Commentary: Toward a Psychodynamic Understanding of Filicide—Beyond Psychosis and Into the Heart of Darkness

Daniel J. Papapietro, PsyD, and Elizabeth Barbo, PhD

Much of the literature on filicide explores acute psychosis, sociopathy, or malignant narcissism (psychiatrically ill versus not psychiatrically ill) as primary explanations of why parents kill children. In this issue, Hatters Friedman *et al.* review the literature on acute psychiatric symptoms in an effort to identify key risk factors for filicide that might have predictive value. In this commentary, we assert the argument that filicide is a complex phenomenon that is the result of more than just psychosis or environmental stressors and that, because not all parents who become psychiatrically ill kill, there may be specific risk factors related to individual underlying psychodynamic conflicts.

J Am Acad Psychiatry Law 33:505–8, 2005

The death of a child, under any circumstances, is a sad and regrettable event. When that death occurs at the hands of a parent, it is only natural to inquire into why such a tragedy could not have been prevented. As Hatters Friedman *et al.*[1] note, the killing of a child by a parent is not a new phenomenon and has been an area of scholarly study for nearly 40 years. In contributing to this burgeoning body of literature, Hatters Friedman *et al.* further explore the psychiatric symptoms of filicide-suicide cases, hoping to determine some predictive characteristic that might allow intervention to prevent a parent from killing a child.[1–4]

Much of the research in this area similarly explores the parent's primary psychiatric symptoms that were active at the time of the crime, generally concluding that the primary psychiatric "motive"[3] for a parent to kill a child is an active psychosis with grandiose or paranoid delusions, suggesting that, if those psychiatric symptoms had been identified early enough, the crime might have been prevented.[2–4] Because we know that not all parents who become psychiatrically ill go on to kill or harm their children, we must seek a greater understanding of the unique psychodynamic makeup of filicidal parents beyond merely categorizing their psychotic symptoms or sociopathic motives if we are to predict and prevent filicide. While it is heuristically important to know what psychiatric symptoms may result in violence, we believe that for prediction and prevention it is necessary to explore psychodynamic factors as part of a "constellation of risk factors" to be explored that might better identify individuals at risk for filicide-suicide.[5]

Since Resnick[6] classified the reasons that mothers kill children (altruism, psychosis, having an unwanted child, accident, and revenge), other research has expanded or restructured those schemas in a variety of ways.[7,8] Notwithstanding all the classification schemas for parents who kill their children, in the end there are only "two broad conceptual categories. . .either psychopathic or psychotic " (Ref. 9, p 20). In the former category are the sadistic, sociopathic, retaliatory, or narcissistic individuals who are typically convicted of murder or manslaughter. In the latter category are those individuals who are psychotic, depressed, or manic with paranoid or grandiose delusions for which they were subsequently ac-

Dr. Papapietro is Clinical Psychologist, Minimum Security Community Preparation Program, Whiting Forensic Institute, and Dr. Barbo is Clinical Psychologist, Maximum Security Admissions Unit, Whiting Forensic Institute, Connecticut Valley Hospital, Middletown, CT. Address correspondence to: Daniel J. Papapietro, PsyD, Whiting Forensic Division, Dutcher Building, Connecticut Valley Hospital, Middletown, CT 06457. E-mail: daniel.papapietro@po.state.ct.us

quitted on grounds of insanity. It is those in the latter category who interest us. To date, beyond identifying the psychotic symptoms active at the time of the crime, little has been done to explore how the parents' psychodynamic and characterological problems also might have contributed to the crime.[9,11] It is our position that only through the extensive psychotherapeutic treatment of filicidal patients will we be able to understand psychodynamically what they were no longer able to repress during an episode of psychosis or mania. Only by looking deeply into the psyche of the individual, into his or her heart of darkness,[12] will we be able to explain and comprehend how a parent could contemplate taking the life of his or her child.

Our interest in this area arises out of our work in a forensic psychiatric hospital with patients who have killed or attempted to kill one or more of their children and were acquitted on the grounds of mental illness or defect. Of those currently in treatment, the only difference between those who made suicide attempts and those who did not is that the latter exhibited a greater level of narcissistic character structure that may have served to prevent harm to the self. Although each of these individuals was floridly psychotic at the time of the crime, and all had significant personality disorders, only one had a pre-existing proximal psychiatric disorder (i.e., a history of aggression, psychosis, mania, or a suicide attempt) that might have predicted a potential for violence.[9] For all patients, the onset of symptoms was subtle and evolved without notice over a few days to a few weeks, but then rapidly gave way to florid psychosis. The final psychotic act of murder (or attempted murder) occurred impulsively, without prior homicidal thoughts or rage, and was in all cases (as predicted by much of the research) driven by delusional beliefs that killing the child or children was an altruistic act to save the child or children or the world from some imminent cataclysm. For each of them, however, such an act of violence was out of character and totally incongruous with how they had lived their lives up to the time of the crime.

Although the sudden act of murder is truly a psychotic act, we also believe that it is—at least in part—the result of severe personality disorder deficits in which "severe lapses in ego control. . .[made] possible the open expression of primitive violence"[13] that had long been repressed from conscious awareness. Furthermore, for such individuals already vulnerable to stress because of characterological pathology, the cumulative emotional and physical stress of parenting very likely played a significant role in the sudden and catastrophic psychological failure of an already brittle and deficient ego. For each of these patients, as part of their personality disorder, it was their repressed rage that was violently released by their psychosis. And it is precisely these instances where "situational factors cannot be ignored in the buildup to the crime, [and that] vulnerability to committing such an act can be fully understood only through exploring the premorbid intrapsychic qualities evident in the personality" (Ref. 14, p 2) if we are ever to comprehend how a parent could consider and complete such a tragic act of violence toward his or her child.[15]

We contend that any exploration of the patients' "premorbid intrapsychic. . .personality" must be informed by a psychodynamic understanding of childhood traumas or losses that resulted in object relations deficits, inadequate ego defenses, or unresolved oedipal strivings. It is the losses, frustrations, or emotional privation and the resultant developmental failures in infancy and childhood that give rise to precocious and overwhelming frustration and that cannot be resolved by the nascent ego of the individual. Frustration that cannot be mitigated (by the primary parent) becomes anger, and anger that cannot be resolved becomes rage, and rage toward the abandoning or frustrating object (the primary parent) is kept repressed and out of conscious awareness. From this repressed rage come fantasies and fears of destroying the object that must themselves be repressed. From a psychodynamic perspective, it is this repressed rage that is subsequently unrepressed until disinhibited by depression or psychosis and acted out through the murder or attempted murder of the child.[16]

Prevention, therefore, should be based on identifying those burdened by such overwhelming rage before their psychological resources fail. This, however, requires that we identify those individuals for whom childhood losses, traumas, or emotional privations have resulted in characterological vulnerabilities to mental illness and who, as parents, may be vulnerable to psychotic decompensation and rage.

Understanding the non-genetic, non-biological psychodynamic processes of filicidal parents may bring us closer to identifying proactively what makes someone vulnerable to a breakthrough of violent rage when depressed, manic, or psychotically disorganized. For these individuals, a predisposition to men-

tal illness may be a direct result of early parental emotional neglect, traumas of various sorts, and a variety of development failures that ultimately result in characterological pathology and vulnerability. Failure to develop sufficient object relational capacities in infancy may then impair the capacity for intra- and extra-familial interpersonal relationships, which further impedes the ongoing development of ego functions to cope with stress and anxiety, out of which arises the structural problems and patterns of a personality disorder.[17–20] These chronic psychological deficits, when carried into adulthood as personality disorders, very often increase vulnerability to major mental illness. Furthermore, these severe deficits may continue to impair their ability as adults to develop appropriate relationships with significant others to obtain emotional support and comfort for themselves. Because of their deficient infant-parent experiences from childhood, such parents do not have the necessary psychological parent-infant paradigms from which they can derive the needed guidance to care for and protect their child. It may be that, for these individuals with impaired relational capacities, inadequate and fragile ego functions, and impaired capacity for object constancy that does not allow a relationship to persist despite intense negative affect, psychosis removes the final psychological barrier to filicide.

Supporting the psychodynamic notion that there are certain necessary, activating or inhibiting cognitive (ego) functions achieved developmentally and incrementally, there is new and evolving neurological research to support the psychodynamic concept of object constancy. Object constancy is theorized as the cognitive ability that allows an infant to maintain the positive concept of the primary parent, in their absence and despite discomfort, frustration, or rage. Moreover, this research suggests that it is a definite, measurable neurological function of the frontal lobes[21] and that this cognitive and emotional growth is a necessary foundation for the individual to cope with stress. With this kind of empirical research, we find support for the conclusion that (psychodynamically speaking) a deficient capacity for object constancy may be the result of generalized frontal lobe defect, suggesting concomitant decreases in impulse control and/or impairment of other cognitive functions. Out of such impaired frontal lobe executive functions, there may arise aggressive, impulsive, disinhibited behavior nosologically considered to be character pathology.

Future research may uncover ways in which expectant mothers (or any parent being treated and pharmacologically stabilized for depression, mania, or substance abuse) can be screened for coping deficits related to childhood trauma, emotional abuse or deprivation, physical or sexual abuse, and parental loss or abandonment so that they may be referred for psychodynamic therapy specifically to assess, identify, and treat unresolved developmental problems.

With sufficient and appropriate therapy, however, we believe that such parents could resolve some of their problems and conflicts, improve their capacity for interpersonal relationships, and enhance their tolerance for stress; and, at the very least, they may be better able to recognize the warning signs of impending emotional disaster and to seek help before catastrophic psychological failure. Unfortunately, long-term psychodynamic psychotherapy in a managed care world is increasingly marginalized by the latest cost-conscious, 10-session, manualized counseling approach. There is, however, a growing body of empirical support for the use of psychodynamically oriented treatment approaches for exactly these kinds of characterological defects.[22] As long as outpatient treatment consists of quick-fix treatment approaches that fail to identify or address underlying and unresolved psychodynamic and coping deficits, the sad, tragic event of filicide will continue to be mostly unpredictable.

References

1. Hatters Friedman S, Hrouda DR, Holden CE, *et al*: Filicide-suicide: common factors in parents who kill their children and themselves. J Am Acad Psychiatry Law 33:496–504, 2005
2. Farooque R, Dabfe D, Ernst F: Filicide: a review of eight years of clinical experience. J Natl Med Assoc 95:90–4, 2003
3. Spinelli MG: A systematic investigation of 16 cases of neonaticide. Am J Psychiatry 158:811–13, 2001
4. Spinelli M: Maternal infanticide associated with mental illness: prevention and the promise of saved lives. Am J Psychiatry 161: 1548–57, 2004
5. Hatters Friedman S, Horwitz SM, Resnick PJ: Child murder by mothers: a critical analysis of the current state of knowledge and a research agenda. Am J Psychiatry 162:1578–87, 2005
6. Resnick PJ: Child murder by parents: a psychiatric review of filicide. Am J Psychiatry 126:325–34, 1969
7. Bourget D, Gagné P: Maternal filicide in Quebec. J Am Acad Psychiatry Law 30:345–51, 2001
8. Guileyardo J, Prahlow J, Barnard J: Familial filicide and filicide classification. Am J Forensic Med Pathol 20:286–92, 1999
9. Kunst J: Fraught with the utmost danger: the object relations of mothers who kill their children. Bull Menninger Clin 66:19–38, 2002

10. Meloy JR: Violent and homicidal behavior in primitive mental states. J Am Acad Psychoanal, 16:381–94, 1988
11. Lewis C, Bunce S: Filicidal mothers and the impact of psychosis on maternal filicide. J Am Acad Psychiatry Law 31:459–70, 2003
12. Conrad J: Heart of Darkness: An Authoritative Text, Backgrounds and Sources, Criticism (ed 3). Edited by Kimbrough R. New York: W. W. Norton & Co., 1987
13. Satten J, Menninger K, Rosen I, *et al*: Murder without apparent motive: a study in personality disorganization. Am J Psychiatry 117:48–53, 1960
14. Cartwright D: The narcissistic exoskeleton: the defensive organization of the rage-type murderer. Bull Menninger Clin 66:1–18, 2002
15. Hillbrand M: Homicide-Suicide. Prof Psychol Res Pract 32:626–36, 2001
16 Nestor PG: Mental disorder and violence: personality dimensions and clinical features. Am J Psychiatry 159:1973–8, 2002
17. Bowlby J: Attachment and Loss: Attachment (vol 1). New York: Basic Books, 1969
18. Bowlby J: Attachment and Loss: Separation (vol 2). New York: Basic Books, 1973
19. Bowlby J: Attachment and Loss: Loss, Sadness and Depression (vol 3). New York: Basic Books, 1980
20. Moncher FJ: The relationship of maternal adult attachment style and risk of physical child abuse. J Interpers Violence 11:335–50, 1996
21. Baird A, Kagan J, Gaudette T, *et al*: Frontal lobe activation during object permanence: data from near infrared spectroscopy. Neuroimaging 16:1120–6, 2002
22. Bornstein R: Reconnecting psychoanalysis to mainstream psychology: challenges and opportunities. Psychoanal Psychol 22: 323–40, 2005