. Permanent placement planning should begin as soon as possible and should certainly not be delayed pending the outcome of father's trial. The emergency placement should not become permanent by default.
2. The decisions about access and custody must be guided by the principle of the child's best interests. In particular the right of the child to have contact with father must be borne in mind. We recommend that the child should see the father at least once in prison to reduce the likelihood of frightening fantasies about his power.
3. Therapeutic help should be available as needed. Crisis intervention and bereavement counselling are likely to be needed by all children who witnessed the killing.
4. Decisions about whether the children are fit to give witness in court at their father's trial must be made by experts. If it is essential that the child does so, he must be supported by someone experienced in anticipating what problems may arise and preparing the child for the experience. The child will probably need post-trial counselling.
5. Consideration must be given to obtaining compensation for the children where appropriate, safeguarding their inheritance, obtaining maintenance from their father, or the State, and to protecting them from family conflict and pressures to side with maternal or paternal relatives. This may mean removing them from a placement with kin if antagonism is harming them.
6. Long-term studies are needed to ascertain what happens to these children, especially when they are returned to their father, and when they grow up. Comparative studies of different treatments are needed.


**References**

1. Black D, Kaplan T. Father kills mother. Issues and problems encountered by a child psychiatric team. *Br J Psychiatry* 1988; **153:** 624-630.
2. Black D, Kaplan T, Harris Hendriks J. Father kills mother: effects on the children. In Wilson J, Raphael B (eds). International Handbook of Traumatic Stress Syndromes. New York: Plenum Press, 1992.
3. Garmezey N, Rutter M. Acute reactions to stress. In Rutter M, Hersov L (eds). Child and Adolescent Psychiatry: Modern Approaches. Oxford: Blackwell, 1985.
4. Yule W, Williams R. Post-traumatic stress reactions in children. *J Trauma Stress* 1990; **3:** 279-295.
5. Terr LC. Children Traumatised in Small Groups. In Eth S, Pynoos RS (eds). Post-Traumatic Stress Disorder in Children. Washington: APA, 1985, pp 45-70.
6. Benedek EP. Children and psychic trauma: a brief review of contemporary thinking. In Eth S, Pynoos RS (eds). Post-Traumatic Stress Disorder in Children. Washington: APA, 1985, pp 1-17.
7. Sugar M. Children in a disaster: an overview. *Child Psychiatry Hum Dev* 1989; **19:** 163-179.
8. Terr LC. Childhood traumas—an outline and overview. *Am J Psychiatry* 1991; **148:** 10-20.
9. Pynoos RS, Frederick C, Nader K, Arroyo W, et al. Life threat and post-traumatic stress in school-age children. Annual Meeting of the American Psychiatric Association, 1985, Dallas, Texas. *Arch Gen Psychiatry* 1987; **44:** 1057-1063.
10. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Washington: APA, 1980.
11. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Washington: APA, 1987.
12. Eth S, Pynoos RS. Interaction of trauma and grief in childhood. In Eth S, Pynoos RS (eds). Post-Traumatic Stress Disorder in Children. Washington: APA, 1985, pp 169-186.
13. Lansdown R, Benjamin G. The development of the concept of death in children aged 5-9 years. *Child Care Health Dev* 1985; **11:** 13-20.
14. Brinich PM. Love and anger in relatives who 'adopt' orphaned children: parents by default. *Bereavement Care* 1989; **8:** 14-16.
15. Pynoos RS; Eth S. Witness to violence: the child interview. *J Am Acad Child Psychiatry* 1986; **25:** 306-319.
16. Ayalon O. Coping with terrorism. In Herchenbaum D, Jememki ME (eds). Stress Reduction and Prevention. New York: Plenum Press, 1983.
17. Yule W. The effects of disasters on children. *Assoc Child Psychol Psychiatry* 1989; **11:** 3-6.
18. Lask B. Novel and non-toxic treatment for night terror. *Br Med J* 1988; **297:** 592.


# REVIEWS

(Continued from page 8)

## PERSPECTIVES ON DEATH AND DYING
## A. S. Berger et al (eds). Philadelphia, USA: Charles Press, 1989. £12.50 pb.*

This book has grown out of a co-operative venture undertaken by the Institute for the Study of Death and the Foundation of Thanatology in America. A variety of perspectives on death and afterlife are described, ranging from African, Islamic, Chinese and Indian, to Jungian psychology and 'near death experience' writings. Each section covers the belief system of the particular group being studied as well as the practical issues that arise as someone approaches death. One of the problems of this type of publication is that the reader may be tempted to assume that every person who describes themselves as Islamic or Hindu or Buddhist is necessarily going to be an equally strict adherent to that particular belief system. However in the chapter entitled 'The Good Death', the authors show how death, dying and bereavement are approached by British Hindus, and it is clear that the underlying belief system is modified by the culture within which people find themselves. It would have been helpful, therefore, to have had a section or chapter which defined the word 'culture' and its relationship to the individuals who live and move within that culture and other cultures.

I was also surprised to see that there was no chapter describing the approach within Judaism or Christianity, (although in Chapter 18, entitled 'Does religion need immortality', Christian tradition is clearly addressed in relation to views on life after death). If this book is to address cross-cultural views, as its title suggests, then it would have been helpful to have both the Jewish and Christian perspectives explained so that those of other traditions might have a clearer picture of what these two groups believe.

The final section of the book looks at paranormal experiences and the phenomenon usually described as 'near death experience'. It is suggested in the conclusion to this chapter that the insights gained in the 'near death experience' can possibly enrich the understanding of people who are working in other fields of study relating to death.

Whilst this book is not exactly bedtime reading, it is a useful resource book for those who wish to have more information about the background of some of the people from cultures other than their own. It is however, important to remember that each individual, irrespective of cultural or religious label, may not necessarily conform to the broad description that is given in any particular book.

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## THE FACTS OF DEATH
## Michael Farrell. London: Robert Hale, 1991. £7.95 pb.

A comprehensive, detailed and informative guide to the practical matters which need to be dealt with after a death. Divided into chapters with specific headings, it is well laid out and can be dipped into as necessary.