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Families, Murder, and Insanity: A Psychiatric Review of Paternal Neonaticide

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ABSTRACT: Neonaticide is the killing of a newborn within the first 24 h of life. Although relatively uncommon, numerous cases of maternal neonaticide have been reported. To date, only two cases of paternal neonaticide have appeared in the literature. The authors review neonaticide and present two new case reports of paternal neonaticide. A psychodynamic explanation of paternal neonaticide is formulated. A new definition for neonaticide, more consistent with biological and psychological determinants, is suggested.

KEYWORDS: psychiatry, neonaticide, paternal neonaticide

No event arouses emotions more than the death of an infant. Even harder to explain, or even comprehend, is the death of a newborn at the hands of a parent. Resnick [1] coined the term neonaticide to describe the killing of a child less than 24 h old. Although this tragedy is not uncommon among mothers, it is exceptionally rare among fathers.

This paper reviews the history of neonaticide and the two cases of paternal neonaticide reported to date [2,3]. It also presents two new case reports, one of which is based on extensive interviews conducted by two of the authors (N. K. and N. B.). Finally, an early hypothesis will be postulated to explain this behavior.

History

The earliest reference to filicide (the killing of a child by a parent) is the Biblical story of the near slaying of Isaac by his father Abraham (Genesis 22). Later, in Greek mythology, it is told that Medea killed her two sons after Jason abandoned her for the daughter of the King of Corinth [4], giving us what since has been termed the Medea Complex [5]. Under the Roman Law, *patria potestas*, the right of a father to kill his own children was protected [6,7].

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It was not until the 300s that Christianity, influenced heavily by Judaic law, began to regard filicide as a crime. Still, mothers who killed their infants or newborns received lesser sentences under both the laws of the church and the state than did parents who killed older children [8–11]. The church consistently dealt leniently with those mothers whose children died by “overlying,” an accidental death by smothering when a sleeping parent rolled over on the infant. The opinions of the church in these deaths reflects an awareness of one of society’s first attempts to understand the severe problem of overpopulation and overcrowding [8–11].

England has traditionally viewed infanticide as a “special crime,” passing its first Infanticide Act in 1623 under the Stuarts and more recent versions in the Infanticide Acts of 1922 and 1938 [12,13]. Most recently, England passed the Infanticide Act of 1978, which allows a lesser sentence for attempted infanticide [14].

Unlike England and other European governments, the United States has not adopted special statutes to deal with infanticide or neonaticide. Nonetheless, juries and judges, as reflected in their verdicts and sentences, have consistently considered the difficulties and stresses of a mother during the postpartum period.

Crosscultural Aspects

It is important to recognize that other cultures have developed different attitudes and mores regarding the killing of infants. The Chinese, as late as the 1800s, sacrificed newborn daughters because they were unable to transmit the family name. Daughters were also viewed as weaker and not as useful in time of war or for agricultural work. In the past, Eskimos killed infants with known congenital anomalies and, often, one of a set of twins [15]. Similarly, Mohave Indians used to kill all half breeds at birth [16].

In their 1981 paper, Sakuta and Saito [17] reviewed infanticide in Japan and describe the two distinct types of infanticide commonly seen. The Mabiki type corresponds to the ancient means of “thinning out” or population control; the Anomie type, a product of modern society, corresponds to the “unwanted child.”

Neonaticide Statistics

The United States ranks first in child homicide for children under the age of four years. Forty-five percent of all child murders in the United States occur in the first 24 h of life and thus can be classified as neonaticide [18,19]. For the period 1982 to 1987, approximately 1.1% of all homicides were children under one year of age. Eight to nine percent of *all* murders are of persons under eighteen years of age. Of these, almost twice as many sons as compared to daughters are victims of filicide [19].

In half of the filicide cases, death occurs literally “at the hands of” the parent. Weapons are almost never used in neonaticide. Drowning, strangulation, head trauma, suffocation, and exposure are all common methods [19].

Maternal Neonaticide

Neonaticidal mothers are generally between 16 and 38 years of age, with almost 90% being 25 years of age or younger. Less than 20% are married. Less than 30% are seen as psychotic or depressed [1,12,20,21]. The majority of neonaticidal mothers are unwed, poor, and have denied or concealed the pregnancy, or both, since conception. They frequently give birth alone and dispose of the baby as if it were an abortion that occurred “too late.”

Paternal Neonaticide

Unlike maternal neonaticide, there are very few cases of paternal neonaticide in the literature. Thus, any statement of the demographics of paternal neonaticide would be both meaningless and misleading, based on too small a caseload to reach statistically significant conclusions. In preparing for his 1970 paper on neonaticide, Resnick [22] reviewed the world literature from 1751 to 1968 and reported only two cases. The authors updated the literature review, contacted twenty metropolitan medical examiner's offices and found the two additional cases (Cases 3 and 4) reported below. Since the original two cases (1 and 2) are rather brief, they will be reproduced for the sake of a thorough review.

Case Reports

Case 1

J. S., born 1879, with positive heredity of mental deficiency, on July 15, 1911, poisoned his new-born child because he felt that his own poor health might result in his death leaving no one to provide for his wife and child. Psychiatric examination revealed no evidence of mental disease, but the presence of mental deficiency. He was considered responsible for the deed and later sentenced to ten years in the penitentiary. On May 1, 1915, having served three years two months, he was released on probation. At no time during his penitentiary residence nor subsequently has he shown any symptoms of schizophrenia [2].

Case 2

A bright 26 year old man was forced into marriage by his wife's pregnancy. He saw the coming child as a bar to his ambition. On one occasion he put poison in his wife's soup hoping that the infant would spontaneously abort or be stillborn. He strangled the infant while delivering it himself. Although free of overt psychosis at the time, he developed a clinical picture of full blown schizophrenia three years later. He too was sentenced to ten years in prison [3].

Case 3

H. was 35 years old when he killed his 5-h-old son in front of the baby's mother (his girlfriend) and a nurse, in a hospital room, by stabbing him repeatedly with a hunting knife. H. had planned this and went to the hospital expressly for the purpose of disposing of this unwanted infant.

H. was born in 1946 to a rural wealthy family from the Northeast. His birth was reported as being normal and atraumatic. There are no materials to suggest any difficulties in early life or as a youngster. His mother admits that she never wanted children and had children only to please her husband.

After attending three different private high schools, H. graduated and moved to New York City, where he studied drafting at an architecture school. He claims to be an excellent draftsman and in fact designed and built two houses when he was eighteen to twenty years of age. He reports that the freedom and independence of being a taxi-cab driver, which he was for about ten years, made that his favorite employment.

However, during this period of his life he was not very socially involved and drank heavily alone to "shut out the rest of the world." He claims that in his early twenties his drinking ceased to be a problem and that he cut down significantly. At age 22 he impregnated a woman, who consequently underwent an elective abortion. His parents divorced when he was 26, and his father died when H. was 29. Throughout his childhood and adult years, H. was well supported financially by his family; a trust fund was established for him after his father's death.

Psychiatric History—H. was seen by a psychiatrist once as a young adolescent at the request of his father for behavioral problems. Also, while living alone in New York City he sought private psychiatric care, but the duration and nature of treatment are unknown.

His first inpatient treatment was in 1979 when he was 33 years old. H. was touring the country at the time, gathering information on railway systems in preparation for a book he was intending to write. In September of 1979 he was arrested at a motel in the Midwest for recklessly firing a .22 caliber Colt semiautomatic pistol in his room and in the lobby area, where two women were working. When questioned why he had been shooting in the lobby, he stated, "It was my mood at the time." When asked why he was shooting in his room, he replied, "Because the person upstairs was playing music too loudly." As a result of his behavior in jail (breaking a television and evidencing "erratic behavior"), he was admitted for psychiatric assessment and found not fit to proceed. The charges were dismissed.

Although he was not cooperative for full psychological testing, the record reflects a history of homicidal threats, assaults on other patients, and an interest in literature pertaining to weapons. The treating psychiatrists felt he was in need of further care and civilly committed him to a psychiatric center nearer to his home. He was transferred in May of 1980 at age 34 with a diagnosis of schizophrenia, paranoid.

Psychological testing done at that time revealed a verbal Intelligence Quotient (IQ) of 108; performance IQ of 98; full-scale IQ of 104 Wechsler Adult Intelligence Scale [WAIS]). A Minnesota Multiphasic Personality Inventory Test (MMPI) is reported to show a "4-2" pattern and was read as valid. The psychopathic tendencies were felt to be chronic and perhaps related to his alcoholic history. The depression was felt to be of a reactive nature and short-lived. The Thematic Apperception Test (TAT) revealed short answers and a sense of defensiveness and guardedness. He was never felt to be psychotic while at the psychiatric center and was discharged in September 1980.

While a patient at the psychiatric center, H. met L., another patient. They had planned on marrying after both were discharged. After their release they lived together off and on, but when she became pregnant her mother insisted that she live only with H. and not in the parental home. The marriage never took place because L. was rehospitalized, partly as a result of the stress of her mother's rejection. At first H. was happy about the pregnancy, but when L. was rehospitalized he urged her to get an abortion. He visited her only once while she was pregnant at the psychiatric center because he "felt uncomfortable around the crazies." He also felt that her hospitalization for her mental problem might "reflect badly" on his family because they were "influential."

When initially questioned about why he killed the newborn, H. explained that he had been an advocate of infanticide for about 15 years. H. has written a 24-page, typed document entitled "The Evils of Overpopulation." His feelings about the incident can be shown by quoting from the document (with his permission).

Considering the circumstances under which the child was born—L. was in a mental institution—she had no plans to return and raise the child with me—it becomes obvious that her pregnancy was not only a great source of embarrassment to me, but it was also a very difficult thing for L. For as far back as I can remember, I have always felt a profound contempt for those irresponsible individuals who bring children into the world when they are unfit to do so. With each passing day of the pregnancy, I was aware of a terrible guilt closing in on me; I could not bear the thought that I should become the object of rational hate. And I knew the consequent social stigma that would attach to me would critically impair my ability to function in society. By destroying the child, I cleared my name and that of my relations, and I relieved L. of a responsibility that she was in no way prepared to handle. Had I allowed the child to live, he might have been raised at L.'s mother's house as her mother had suggested; if so, there never would have been an end to this miserable affair. The child might have been taken by adoptive parents, but adoptive parents are, in general, inferior to natural parents. Furthermore, L. is mentally retarded to a moderate degree. I destroyed our child because I thought he would have inferior racial characteristics.

Good children come from good parents; bad children come from bad parents. Bad parents are not necessarily bad people. L. and I are good people, but we would have been bad parents; we would have been unable to take care of our child properly. It follows that I destroyed a creature of negative potential. My son was an evil child; it was my responsibility as a parent to destroy him.

In other chapters of his writing, H. explains that since L. wanted a girl and had said that a boy would be “too hard to raise—too messy,” both of them were in agreement. He states that had it been a girl, he would not have killed the child. It was upon receiving a call from his sister informing him that L. had given birth to a baby boy that H. went to the hospital expressly to kill the baby.

Furthermore, H. cites the historical basis of the infanticide argument. He explains how humans as well how other species use and have used infanticide as a means of population control, and he even comments on the relationship between abortion and infanticide. Lastly, he notes how many prominent philosophers and even some famous leaders have advocated infanticide.

H. underwent a two-month inpatient psychiatric evaluation after he killed his son. His interaction on the ward was limited, and he spent most of his time working on his case. His mental status examination at that time was remarkable for flattened affect, social withdrawal, emotional detachment, and no remorse for his action. Specifically, there was no evidence of hallucinations, delusions, or inappropriate thought processes. H. received no medications while in the hospital.

H. was found guilty of second-degree murder and received the maximum sentence of 25 years to life. He did not raise an insanity defense. He feels “cheated” in that he was not allowed to enter a defense of justifiable homicide and therefore present to the court his view of infanticide. He is serving his sentence in a maximum security prison and is on no medication. He carries a diagnosis of schizophrenia, chronic, paranoid, in remission.

Follow Up—Since the trial, H. has been admitted to the State Forensic Hospital on two occasions. Both of these admissions have been for disruptive behavior in the prison associated with psychosis and auditory hallucinations. On each occasion he has stabilized without the use of medication.

Case 4

In 1983, X. was a 36-year-old professional residing in the Midwest with his pregnant wife and 6-year-old daughter. This pregnancy had been marked by acute polyhydramnios but was not considered to be a “high-risk” pregnancy nor particularly difficult. A few days before the term delivery, amniocentesis was performed to test for maturity of the infant’s lungs.

Upon delivery, with the father in attendance, it became immediately obvious that the baby was not entirely normal. The infant was cyanotic and not breathing. It took about 7 min of resuscitative intervention before the baby “pinked up.” The baby boy was obviously deformed, with a cleft lip and palate, low-set ears, short arms, and webbed hands [23].⁴

After the baby was stabilized and placed in an incubator, the obstetrician turned to repair the episiotomy on the mother. The father picked up his newborn son, bent down, and smashed the infant’s head on the floor, killing him instantly. The autopsy revealed that the baby had at least five valvular heart defects and that the presentation was consistent with a diagnosis of Trisomy 13, a genetic abnormality that is essentially incompatible with sustained life [23].⁴

⁴R. M. Daley, District Attorney, Cook County, personal communication, Jan. 1988.

X was charged with murder, and a defense of temporary insanity was presented. The case has been tried twice and both times the juries have been unable to reach a verdict. Recently, a judge has ruled that X will not stand trial again; however, the District Attorney has appealed and the case is still pending [23].⁴

X has great remorse and sorrow for his actions. He feels that he was “unprepared for anything out of the ordinary” for anything but a “normal birth and delivery. . . . To be left in a room for 30 minutes and seeing the problems the baby had was a terrible thing to go through as a father. . . . I’m sorry this happened. Given a second chance, it would not happen again” [23].⁴

Discussion

Although numerous authors have reported cases of maternal neonaticide, few have gone so far as to suggest a psychodynamic explanation for this behavior. No one has attempted to explain the psychodynamics related to the limited number of cases of paternal neonaticide. In categorizing maternal neonaticide, Resnick [1] delineated five types, including altruistic (with suicide or to relieve suffering), acutely psychotic, unwanted child, accidental, and spouse revenge.

Although statistics pertaining to maternal neonaticidal deaths are incomplete, it seems reasonably clear that the “unwanted child” is the most common type. These women use denial as the predominant defense mechanism, a fact which can no longer be avoided when birth occurs. This sudden dissolution of the major defense causes overwhelming fear, particularly fear of abandonment by the mother, from whom the pregnancy was hidden all along. This acute breakdown of defenses serves to produce disorganized thinking, impaired judgment, and possibly even psychosis.

Using Resnick’s classifications [1], the authors would categorize the four cases of paternal neonaticide as follows: Case 1—altruistic; Case 2—unwanted (but later became schizophrenic); Case 3—psychotic, not acute; and Case 4—psychotic, acute.

By comparing these four cases with the most common dynamic formulation in maternal neonaticide, it appears that the issues of impulsivity and premeditation are significant distinguishing factors. Only in Case 4 was the patient’s behavior considered “impulsive”; in the other three cases some degree of “premeditation” was involved. Further tracking and clarification of this trend will be important as additional cases are reported.

The issue of premeditation is also given consideration by the criminal justice system. This may be one of the reasons that fathers who kill their children are far more likely to be sentenced and to serve time in prison as compared with the mothers who are found guilty of the same or a similar crime [19].

After reviewing and analyzing the four cases of paternal neonaticide, the authors suggest further refinement of Resnick’s definition. The first subtype would include those killings which occur “at birth.” This is seen almost exclusively in maternal cases, since men rarely have accessibility to the newborn. The “neonatal” period should be expanded to be consistent with biological and psychological determinants. The American Pediatric Association and The American College of Obstetrics and Gynecology both consider the neonatal period to be longer than the first 24 h of life. Some of these definitions include at least the first three months of life [24–26]. In psychiatry, we recognize that postpartum depression and psychosis may develop many weeks after birth and may in fact be related to weaning, an event which is quite distant from the time of birth [27]. The final category would be those cases which occur after the neonatal period and should be termed infanticide.

In conclusion, the authors propose that infanticide should be divided into three subtypes as follows: A—at birth, B—birth to six months of age, and C—six months to one year of age.

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