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CASE REPORT

PSYCHIATRY & BEHAVIORAL SCIENCES

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Filicide, Attempted Filicide, and Psychotic Disorders*

ABSTRACT: The objective of the study was to describe and discuss the cases of two women who faced criminal charges, one for attempting to murder her three children and the other for killing her 1-year-old boy. After a forensic psychiatric assessment of their level of criminal responsibility, these patients were considered not guilty by reason of insanity and were committed to forensic mental hospitals. These two patients received a diagnosis of paranoid schizophrenia, according to the DSM-IV-TR criteria. In both cases, psychotic symptoms were present before the manifestation of violent behavior, in the form of persecutory delusions, auditory hallucinations, and pathological impulsivity. The investigation into cases of filicide may contribute powerfully to expand our understanding of motivational factors underlying this phenomenon and enhance the odds for effective prevention.

KEYWORDS: forensic science, violence, crime, schizophrenia, homicide, murder

Filicide is generically defined as the killing of a child by a biologic or an adoptive parent (1,2). Other terms are employed to describe the murder of children in more specific contexts. Neonaticide is the killing of an infant during the first 24 h of life (3). In criminal law, infanticide refers to the killing of an infant who is <12 months old by a mother who has not fully recovered from pregnancy or who suffers from some degree of mental disturbance (4).

Psychotic symptoms can induce people with serious mental disorder to believe that they are in mortal danger and lead to assaults and even murders. A study by Taylor (5) found a strong association between psychotic symptoms and recent violent behavior, given that 93% of her sample presented psychotic symptoms when they committed these crimes and 47% were "probably" or "definitively" motivated by these symptoms. Other studies also found an association between persecutory delusions and auditory hallucinations and the motivation to commit murder (6,7). In a study that examined filicidal mothers, Lewis and Bunce (8) evaluated 55 women who were divided into psychotic (n = 29) and nonpsychotic groups (n = 26). Within the first group, 18 (62.1%) women had command hallucinations, 23 (79.3%) reported paranoid delusions, 15 (51.7%) believed their children were dangerous, and 26 (89.7%) heard auditory hallucinations.

It has been suggested that, besides psychotic symptoms, other factors may predispose women to kill their children. These include financial difficulties, social isolation, being a single mother, work problems, factors related to the upbringing and education of the mother, history of sexual abuse during early years of life, marital troubles, jealousy, alcohol abuse, physical illness, and mood disorders (9).

In fact, of 89 women who were admitted to a safeguarding hospital in England during the years 1970–1975 under the charge of having killed one or more of their children (n = 109) and diagnosed as suffering from a mental disorder, only 24 were diagnosed as such at the time of the study and only 14 of them showed psychotic disorders (10). None of the women who had killed newly born babies (neonaticide) were considered to have mental disorders. Maternal mental disorder was more frequently implicated in the killing of children of a year or more in age. The findings of this study reinforce the idea that there is an association between maternal filicide and the presence of certain stress factors in the mother's life, such as having been a victim of domestic violence, early parental separation, and record of attempted suicide.

Among the serious mental disorders that are associated with filicide, schizophrenia and mood disorders are the most prevalent. Friedman et al. (11) undertook a retrospective study of women with mental disorders who committed filicide and were considered not guilty by reason of insanity. The sample consisted of 39 mothers who attempted to kill 54 of their 91 children and succeeded in killing 46. Eighty-two percent of the women received a diagnosis of a psychotic disorder or of a mood disorder. Krischer et al. (12) reviewed the records of 840 women who were committed to a forensic psychiatric hospital under the charges of filicide (n = 45) or attempted filicide (n = 12). There were seven cases of neonaticide, 12 of infanticide, and 37 of filicide. Sixty-three percent of the female offenders were diagnosed with a mental disorder related to the schizophrenic spectrum (schizophrenic, schizoaffective disorder, and delusional disorder) and 30% to one related to the affective spectrum. A review of 85 filicide cases in Turkey (13) showed that nearly half of the perpetrators had been diagnosed with serious

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mental disorders, including schizophrenia (61%) and major depression (22%). The majority of the victims were <12 years old (82%).

It must be noted, however, that although statistical and empirical evidence indicates a positive relationship between severe mental disorder and violent behavior, this association accounts for a relatively small proportion of the violence that occurs in society. In underdeveloped countries with high levels of community violence, where criminality is usually associated with precarious socioeconomic conditions, the relative contribution of mental disorders to homicides statistics is usually less substantial and social and familiar factors may play a more significant role.

So far, few studies have investigated the epidemiology of child abuse in Brazil. In a survey conducted by Ferreira (14) in a pediatric unit in the city of Rio de Janeiro, most victims were girls (70.5%) and were aged between 2 and 10 (81.7%). Intrafamilial abuse accounted for 47.3% of the cases. In a recent report issued by the Brazilian Multiprofessional Association for the Protection of Children and Adolescents on 1547 cases of child abuse, 52% of the victims were aged between 7 and 14, 37% were younger than 6 years of age, and 11% were between 15 and 18. In 76% of the cases, the victims were girls (15). A study conducted in the city of Campinas (Center for Reference, Studies and Interventions for Children and Adolescent) involving 3644 cases of suspected child abuse found that 47.1% victims had been physically harassed, 20.2% were neglected or abandoned, 10.9% had been psychologically abused, and 6% had a history of sexual molestation. In the remaining 15.8% of the cases, the suspicions were found to be baseless (15). The vast majority of the offenders did not meet criteria for legal insanity.

Mendlowicz et al. (16) performed a retrospective study of 53 women accused of murdering their newborn children in the city of Rio de Janeiro, Brazil, between 1900 and 1995. The authors found that 11 neonaticidal women were referred for psychiatric evaluation, but only nine had their mental health assessed. Four of them had previously reported experiencing abnormal mental states during the offense. While one of them was diagnosed with mental retardation, the other eight were considered mentally competent to stand trial.

We will now present the cases of two women who faced criminal charges, one for attempting to murder her three children and the other for killing her 1-year-old boy. After a forensic psychiatric assessment of their level of criminal responsibility, these patients were considered not guilty by reason of insanity and were committed to forensic mental hospitals. Information about these cases was obtained from case records and clinical examination by the authors.

Case 1

A. is a 39-year-old, divorced, illiterate black woman who was raised by adoptive parents. According to legal records, in 2006, the patient threw her three young children, a 4-year-old girl and two boys, aged 3 and 1, into a river near her house. The young would-be victims escaped unharmed as they were immediately rescued from drowning by a bystander. The patient lived with her children (offspring of two different partners) and an aunt. Her last companion had abandoned her approximately a year before the attempted murder. The patient used to work as a house servant. There were no previous reports of aggressive behavior toward the children, of psychiatric treatment, or of alcohol and drug abuse. At the time of the criminal deed, the patient was not undergoing any type of treatment or using medications. It has been reported that in the days preceding the crime, the patient was agitated, sleepless, mumbling, and talking continuously to herself. She presented psychotic symptomatology characterized by persecutory delusions, auditory hallucinations, formal thought disorder, and poverty of speech. A. was given a diagnosis of paranoid schizophrenia (DSM-IV-TR) (17), found not guilty by reason of insanity, and committed for involuntary treatment.

During the forensic examination, A. stated that "I was hearing voices telling me to kill myself and my children…it was desperation, my husband drop me out and left me on my own to look after the children…I thought I not would be able to bring up the three children without a father". She denied any form of physical abuse toward the children before the crime. At the time of our psychiatric examination, the patient showed marked lack of personal care, disorganized discourse, blunted affect, persecutory delusions, and ideas of self-reference.

Case 2

B. is a 43-year-old, single, black, elementary school dropout woman. According to her criminal records, in 1987, the patient killed her 1-year-old son by throwing him through the window of the apartment where they lived. She had no companion and did not know who the father of her child was. In the legal-psychiatric evaluation, the patient reported that she got into a harsh argument with her sister, because B. wanted to go out while leaving the child alone at home. B. told us that: "I don't know what happened...I just did it...it occurred to me that the suffering of bringing up a child with difficulty had just begun...I thought that I would not have money enough to pay for schooling and that at school they would mistreat my child....I thought that they would abuse him because he was dark skinned." She also believed that she was being targeted by strangers just for being black. B. had several previous psychiatric hospitalizations. At the time of her first hospitalization, when B. was just 19 years old, she told us that she used "to hear a voice in my head and imagined a lot of things." She often talked to herself, walked aimlessly through the streets, and threw stones at the bystanders. She had already been arrested several times for assaulting people in the streets. B. also had a history of alcohol abuse since she was 21 years old. In her hospital records, there were several reports of physical aggression against other female inpatients. Her psychiatrist described thought disorganization, persecutory delusions, ideas of self-reference, and irritable mood. At the time of our psychiatric examination, B. showed markedly blunted affect and indifference. The patient told us that: "I think that they (the female inpatients) are jealous of me, they look at me in a different way." B. was given a diagnosis of paranoid schizophrenia (DSM-IV-TR) (17), found not guilty by reason of insanity, and has been committed for involuntary treatment for the last 20 years.

Discussion

Relatively little is known about the factors and circumstances predisposing to maternal filicide, and this lack of knowledge limits our capacity to intervene effectively to prevent it. From a medico-legal perspective, issues regarding the nature and intensity of the mental disturbances and how they may influence the assessment of the degree of criminal responsibility of the offender are major concerns associated with the act of filicide (4).

In Brazil, the most important expert examination is the Penal Imputability Exam, which consists of a psychiatric examination that starts with the study of the criminal process and with interviews with the patient. The evaluation of criminal responsibility, according to the Brazilian Penal Code, is based on a biopsychological concept. This implies that full penal responsibility can only be

excluded if the offender was, at the time of the criminal deed, suffering from a mental disorder (i.e., a biologic cause) and, as a consequence, was completely incapable of understanding the unlawful nature of his/her acts or to restrain him/herself from committing them (psychological consequences). The existence of a causal link between the mental disorder and its psychological consequences must be established beyond doubt (18). The possibility of cases with limited responsibility, which result from partial impairment of cognitive or volitional functions, is also acknowledged. Those who are deemed not responsible for their unlawful acts are committed to involuntary treatment in forensic mental hospitals. Therefore, the diagnosis of a serious mental disorder is an essential prerequisite to exclude the penal responsibility of any filicidal mother and to have her treated, rather than punished.

D'Orban (10) demonstrated that maternal mental illness was more likely to be implicated in the killing of children older than 1 year. Our two vignettes illustrate this aspect well. They represent cases of real or attempted pathological filicides, in which the parent was undoubtedly suffering from a major mental disorder at the time of the crime. Both offenders obviously lacked the psychological, material, and social resources to cope with the significant stressors they were facing just before the criminal event. They had limited social support, were living in a situation of conflict with other family members, felt overburdened as the primary caregiver of their children, and faced worsening mental illness. In Case 1, for instance, the patient complained that she has been abandoned by her husband. In Case 2, B. described situations of family conflict.

In our two cases, the patients also presented persecutory delusions and auditory hallucinations at the time of the crime. Patient A. even described command hallucinations instructing her to kill. Given the current state of knowledge showing relatively high rates of serious psychopathology among parents who kill their children, it has been recommended that forensic psychiatrists keep a high index of suspicion for the presence of serious mental illness whenever they examine a filicide offender (2). The diagnosis of psychosis has obviously important implications for treatment planning, prognosis, and preventive efforts in filicidal women. It is critical to acknowledge that psychotic motivation for filicide transcends cultural and national boundaries; although we have reported cases that happened in Brazil, similar cases can possibly occur in almost any other country.

A recent study found that that the most common cause of death was asphyxia (in 38% of the cases), followed by assault with instruments (in 20% of the cases) (13). Beating and suffocation were the methods most commonly employed by women to kill their children (8,11). In contrast with the findings of previous studies on filicide, in neither of our cases were asphyxia nor any potentially lethal instrument employed (19). Their atypical, nearly bizarre actions were characteristic of the unplanned, impulsive acts evolving from high levels of situational stress, frustration and anger, and reflecting a deeply distorted contact with reality.

A past record of aggressive behavior has consistently been considered as a forewarning of future acts of violence in several populations of patients (20,21). In our second case, the patient had a history of markedly aggressive behavior even before killing her child. This observation highlights the importance of adopting preventive strategies, which should include immediate intervention at the first signs of impeding violence. A thorough investigation into a history of alcohol or drug abuse in filicidal women is also paramount. Current or recent use of alcohol, as in our second case, could negatively affect factors as mood stability or the severity of psychotic symptoms. It could also increase refractoriness to treatment and worsen prognosis (22).

While a number of studies found that poor attendance at outpatient visits and lack of compliance with treatment frequently preceded murders committed by individuals with severe mental disorders, others reported that homicide seems to occur soon after the beginning of mental disorder, even before the offender has established a contact with mental health services (23,24). In only one of the two cases reported here, the patient had a record of previous psychiatric treatment. However, neither of them was under psychiatric treatment at the time of the crime, illustrating the fact that many patients with homicidal penchant were not undergoing regular treatment before manifesting this kind of behavior. It is important that the mental health services work with patients and families to increase attendance at psychiatric outpatient clinics and to foster treatment compliance in people with severe mental disorders.

The investigation into cases of filicide may also help establish the risk factors for lethal when compared to nonlethal child maltreatment, expand our understanding of motivational factors underlying this phenomenon, and thus further contribute to effective prevention. Despite the fact that prospective studies are considered more effective for the determination of risk factors from a methodological point of view, the relative rarity of filicide makes this undertaking difficult. Besides current and past psychiatric diagnosis, studies should investigate other risk factors for filicide, such as sociodemographic and cultural factors, level of social support, and history of previous interpersonal violence.

References

1. Stanton J, Simpson A. Filicide: a review. Int J Law Psychiatry 2002;25(1):1–14.
2. Bourget D, Grace J, Whitehurst L. A review of maternal and paternal filicide. J Am Acad Psychiatry Law 2007;35(1):74–82.
3. Resnick PJ. Child murder by parents: a psychiatric review of filicide. Am J Psychiatry 1969;126(3):325–34.
4. Bourget D, Labelle A. Homicide, infanticide, and filicide. Psychiatr Clin North Am 1992;15(3):661–73.
5. Taylor PJ. Motives for offending among violent and psychotic patients. Br J Psychiatry 1985;147:491–8.
6. Link BG, Stueve A, Phelan J. Psychotic symptoms and violent behaviors: probing the components of ''threat/control-override'' symptoms. Soc Psychiatry Psychiatr Epidemiol 1998;33(Suppl. 1):S55–60.
7. Cheung P, Schweitzer I, Crowley K, Tuckwell V. Violence in schizophrenia: role of hallucinations and delusions. Schizophr Res 1997;26(2–3):181–90.
8. Lewis CF, Bunce SC. Filicidal mothers and the impact of psychosis on maternal filicide. J Am Acad Psychiatry Law 2003;31(4):459–70.
9. Bourget D, Gagné P. Maternal filicide in Quebec. J Am Acad Psychiatry Law 2002;30(3):345–51.
10. D'Orban PT. Women who kill their children. Br J Psychiatry 1979;134:560–71.
11. Friedman SH, Hrouda DR, Holden CE, Noffsinger SG, Resnick PJ. Child murder committed by severely mentally ill mothers: an examination of mothers found not guilty by reason of insanity. J Forensic Sci 2005;50(6):1466–71.
12. Krischer MK, Stone MH, Sevecke K, Steinmeyer EM. Motives for maternal filicide: results from a study with female forensic patients. Int J Law Psychiatry 2007;30(3):191–200.
13. Karakus M, Ince H, Ince N, Arican N, Sozen S. Filicide cases in Turkey, 1995–2000. Croat Med J 2003;44(5):592–5.
14. Ferreira AL. O atendimento a crianças vítimas de abuso sexual: avaliação de um serviço público [Doctoral Thesis]. Rio de Janeiro (Brazil): Escola Nacional de Saúde Pública, 2002.
15. Laks J, Werner J, Miranda-Sá LS. Forensic psychiatry and human rights throughout life: children, adolescents and the elderly. Rev Bras Psiquiatr 2006;28(Suppl. II):S80–5.
16. Mendlowicz MV, Jean-Louis G, Gekker M, Rapaport MH. Neonaticide in the city of Rio de Janeiro: forensic and psycholegal perspectives. J Forensic Sci 1999;44:741–5.
17. American Psychiatry Association. Diagnostic and statistical manual of mental disorders. 4th edn. text revised. Washington, DC: American Psychiatric Press, 2000.

18. Taborda JGV. Criminal justice system in Brazil: functions of a forensic psychiatrist. Int J Law Psychiatry 2001;24(4–5):371–86.
19. Lewis CF, Baranoski MV, Buchanan JA, Benedek EP. Factors associated with weapon use in maternal filicide. J Forensic Sci 1998;43(3):613–8.
20. Tardiff K, editor. Prediction of violence, in medical management of the violent patient. New York, NY: Marcel Dekker, 1999.
21. Steinert T. Prediction of inpatient violence. Acta Psychiatr Scand 2002;106(Suppl. 412):133–41.
22. Vanamo T, Kauppi A, Karkola K, Merikanto J, Räsänen E. Intra-familial child homicide in Finland 1970-1994: incidence, causes of death and demographic characteristics. Forensic Sci Int 2001;117(3):199–204.
23. Flynn SM, Shaw JJ, Abel KM. Homicide of infants: a cross-sectional study. J Clin Psychiatry 2007;68(10):1501–9.
24. Meehan J, Flynn S, Hunt I, Robinson J, Bickley H, Parsons R, et al. Perpetrators of homicide with schizophrenia: a national clinical survey in England and Wales. Psychiatr Serv 2006;57(11):1648–51.

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