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A TRANSCULTURAL FORENSIC PSYCHIATRIC PERSPECTIVE OF A MOTHER WHO KILLED HER CHILDREN

J. Arturo Silva, M.D., Gregory B. Leong, M.D., Joe Yamamoto, M.D.,
Robert Weinstock, M.D., and Michelle M. Ferrari, M.D.

Parents who kill their children constitute a phenomenon recorded throughout human history. In recent years this problem has become an area of increasing concern in many countries and cultural settings. In this article we present the case of a Japanese woman who killed her two children. We analyze the case from both a traditional psychiatric-legal perspective and a psychosociocultural perspective utilizing the model of the cultural formulation as recently delineated in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). The latter approach may provide a more comprehensive matrix by which to understand cases with prominent transcultural factors.

Parental child killing behavior continues to be a focus of intense attention by both the scientific and public communities (1-5). The problem has attracted both local and international study (6, 7), with much discussion aimed especially at developing preventive measures. Development of a system for the comprehensive analysis of this behavior merits attention as a starting point to address the multiplicity of issues raised by the problem. Given that parental child killing behavior is a worldwide phenomenon and that it occurs across all major ethnic groups in the United States, the most appropriate analysis of this behavior requires that the parent be evaluated from both an individual and a biopsychosociocultural perspective (8, 9).

This article has four parts. First, we present the case of a Japanese woman who killed her two children. This case received notoriety in both the legal and media arenas, especially because cultural factors were a significant focus in the courtroom and in newsprint (10-12). Second, we provide an overview of the different classification schemas that have been proposed for parental child killing behaviors from a psychiatric perspec-

tive. Third, we classify the case by using a modified method of Resnick's classification for parental child killing behaviors (13, 14). Fourth, we analyze the case from a biopsychosociocultural perspective (9, 15) and illustrate the use of the cultural formulation of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV; 16) as a tool to facilitate the psychosociocultural analysis of the index case.

CASE REPORT

Mrs. K, a 32-year-old Asian female, was born and raised in Japan by her natural parents. She immigrated to the United States at age 18 to further her education. It was during this experience that she developed functional English language skills. She met Mr. D, a third-generation Japanese-American male, when she was 22 and married him soon thereafter. Her mother disapproved of the union because she deemed him irresponsible. The marriage only lasted two years. Although Mrs. K's mother disapproved of the marriage, she also opposed the subsequent divorce. Mrs. K's mother had given Mrs. K the impression that the divorce had disgraced not only Mrs. K, but also the entire family. As a result, once during a heated argument, her mother had stated, "You are not my daughter, I'm not your mother." Mrs. K continued to have interpersonal difficulties with her mother after that.

After the divorce of Mrs. K's parents when she was five years old, Mrs. K was raised by her mother. She seldom spent time with her father. Moreover, Mrs. K recalls that during the little time they spent together, her father emotionally rejected her as demonstrated by his reluctant public acknowledgment that she was his daughter. Mrs. K, at age 28, remarried a Japanese national who was living and working in the United States. Her mother was more agreeable to the second marriage because her new son-in-law was from Japan and had a stable work situation. They had two children, a son and daughter, who were age four years and six months, respectively, at the time of their deaths. Mrs. K and her second husband, Mr. B, began to have marital difficulties that worsened after discovery of her husband's infidelity. Upon learning of the infidelity, she initially had rela-

tively little emotional response. However, she eventually became markedly despondent and subsequently delusional.

At age 32, when Mrs. K became clinically depressed, she also developed the delusional thought that her mother and father were not her biological parents and referred to them as adoptive parents. She also began to experience paranoid thinking, believing that the whole world detested her and her two children. She also believed that people wanted to sexually abuse her and the children. These thoughts led to the conviction that if she were to die, her children would remain at the mercy of others who would make her children suffer. These delusions as well as her feelings of hopelessness and helplessness had a crucial role in her decision to kill her children. Mrs. K also had stated that she had learned from her upbringing in Japan to be responsible for her children. Mrs. K also experienced delusions that her physician and the nurse who worked in the physician's office were not bonafide health care providers but impostors who were part of a plot aimed at taking children from their parents and placing them for adoption. She believed that her visit to her physician had all been staged as a part of a plot to harm her. A neighbor who had seen her during this time had mentioned that her speech appeared to be incomprehensible. She also was experiencing insomnia. No acute medical problems were present. Concerning her past history there was no evidence that she had experienced a major depressive episode or other major mental disorder prior to her current symptomatology. Mrs. K denied any history of substance abuse. She had no history of major medical problems. There was no family history of mental disorders.

Mrs. K met DSM-III (the diagnostic standard at the time of the index evaluation) diagnostic criteria for major depressive episode with psychotic features (17). Using the available information, the case of Mrs. K would qualify for the following DSM-IV diagnoses:

Axis I (clinical disorder)

1. Major depressive disorder, single episode, psychotic

Axis II (personality disorder)

1. No diagnosis

Axis III (general medical conditions)

1. No diagnosis

Axis IV (psychosocial and environmental problems)

1. Problems with primary support groups
2. Problems associated with recent migrant status
3. Problems related to interaction with legal system

Axis V (level of functioning)

Highest past year, GAF = 75

Around the time of the homicides and suicide attempt, GAF = 5

Mrs. K's perception of extreme hopelessness led to her decision that suicide was the only solution to her predicament. Because she could not depend on anybody to care for her children and having viewed them as totally dependent on her, she also included her children in her maladaptive plans to resolve her problems. In this state of mind, she walked to the beach holding her infant daughter in her arms and holding her son's hand. She then walked into the ocean. Shortly thereafter both Mrs. K and her children received cardiopulmonary resuscitation, but only she could be revived. She later stated that the purpose of the walk was not to commit suicide or kill the children but to achieve a state of peace by entering the water. Mrs. K was charged with two counts of murder and two counts of felony child endangerment. A plea bargain was eventually worked out between the prosecution and her attorneys and she pled no contest to two counts of voluntary manslaughter. She was sentenced to one year in the local county jail and five years probation. If she had been convicted of the charged crimes and "special circumstances" had been found, she could have faced the death penalty.

DISCUSSION

The Psychiatric-Legal Perspective

Just over two decades ago, Resnick proposed a system for classifying parents who kill their children (13, 14). He provided five categories primarily based on motive: 1) "altruistic" filicide, 2) acutely psychotic filicide, 3) "unwanted" child filicide, 4) accidental filicide, and 5) spouse revenge filicide (13). Although his classification schema included diagnostic and developmental components, his focus was on motivational factors. In 1973 Scott called attention to the factors other than those associated with conscious individual motivations of the perpetrator. He therefore proposed to incorporate child killing categories not only by focusing on the perpetrator but also from victim-related factors (18). An example of this would be a child with physical ailments and irritability who in turn places additional stress and strain far beyond that of dealing with a healthy child, particularly in the case of a psychologically vulnerable mother with a limited support system. In 1979 d'Orban studied 89 women charged with murder or attempted murder of their children and proposed a categorization scheme that essentially incorporated Resnick's and Scott's classifications (19). Then in 1990 Bouget and Bradford recognized that cases of child killing behavior may not necessarily fall into a single causal category but have multiple etiologies (20). Resnick himself was aware that his proposed categories could overlap and had stated "when overlapping occurred in the proposed groups, each case was classified by the single most important motive" (13; 329).

In the present case we have taken into account that more than one motivational category may be significant in assessing motives of parental child killing behavior. Therefore, we analyzed the case of Mrs. K as a function of the two motivational categories applicable to her. Because, the more prominent causative factor in her case was the presence of a mental disorder, namely major depressive episode with psychotic features (16, 17), the primary "motivational" category was acutely psychotic filicide. Perhaps the most significant feature of her depression was her delusional

thinking. Mrs. K delusionally believed that she was the adopted daughter of her objective biological parents and therefore became inhibited about even considering to ask her mother for assistance. This situation further increased her sense of isolation. Mrs. K also experienced paranoid delusions in which she believed that people, overall, did not like her, and that they wanted to sexually attack her and her children. Her delusional state caused her to avoid people in general, thus resulting in her isolation. Her delusional beliefs enhanced her impression that there was no one from whom to seek help.

At times some of Mrs. K's delusions were suggestive of delusional misidentification. In these delusions the affected individual may believe that the physical and/or psychological identity of others may change radically resulting in new personal identities (21,22) This was evident when she sought help but concluded that the nurse and the physician were not health care professionals but impostors involved in a plot to harm her. In the past she had identified these health professionals as authentic. She came to believe that the physician and nurse were involved in a plot to take away children from their parents and give them away in adoptions. This delusion, in essence, eventually precluded her from asking for medical assistance for either herself or her children. Her paranoia and the subsequent isolation further fueled her feelings of hopelessness and helplessness that eventually convinced her that suicide and homicide were the only viable solutions.

Mrs. K believed that she and her children were disliked and endangered. This effectively eliminated the possibility that others could care for her children if she were to die. Her impaired judgment resulted in her inability to develop potentially reasonable solutions to her dilemmas and contributed to formulating her resolve to include her children in her own death wish.

The second motivational factor utilizing Resnick's categorization in Mrs. K's case was "altruism." Although her wish to not leave her children in the care of others was kindled by psychotic thinking, this choice does

not invalidate having killed her children to protect them from putative potential harm by others. Her motivation for killing her children was not due to maliciousness, but psychotically distorted altruism.

The classification of parental child killing behavior cannot usually be solely ascribed to a single or even multiple motives because motivation alone cannot accurately describe the rich contextual process encompassing parental child killing behavior. Specifically, a combination of conscious and unconscious thoughts and behaviors surrounding the homicidal act usually appears to be operating (18). Moreover, causative factors relevant to homicidal behaviors are not limited to the confinements of the perpetrator's mind and body but may also be influenced by contextual variables such as culture, socioeconomic status, geographical factors and even factors that may best be appreciated from psychohistorical points of reference. The case of Mrs. K can therefore be most comprehensively understood and analyzed from a version of Engel's biopsychosocial approach (15), the biopsychosociocultural viewpoint, in which the cultural contribution receives a major emphasis in the analysis (8, 9).

The Psychosociocultural Perspective

The current psychiatric diagnostic system in use in the United States, the DSM-IV, incorporates the use of psychosociocultural assessment in its cultural formulation outline. Mezzich describes the outline as "an idiographic statement intending to supplement standardized diagnostic ratings with a narrative description of the cultural framework of the patient's identity, illness, and social context and of the clinician-patient relationship" (23; 649). The cultural formulation is divided into five parts: cultural identity of the individual, cultural explanation of the individual's illness, cultural factors related to the psychosocial environment and levels of functioning, cultural elements of the relationship between the individual and the clinician and an overall cultural assessment for diagnosis and care. In this section we describe the case of Mrs. K in terms of the cultural formulation outline. Such description, however, should be considered provisional not only because of limitations of knowledge regarding case histo-

ries but also because the application and development of the cultural formulation should be considered as being in its early stages not only in regard to general psychiatric cases but also for cases of Asian Americans (24-28) and for cases involving psychiatric-legal issues. In this article we describe relevant information for each section of the cultural formulation, then a brief discussion equivalent to an overall cultural assessment for that section is provided. A final section discusses cultural and legal interactions relevant to the case.

1) Cultural identity of the individual: Mrs. K's cultural identity was Japanese, consistent with the fact that she had been born and raised in Japan. Her native language was Japanese. She developed conversational English skills as an adult only after residing in the United States. Even when residing in the United States she socialized and married men of Japanese cultural and ethnic background. Moreover, while she lived in the United States, she generally preferred friendships with persons who had a Japanese background. She continued to maintain traditional Japanese values that included strong beliefs in responsibility for the integrity of the family, even at the time when she became psychotically depressed. She interacted with the United States mainstream culture on a daily basis such as when she had worked or attended school. Prior to the onset of her depression she had no difficulty in functioning.

However after she became mentally ill, her delusions in part caused her to distort her need to care for her children to the extent that she believed only she could care well for them. These convictions were further driven by her paranoid delusions that caused her to believe that no one could be trusted and that she could not leave her children to people who hated them. It should also be emphasized that the Japanese culture is characterized by a strong group orientation (29, 30). The integration of the individual into the family, community, and culture are important aspects of this group orientation. However in Mrs. K's case, her depressive delusional condition caused her to experience feelings of hopelessness which in turn reinforced her belief that she no longer belonged to a network that

could assist her in successfully facing her life problems. To some extent her hopelessness was reality based because her estranged husband objectively no longer provided her with needed emotional support. Furthermore, she did not have her family of origin in the United States, although her family relationships, especially that with her mother, had already deteriorated.

2) Cultural explanation of the individual's illness: Mrs. K did not suffer from any psychiatric condition that could be termed a culture-bound syndrome (14). In these syndromes, thoughts, emotions and behaviors are defined as psychopathological from the context of specific cultures (31, 32). However, as previously mentioned, her depressive ideas were interpreted through her cultural lens in which she considered herself responsible for the welfare of her children and the integrity of the family. An additional cultural value was deference to the authority of her husband and her duty to keep her husband satisfied. Thus, after becoming depressed upon learning of her husband's infidelity, rather than expecting her husband to assume responsibility for the consequences of his actions, she internalized the failure of her marriage mostly as a product of her own inadequacy as a wife.

Underlying Mrs. K's delusional belief are the related issues of authenticity and sense of belonging, both of which are important in the Japanese culture. A strong sense of family has been an important foundation of traditional Japanese culture and society (29, 30). The concept of authenticity involves validation as an integral part of the family unit. For Mrs. K the issues of authenticity and belonging led to her general uneasiness about living abroad in the United States. When she became delusional she viewed the world as extremely hostile and became convinced that the surrounding society rejected her and sought to harm her. Moreover, she appeared to have misidentified beneficent health care providers as impostors who plotted to steal her children.

The ultimate way in which Mrs. K tried to resolve her perceived problems was to kill herself and her children. The way in which she con-

ceptualized suicide can also be understood from a cultural perspective. The topic of suicide in Japan has been the object of serious study. The phenomenon may cover many forms that range from relatively passive approaches such as drowning to dramatic forms such as *hara kiri* (self-stabbing) (25, 33, 34). In Mrs. K's case her suicidal behavior is more complex in that she also lethally harmed the children she cherished.

The present case can also be explored as a case within the "murder-suicide" spectrum. Although the term murder-suicide restricts the category, similarities would exist for cases of a more broadly defined group encompassing attempted suicide/suicide coupled with attempted homicide/homicide. In many such cases the sequence of events involves a person who commits homicide followed by suicide usually within a week of the killing (36). The classification of murder-suicide is still in its embryonic stages. Marzuk and colleagues have proposed a classification of murder-suicide based on both victim-offender relationships and causes of action (36). Although in the case of Mrs. K and her children, the perpetrator did not die, the event nevertheless places her close to the spectrum of familial murder-suicide, since she killed her children and seriously attempted to kill herself. Concerning causation, her homicidal-suicidal behavior involved ideas of altruism, mercy killing and interpersonal difficulties with the father of the children (36).

The case of Mrs. K can be better understood by taking into account the nature of her suicide attempt. Suicide attempts have also been classified according to personal psychodynamics and social group orientations (34). One of these types of suicidal behaviors is egoistic suicide. In this type of suicide, the person experiences a dearth of meaningful communication with the social environment along with a concomitant rise of idiosyncratic thoughts, emotions and behaviors. Mrs. K's suicide attempt may be conceptualized as egoistic insofar as her psychotic depressive state caused her to adopt a highly idiosyncratic paranoid view of the world in which she believed that she would be harmed and perhaps even killed. She used projective defenses commonly seen in psychotic states as exemplified by

her projecting her poor self image and self deprecatory feelings and ideas onto others, with the belief that there was a conspiracy against her. Her parents' disapproval of her and their symbolic statements that she was not their daughter were interpreted literally. Her anger at them was expressed as delusional misidentification via the belief that they were inauthentic parental figures who rejected her as a daughter. Her psychotic state insured that there was little meaningful communication between her and society.

Another type of suicide is fatalistic suicide, a behavior that is a function of the individual's a) loss of both group and personal goals, b) strong conformity to society norms, c) strong sense of shame and obligation, d) low degree of self-expression, and e) minimal communication" (34; p. 11-12). According to Iga, this type of suicide is especially important in suicides by the Japanese because it is a reaction to "the ineluctable and inflexible nature of a rule against which there is no appeal" (34; p. 11). In a society such as Japan in which the component power structure is perceived as relatively inflexible and in which there is relatively little room for individual expression and negotiation, then under some circumstances a fatalistic solution consistent with suicide may occur. In Mrs. K's case she not only was affected by paranoia and depression, but also to a certain extent she accurately noted that she had few friends and no husband upon whom she could rely. Moreover, she accurately viewed the United States as a place that was culturally foreign to her and geographically distant from her country and family of origin. Mrs. K also experienced a strong sense of shame for having "failed" as a wife. From her point of view she was in large part responsible for her husband's infidelity. It should be stressed that her belief is not only a function of a psychotically depressed state but also of a culturally congruent process in a Japanese woman who viewed herself as having acquired responsibility for the preservation of marriage. This responsibility is common even in modern day Japan in which women are expected to remain faithful to their husbands regardless of the husbands' extramarital activities. This also is evident in the Japanese legal

system that still does relatively little to protect the rights and welfare of women who experience serious physical and psychological abuse by their spouses (33, 37-39).

It is perhaps from this perspective that we may best understand Mrs. K's combined suicidal and homicidal behavior. It is important to stress that, historically, *oyako shinju* (parent-child suicides) have not been uncommon in Japan. This is consistent with the notion that the child is not only a family member but a parental possession whose welfare is expected to be closely guarded by the mother. Therefore, in the event that a mother decides to end her own life, it is more ethical and merciful to also end the lives of her children rather than leave them to a hostile world. It also would be consistent for her to believe that if her own life was hopeless, so were the lives of her children. In fact mothers who commit suicide without killing their children may be viewed as *oni no yo na hito* or "demonlike person" (34). Therefore, while Mrs. K's homicidal behavior may superficially appear to be a product of her psychotic depression, it should be clear that the killing of her children cannot be divorced from the typical Japanese belief in *oyako shinju*.

3) Cultural factors related to the psychosocial environment and levels of functioning: In this area of the cultural formulation we take into account "culturally relevant interpretations of social stressors, available support systems, and levels of functioning and disability" (16; p. 844). The stressors include those from "the local social environment and the role of religion and kin networks in providing emotional, instrumental and informational support" (16).

The most significant stressor that Mrs. K experienced was marital problems. Although this is a situation that is viewed as a serious stressor in many cultural contexts, we emphasize that the high degree of familial interdependence characteristic of Japanese culture strongly influenced Mrs. K to view her husband's rejection of her as particularly devastating to her self-concept and her world view. This situation was worsened by the fact that she was living in a country and culture foreign to her. In other words,

the consequences of her recent immigrant status constituted a significant stressor. This resulted in Mrs. K not having either the emotional support or geographic proximity of her extended family of origin. Moreover, her residence in the United States insured that she had less at her disposal of a "culturally congruent" framework that she could have readily accessed had she had been living in Japan. Although enclaves of Japanese nationals reside in the United States, their small size makes it difficult for an individual to identify a support system here. Finally, her descent into paranoid thinking that included her parents as well as society foreclosed any last hope of her trying to access support from anyone. The psychotic process essentially deprived her of her sense of membership in her family of origin and in the community-at-large. It should also be emphasized that Mrs. K's relationship with her mother had been an ongoing stressor of at least several years duration. Specifically, Mrs. K's relationship with her mother had been strained when her mother disapproved of her first husband. Even before the onset of her delusional depression, Mrs. K did not believe her mother treated her as a true daughter, and also had similar feelings toward her father. When Mrs. K later became depressed she intensified this maternal estrangement into a delusional belief that she was "adopted."

4) Cultural elements of the relationship between the individual and the clinician: In this section "differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment" (16; p. 844) are explored. After her arrest for the homicides of her children, several psychiatrists interviewed Mrs. K. Two of these psychiatrists provided extensive psychiatric analyses of her mental state at the time of the homicides of her children. From this information, psychiatric-legal opinions were derived, consistent with the position that Mrs. K met California's M'Naghten-like criteria for legal insanity. Two other psychiatrists reached similar conclusions regarding the sanity question. However, they went further in that they also shed light on the nature of combined homicide-suicide states from the context of Japanese culture. They also explored the meaning that Mrs. K's homicidal be-

havior had for her and clarified the nature of the connection between such culturally mediated meanings and her psychopathology. A final point to be made is that one of the evaluating psychiatrists who had performed a detailed cultural evaluation of the case was able to derive such analysis from his extensive experience with the Japanese culture and the fact that he was Japanese American. It is likely that his familiarity with the Japanese culture and his cultural awareness allowed Mrs. K to become more comfortable in providing her history. However, equally important, the other psychiatrist who provided a culturally sensitive approach was not known for such expertise. This psychiatrist's evaluation is therefore illustrative of the fact that a careful psychosociocultural evaluation is possible without experience in a specific culture if the psychiatrist is sensitive to the issue and gathers sufficiently comprehensive information. Regardless of the level of experience with a specific culture, appropriate attention to cultural factors in a forensic setting may not only directly clarify traditional issues such as competency, sanity and diminished capacity (or currently in California, diminished actuality), but may also clarify the special meaning that homicide followed by suicide may have in a given culture and that such actions may also be the product of a psychotic state. It should, however, be stressed that cultural factors alone are not considered to be sufficient for a finding of insanity or diminished capacity. In those who meet criteria for insanity or diminished capacity, cultural factors may make such an opinion more understandable and credible.

Officially, Mrs. K was convicted of two counts of voluntary manslaughter of her two children. She received a sentence involving the lower limits of the range of possible legal sanction which could have been 13 years in state prison. She spent one year in jail and was released on probation. Clearly the major factor involved in the sentencing was her impaired mental state at the time of the homicides. Nonetheless, the cultural aspects of the case were also known to the prosecution and judge, and could have had an impact on the plea bargain offer and lenient sentencing. Therefore, the clarification that a homicidal act may have a deeper moral meaning in

a given society may have some potential for mitigation in the sentencing phase. Alternatively, this use of cultural factors in a legal proceeding may have the opposite effect on the jury (or judge) as they could view such factors as making the defendant appear more blameworthy. Thus, for example, an international terrorist on trial may offer a culturally mediated explanation for his violent actions. However these actions may then be more clearly conceptualized as a cultural invasion of the target country and the terrorist merely as a criminal deserving of legal sanction.

CONCLUSION

The overall cultural assessment for diagnosis and care indicates that the most important cultural issues of the present case involved: 1) attitudes about the roles of men and women, 2) immigrant status as a form of stress, 3) interactions between the nature of psychosis and cultural norms, 4) the nature of murder-suicide, and 5) the role of culturally competent mental health professional in the psychiatric-legal examination.

The case of Mrs. K highlights the biopsychosociocultural approach for the psychiatric evaluation of parents who kill their children. The case also suggests that a truly comprehensive forensic psychiatric evaluation must encompass biological, psychological, social, cultural and ecological as well as the requisite forensic aspects. In particular, a psychiatric-legal evaluation that focuses on motivational as well as other factors within the confines of the organism as a way to understand a crime, at the cost of ignoring psychosociocultural factors that make up a large part of a person's mental state, can yield confusing and incomplete forensic psychiatric assessments. With the introduction of the cultural formulation outline to mainstream psychiatry in DSM-IV, we may see an increasingly important contribution by considering cultural factors in forensic psychiatric assessment. Specifically, the biopsychosociocultural evaluation of parental child killing behavior must include not only carefully designed psychiatric diagnostic or criminologic tools but will necessitate the development of measures such as acculturation scales and stressor scales that take into account factors frequently associated with ethnicity and culture such as re-

cent immigration, racism, ethnocentrism, as well as traumatic experiences, such as war and torture. The cultural formulation of DSM-IV constitutes an improvement in the clinical evaluation of ethnic and cultural minorities in the United States, but should only be considered a starting point along the way to systematize psychiatric and psychosocial problems associated with culture and ethnicity. The development of tools designed to effect a comprehensive biopsychosociocultural evaluation will likely serve as a catalyst for the development of the emerging new subfield that may be best termed "transcultural forensic psychiatry." This area will find wide application in the United States and elsewhere, particularly in clinical mental health practice as well as in the study of violence and other forms of aggression.

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