CASE REPORT

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Familicide, Depression and Catathymic Process

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ABSTRACT: A case of familicide by a 36-year-old male is reported. After years of stable marriage, exemplary military service, and steady employment, the subject developed his first episode of depression triggered, in part, by his inability to solve a problem associated with completion of a home improvement project. As the depression intensified, and dormant conflicts regarding his competency and self-esteem were rekindled, he experienced pronounced feelings of failure. After an extended period of agonizing about his problem, the idea suddenly emerged that his only recourse was to kill his family and himself, in order to spare everyone the humiliation of his perceived inadequacy. Such a fixed idea, along with a mounting pressure to act, is characteristic of the (chronic) catathymic process, in which a subject, without apparent motive, resorts to extreme violence directed at someone close to him. A detailed discussion of this case within the framework of catathymic process adds to our knowledge of family mass murder and refines the profile of potentially familicidal men.

KEYWORDS: forensic science, forensic psychiatry, forensic psychology, familicide, mass murder, catathymic process

Familicide—mass murder typically involving the offender's spouse and one or more of the children—is a rare and poorly understood form of homicide. Although there are no U.S. crime statistics on family mass murder, there have been a number of cases previously reported (1–8). Dietz (9) has described the prototypical family annihilator as a depressed man who often drinks excessively, kills his family and sometimes himself. His victims are usually shot, stabbed, or strangled; occasionally the pets are killed and the house set on fire. "If these cases make the national news, it is a brief appearance . . . They are regarded as family business . . . too close for comfort (p. 481)."

In their classification of familicidal offenders, Wilson, Daly, and Daniele (10) differentiate between an accusatory and a despondent group. The former is typically a man who is angry at his wife for suspected infidelity or her intention to end the marriage. His hostility is conspicuous, and he often has a history of violence. Such offenders are frequently controlling, jealous, sometimes paranoid, and often have a proprietary view of their families (11,12). In contrast, the despondent type is a depressed and brooding man who anticipates "impending disaster for himself and his family and who sees familicide followed by suicide as 'the only way out.' . . . Expressions of hostility toward the victims are generally absent (10, p. 288)." In his study of "fatal families," Ewing (13) found that depressed familicidal males had lost control over all aspects of their lives and viewed themselves as failures: "Faced with . . . overwhelming threats to their roles as providers, controllers, and central figures in the lives of their families, each of these men became desperate, depressed, suicidal, and homicidal (p. 136)." The motivations and dynamics of the accusatory familicidal offender, who acts out of extreme anger and jealousy (14), are fairly overt and much less complex than those of the despondent offender, who is not angry at his family members but, rather, views them with sympathy. Although depression is the most obvious clinical manifestation in the despondent group, the idea that family mass murder is the only possible solution to his problem cannot be explained by the depression alone.

The concept of catathymic process is of particular relevance in understanding the despondent familicidal male. This term has been used somewhat differently by various authors (15), all attempting to explain cases of extreme, ostensibly unmotivated, violence that takes place in the context of an interpersonal relationship. Wertham (16) originated the expression to describe a clinical condition in which strong, underlying, emotionally charged conflicts emanating from unconscious fears, wishes, or ambivalent strivings bring about a change in the individual's thinking. The key feature, especially in the more chronic or protracted form of the condition, is the individual's acquiring "the idea that he must carry out a violent act against others or against himself. The idea appears as a definite plan and is accompanied by a tremendous urge to carry it out. The plan itself meets such resistance in the mind of the patient that he is likely to hesitate and delay. . . . The thinking of the patient may have an almost delusional character in its rigidity and inaccessibility to logical reasoning . . . The patient decides that a violent act against another or against himself is the only way out (16, pp. 974–5)."

The following case of familicide elucidates a depressed man's motivation to murder his entire family as a manifestation of catathymic process.

Family Background

F.C. was 36-year-old at the time of the familicide, living with his 30-year-old wife of eight years and their three children ages 5 years, 4 years, and 4 months. The family lived in their own home, purchased five years earlier. For the past 12 years, F.C. had worked at a local utility, where supervisors described him as "industrious, quiet, and even-tempered." He and his wife were active in their church and regularly counseled newlyweds. F.C. was also a mem-

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ber of the local zoning board and served in the National Guard as well as the Air Force Reserves, following his discharge from the Air Force years earlier. He was portrayed by neighbors as "a friendly and pleasant man who lived for his family." On weekends F.C. worked part-time in a construction company to earn additional income. His parents were both retired, and his two brothers were firefighters in a nearby town.

Two years before the incident F.C., with the help of some friends and neighbors, added a second story to his home, because he and his wife anticipated having a third child. Six months prior to the event, he also added a family room, with its own heating system. Unfortunately, F.C. was unable to get the stove to work properly, and over the next several weeks, he became more and more upset. His growing obsession with this relatively minor mechanical problem began to assume a significance that would ultimately lead to fatal consequences.

Criminal Offense

About one month prior to the homicides, F.C. sank into a deepening depression triggered by his inability to solve the heating system problem. He became obsessed with what he perceived as "a failure on my part." He lost weight and "didn't feel well." F.C. explained, "I couldn't face the failure. I got so worked up, I couldn't figure any way to keep my family from being hurt by my failure. The failure was the heating system. I couldn't get it to work. There was no way to handle this. I couldn't face the failure." He became more and more depressed and had thoughts of suicide. At one point, he ran in front of a car, but the car merely grazed him and he went home uninjured. He began to sleep poorly and to wake up in the early-morning hours; he would then pace the floor, thinking about the malfunctioning heating system and trying to figure out how to deal with his overwhelming feelings of failure and the humiliation of explaining the problem to his family. At about this time, he got the idea in a "split second to get a knife and do it; myself was telling me, 'If we all go, I wouldn't have to face this problem and they wouldn't be left behind to handle the problem for me.'" Once this idea emerged, he "could not let it go. I kept thinking of killing us all; it became stronger and stronger, clearer and clearer."

On the morning of the familicide, he woke at 3 a.m., as he had done for the past week, and paced the floor, obsessed about his inability to figure out his heating system. He became "overwhelmed" with the idea that he and his family had to be killed. He went to the cellar, got his hunting knife, and first stabbed his wife 37 times. There were 20 stab wounds to the chest and abdomen and 16 to the shoulders, arms, and hands, indicating some defensive wounds as well. He also killed his 5-year-old daughter (stabbing her 34 times in the back and chest) and his 4-year-old son (stabbed 18 times in the back, chest, and abdomen). He then went into the nursery and stabbed his 4-month-old daughter 21 times in the back. After these killings, he stabbed himself 26 times in the chest and abdomen and cut his wrists. F.C. was lying on the floor in a pool of blood, with his 6-in. hunting knife next to him, when a neighbor, who had come by to take F.C.'s daughter to school, looked into the kitchen after no one answered the doorbell. F.C.'s survival was described as miraculous.

Clinical Findings

F.C. was examined in a psychiatric facility connected to the County Jail, where he was housed awaiting trial. He was oriented, in good contact with his surroundings, but severely depressed and, at that point, also suicidal. He was withdrawn and his entire body trembled almost without cessation throughout the ten hours spent with him. At times, F.C. mumbled to himself, although he denied that he was responding to any auditory or visual hallucinatory phenomenon. He appeared disheveled and looked terrified. His attention span and ability to concentrate were both impaired, consistent with an individual suffering from severe depression with agitation.

F.C.'s performance on the intelligence tests revealed average capacity (Full Scale WAIS-R IQ = 95) with no evidence of any organicity. Verbal and nonverbal subtest results were within average limits, and there was no striking pattern of strengths or weaknesses, except for a few items that were negatively affected by poor concentration. Complete neurological evaluation revealed no abnormalities. F.C. had all of the usual laboratory tests, including an EEG (sleep-deprived and awake) as well as a CAT scan and an MRI, all of which were normal.

F.C.'s premorbid personality was somewhat difficult to assess, since the test results were colored by the current depression and his being overwhelmed by the act he had just committed. The Rorschach showed no evidence of a formal thought disorder, nor were there indications of paralogical, fluid, or disorganized reasoning. However, there were two noteworthy perceptions on the Rorschach: one, "a man's tiny penis"; the other, "two penises that are very small." Such perceptions strongly suggest feelings of inadequacy that run quite deep, to the core of F.C.'s personality.

Projective figure drawings also revealed a poor self-image and feelings of inferiority, evidenced by tiny figures without any elaboration at all. There were suicidal themes on the TAT, with one story of a man who committed suicide because "he couldn't handle the problem in his life, an everyday problem. It was easier to face death. It could be done so quickly. He is gone now and no more problems." His performance on the MMPI was typical of an individual experiencing a major depression and corroborates the aforementioned findings, including feelings of weakness and low self-esteem.

Discussion

Most crime, including homicide, is a result of social, environmental, or situational factors rather than an outgrowth of psychogenesis (17). The psychiatric diagnosis per se rarely explains a homicide, except where the act was a direct result of a paranoid psychosis, a toxic state, or in relatively rare cases, an organic condition (18). Malmquist (19), reviewing the spectrum of depressive disorders and their relationship to homicide, concluded that one cannot determine, on the basis of depression alone, why some individuals just stay depressed for long periods of time, some commit suicide, and others become homicidal. Severe states of depression, however, may loosen controls and disrupt and disorganize the inhibitory functions of the psyche, so that the basic repressed conflict and emotion break through to the surface.

There is little question that F.C. slipped into a deepening depression for one or two months prior to the familicide. Insidiously, his mood became lower and lower; he lost 15 lb, experienced disturbed sleep, entertained thoughts of suicide, and became obsessively preoccupied with his perceived failure. As with many other similar cases, F.C.'s severe depression was unrecognized by his family and friends (20). Mrs. C. told him to "snap out of your mood" and became annoyed when he attempted to explain his condition to her. Yet, while F.C's feelings of failure are generally understandable as an outgrowth of the depression, the depression alone does not explain his arriving at the idea that the solution to the heating system problem was to kill his whole family.

The idea that violence must be committed as a way of liberating unbearable inner psychic tension is the hallmark of the catathymic process (21). Such an idea often emerges suddenly but then maintains a root-like fixation that the individual cannot free himself of—except by commission of the violent act. In F.C.'s words, "I could not shake the thought . . . The idea became stronger and stronger . . . It wouldn't let go . . . The idea was there for several weeks and became clearer and clearer." The future offender often "develops a plan and feels a strong urge to put the plan into action" (22, p. 166). Revitch and Schlesinger (18,23) refer to an incubation period, lasting from several days to a year, where the individual becomes obsessively preoccupied with the prospective victim(s) and develops the idea that violence is the solution to the problem or conflict that has created enormous inner tension. F.C. remarked, "I got the idea to kill everyone and myself, which first seemed illogical. As I kept thinking about it and thinking about it, it became clearer and clearer: it seemed the only way to go."

Wertham (22) concluded that the individual who develops catathymic symptoms was predisposed by experiencing an early precipitating or traumatic event that created an inner, emotionally charged, conflict. The conflict lies dormant until the individual's defenses become injured by a disturbing interpersonal relationship or weakened by the effects of severe depression; then the conflict emerges, disrupting logical thinking, and a violent act is seen as the only way to gain relief. Emotional tension becomes extreme, and thinking becomes more and more egocentric. A majority of despondent familicidal men report that they experienced a feeling of pronounced failure prior to the act (13). Many had lost jobs and social position—a major blow to male self-esteem. Job loss and disruption of relationships have been noted as triggers for some homicides stemming from deep psychological sources (24,25).

F.C's inability to solve the heating problem brought to the surface a long-suppressed conflict regarding his intellectual competency and his lack of a college education. By working several jobs and many hours of overtime, he tried to earn enough money to demonstrate that he was an adequate provider: "I made as much money or more money than a lot of guys who finished college." He frequently boasted to others that college "didn't teach you how to solve commonsense problems of life." He also remarked that he could solve daily problems "better than any college grad." His feelings about his intellectual competency overwhelmed him as his defenses became loosened by his depression. He was unable to tolerate the humiliation of his inability to solve a daily problem such as the malfunctioning heating system, because he had prided himself on always being able to handle such tasks. He felt he could not let his family know of this perceived failure.

Following the violent act, the catathymic offender often experiences a feeling of inner relief, despite the devastating circumstances he has created. A similar phenomenon has long been observed in individuals who survive very serious suicide attempts (26): They "abruptly become much better mentally . . . The depression seems to lift. . . . All the various fears and tensions disappear (p. 9)." I previously reported a case of a 29-year-old male who killed his wife, as a consequence of the catathymic process, and described a feeling of "inner peace" following the murder (27). If the catathymic tension is not completely discharged after the violent act, suicide often follows homicide. But when the catathymic tension is fully released with the murder, the offender may no longer feel the pressure to kill further. Macdonald (6), for example, reports the case of a 55-year-old dentist who killed his wife and son and had planned to kill himself; but then "he seemed to have no energy to do this (p. 187)." F.C. stated that "the horrible feeling" he experienced was no longer present, following the murders and near fatal suicide, but he was totally distraught by his deeds.

The catathymic process can be useful in explaining to a court the motivation and thinking patterns of the offender, beyond what can be offered by a psychiatric diagnosis alone. Following a bench trial, F.C. was found legally insane, in accordance with the M'Naghten standard, and committed to a psychiatric facility, where he has resided for the past eight years. The judge commented that the explanation of F.C.'s "defective reasoning . . . as an outgrowth of the catathymic process . . . was very helpful in applying the facts of this case to the law. . . . His conduct could not be accounted for solely by a diagnosis of depression, even psychotic depression."

The devastating consequences of familicide—not only for the primary victims but also for those who survive (including distant family members, friends, and community)—underscores the need to develop effective prevention strategies. The depressed familicidal male often has contact with health care providers (28,29) who frequently do not recognize the connection between depression and homicide, although they are well aware of the connection between depression and suicide (30). In fact, the literature on homicide and depression is remarkably sparse (31) despite the long recognized role of hostility and anger in the psychogenesis of mood disorders (32,33). Accordingly, health care providers, police, or other investigators should routinely question depressed individuals to discern the presence of homicidal ideas, with the same conscientious detail used in assessing risk for suicide. Marzuk, Tardiff, and Hirsch (34) go even further, arguing that "clinicians encountering the depressed senior male of a household should consider the risk of familicide-suicide (p. 3181)." Awareness of the various clinical manifestations of the catathymic process, particularly where the individual voices a belief that his problem can be solved through violence (35), further refines the profile of the depressed individual at greatest risk for familicide.

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