Shanghai Archives of Psychiatry, 2015, Vol. 27, No. 5

•Case report•

Infanticide by a mother with untreated schizophrenia

Rahul SAHA[1,3,*], Shubh Mohan SINGH[2], Anil NISCHAL[3]

Summary: This case report describes a 30-year-old mother of four with a 6-year history of obvious paranoia and psychosis from a poor rural farming community in India. Her symptoms and social functioning deteriorated over time, but the family did not seek medical care until she killed her 3-month-old daughter while under the influence of command hallucinations. Subsequent treatment with antipsychotic medication resulted in control of her psychotic symptoms and greatly improved psychosocial functioning. This case is an example of one of the many negative consequences of a community's failure to recognize and treat mental illnesses. The patient had severe symptoms that were obvious to all for 6 years prior to the infanticide, but the family's lack of basic knowledge about mental illness, the lack of locally available mental health care, and the relatively high cost of care prevented family members from obtaining the treatment that almost certainly would have prevented the tragic death of her infant. Changing these three factors in poor rural communities of low- and middle-income countries is the challenge we must work together to address. Infanticide secondary to untreated mental illness is a glaring reminder of how urgent this task is.

Keywords: schizophrenia; infanticide; at-risk mothers; India

[*Shanghai Arch Psychiatry.* 2015; **27**(5): 311-314. doi: http://dx.doi.org/10.11919/j.issn.1002-0829.215058]

1. Introduction

The prevalence of schizophrenic disorders is usually estimated as less than 1% of the population, but persons with schizophrenia account for between 5 to 20% of all homicides by persons with mental disorders.[13] The incidence of homicide by severely mentally ill individuals is approximately 0.13 per 100,000 per year in most countries,[2] but it is higher in countries with higher total homicide rates.[4] Few studies have attempted to estimate the rate of homicide by individuals with schizophrenia, but the figure of 1 in 3000 males with schizophrenia per year estimated by Wallace and colleagues[3,5] in 1998 is widely quoted. However, these figures do not distinguish between individuals who have never been treated, those who are not currently being treated, and those who are currently being treated; there may be significant differences in the homicide rates between these three groups of individuals with schizophrenia.

If the risk of homicide is greatest during the first episode of illness in schizophrenia, earlier recognition and treatment of persons with schizophrenia could reduce the risk of homicide. This possibility is supported by the findings of two recent ecological studies. The first found a lower rate of homicide during the first episode of psychosis in countries where the duration of untreated psychosis was shorter.[6] The second reported a dramatic decline in rates of homicide by people with mental illnesses in England and Wales that started at the time community-based primary psychiatric care became available, despite a rise in other forms of homicide over the same period.[4]

This case report describes a tragic infanticide in India by a mother who had an untreated severe mental illness.

2. Case history

Mrs. X, a 30-year-old housewife from a poor rural household, was brought to the adult psychiatric outpatient department at King George's Medical University (KGMU) in Lucknow, Uttar Pradesh by her husband with a 6-year history of suspiciousness, muttering to self without obvious reason, and decreased sleep. One of the main reasons the family brought her to the city for professional psychiatric evaluation was that she had killed her 3-month-old daughter 8 months earlier.

[1]Department of Psychiatry, Dr. Ram Manohar Lohia Hospital, New Delhi, India
[2]Department of Psychiatry, Post Graduate Institute of Medical Educational & Research, Chandigarh, India
[3]Department of Psychiatry, King George's Medical University, Lucknow, Uttar Pradesh, India
*correspondence: drrahul.saha19@gmail.com

A full-text Chinese translation of this article will be available at http://dx.doi.org/10.11919/j.issn.1002-0829.215058 on February 26, 2016.

About 6 years previously (when she was 24 years old), she started to believe that her husband was involved in a conspiracy, the goal of which was to kill her. She gradually stopped eating with other family members because she was afraid that her husband would try to poison her. Three years previously she and her husband stopped living with the husband's parents and moved to a nearby house because she was suspicious about the intentions of her in-laws. She also believed that her children were involved in this conspiracy and would kill her when they grew up. Driven by this fear of being killed, she had attempted to kill her husband at night on four separate occasions.

During the course of her illness other changes in her behavior included muttering to herself without any obvious reason, smiling to herself, and gesturing in the air. Sometimes she reported hearing the voices of her dead parents and said that she would talk to them. She progressively decreased her interactions with family members, showed little initiative for work, did not engage in any pleasurable activities, and became apathetic and withdrawn. Gradually she stopped doing any household activities, including caring for her children and husband. Her self-care deteriorated; she would often go without bathing for weeks. She would not leave her room for days at a time and refuse any food offered to her or, alternatively, wander aimlessly in the neighborhood. Her sleep decreased to 1-2 hours per day; throughout the nighttime she would continually mutter to herself and pace about the room.

The intensity of the symptoms varied over time, including moderate exacerbations during the prenatal period of her pregnancies (she had four children aged 6 years, 3 years, 1 year, and 3 months at the time of the death of her daughter). When the symptoms were severe, her husband consulted the local faith healers who suggested that the symptoms were a 'supernatural spirit' trying to control her and recommended the use of various local herbs (which were not effective). They also recommended locking her up in her room when her symptoms were severe, so her husband frequently locked her up in the home. There was no change in the symptoms after the birth of her fourth child, so she was allowed to sleep with the baby in the belief that this would help reduce her suspicions about family members. There was no warning about what was to follow.

At 3 a.m. one morning she woke and, after checking that her husband and other children were asleep, took her 3-month-old daughter out of the house, smothered her, and concealed the body in a mesh net in a nearby pond. When her husband woke to find that his wife and daughter were not in the house, he went searching for them in the neighborhood. When he found her and asked her about the whereabouts of her daughter, she told him that she had killed the child and showed him the location of the body. According to her husband, she appeared unconcerned about the episode at the time and subsequently showed no remorse. When asked about the reason for her behavior she stated that "It needed to be done" and that her mother (who had died 5 years previously) asked her to do it.

Following this tragic incident, the villagers and in-laws came to the support of the family. No official complaint was lodged with the police, but her husband was advised by local villagers to consult a general medical practitioner. When he did this, the patient was diagnosed as 'psychosis' and treated with benzodiazepines for sleep. The medical practitioner also recommended taking her to a specialty psychiatric center in the city for formal diagnosis and treatment.

When she was brought to our outpatient department, the mental status examination revealed decreased psychomotor activity and poor personal hygiene. She was conscious of self and her surroundings and was oriented to person, time, and place. Her attention was alert, but her concentration was impaired. Her affect was fearful throughout the interview. Her thinking showed well systematized delusions of persecution, of reference, of infidelity by her husband, and of being controlled by others. She also reported having heard command auditory hallucinations instructing her to kill her infant daughter who she believed would otherwise kill her when she grew up. The voices, which she recognized as those of her dead parents, also commanded her to kill her husband and told her that her husband was responsible for their deaths five years previously. When asked about why she had not killed her other children, she replied that she had planned to kill them, but she did not do so because they were old enough to resist her.

Her immediate, recent, and remote memory was intact. She had limited general knowledge and poor math abilities. Her abstract thinking and judgment were impaired. She had no insight about her illness. All of her routine blood tests and X-ray examinations were within normal limits. Her IQ test revealed low-average intelligence (IQ=75-80, mental age approximately 12.5 years). The psychogram generated from a Rorschach test suggested schizophrenform psychosis. Her premorbid personality was reported by the husband to be normal, she did not use alcohol or other drugs, there was no history of epilepsy or serious head trauma, and there was no family history of mental illness.

On the basis of her history and mental status examination she was diagnosed as having paranoid schizophrenia and hospitalization was recommended. However, due to lack of financial and social support, her husband refused to hospitalize her. She was started on olanzapine 10 mg twice daily and lorazepam 2 mg twice daily on an outpatient basis and was scheduled for regular follow-up visits every 2 weeks for the next 2 months. When re-evaluated 6 months later, she was being maintained on olanzapine 10 mg twice daily, lorazepam 2 mg at bedtime, and 40 mg long-acting flupenthixol every 4 weeks. Her behavior toward her family had improved. She had started taking care of

her children and reported that she regretted having killed her daughter. The intensity of her delusions and hallucinations had lessened to the point where she only heard the voices occasionally. Her husband reported no bizarre or threatening behavior.

3. Discussion

This case highlights the need of identifying and helping mothers who are at-risk for harming their children. Mental health providers are one of the many stakeholders who need to participate in this effort; other key stakeholders are family members, teachers, different types of community workers, and general medical practitioners. Whenever a mental illness is present or suspected in a mother who is responsible for caring for her children, family members, service workers, and clinicians must sensitively inquire about and continually monitor the effect of the mother's illness on the children in terms of potential neglect, abuse, battering, or outright attack. This is usually approached by asking the mother (and other family members if present at the interview) about childrearing practices, parenting problems, and feelings of being overwhelmed. When a risk to the health or well-being of the children is identified, active interventions dictated by custom and (if relevant) legal measures need to be instituted to protect the children. In most rural communities of low- and middle-income counties without family protective services, this will involve mobilizing members of the extended family to help in the care of the at-risk children. At the same time treatment of the mentally ill mother must focus on improving her functioning to a level where she can safely resume responsibility (or partial responsibility) for caring for her children.

A recent study of Indian mothers with severe mental illness in the postpartum period found that mothers with delusions about their infant engaged in more abuse.[7] One report from western counties found that up to 4% of mothers with untreated postpartum psychosis will carry out infanticide.[8] Early screening and identification of mental illness, in both the antenatal and postnatal periods, is important; the Edinburgh Postnatal Depression Scale[9,10] is a validated tool that is often used to do this. Severe depression, suicidality, psychosis, and a prior history of child abuse in the mother are all associated with increased risk of infanticide. Psychotic mothers experiencing persecutory delusions with active hallucinations, aggressive behaviors, gross disorganization, or fear that their children may suffer a fate worse than death should either be hospitalized or separated from their children. These mothers may be reluctant to disclose their delusional ideas, but their delusions may sometimes be elicited through a sympathetic exploration of their concerns for the safety of their children. In this case the presence of gross psychotic symptoms was responsible for the tragic incident. Had there been timely evaluation and treatment, such an incident could have been avoided.

It is, however, important to remember than more infanticides occur due to fatal maltreatment by mothers without a mental illness than because of maternal psychiatric illness. The reasons for such infanticides include failure of the child to respond to maternal demands such as to stop crying,[11] an unwanted child (e.g., female infants in strongly paternalistic cultures), revenge on the husband (who may be having an affair), and so forth. Mothers who batter their children to death are likely to have abused their children more than once before the actual death,[11,12] so there is an opportunity for prevention if family members or other actors (teachers, doctors) take appropriate action when the initial episodes are identified. Mental health professionals who become involved in such cases need to try to understand the complex psychosocial issues affecting the various actors in the case and use this information to ensure the best possible outcomes for the children.

4. Conclusion

Prevention of infanticide by mothers with mental illnesses requires a) increasing basic knowledge about mental illness in the community, b) making mental health services locally available and affordable (preferably free-of-charge) for all, and c) decreasing the stigma of mental illness so individuals and their families are willing to seek mental health care. Achieving these goals, particularly in poor rural communities of low- and middle-income countries, is a major challenge that has not yet been prioritized by many local and national governments. Psychiatrists and other stakeholders interested in mental health need to become active and persistent advocates who continuously encourage their communities to allocate the intellectual manpower and financial resources needed to address this problem. Psychiatrists also have the additional role of identifying at-risk mothers[13] and, if an infanticide does occur, of providing services to the mothers, their families, and their communities to help resolve the long-term grief, guilt, and anger that often ensues.

Funding

No funding was received to prepare this case report.

Conflict of interest statement

The authors report no conflict of interest related to this case report.

Informed consent

The patient's husband provided written informed consent for the publication of this case report.

未治疗的精神分裂症母亲弑婴案例

Saha R, Singh SM, Nischal A

概述：本病例系一位 4 个孩子的母亲，30 岁，来自印度贫困农村，有明显偏执和精神病史 6 年。患者的症状和社会功能已经越来越恶化，但家人一直没有带其就医，直到她在命令性幻觉的影响下杀死了自己 3 个月大的女儿。此后使用抗精神病药物治疗，患者的精神病性症状得到控制，心理社会功能也明显改善。该案例是在社区中未能识别和治疗精神疾病造成诸多负面后果的典型案例之一。该患者在弑婴之前已经有长达 6 年的显而易见的严重症状，但由于家人缺乏关于精神疾病的常识，当地缺少精神卫生保健资源，加上医疗费用相对昂贵，患者未能得到及时治疗，导致了这起原本可以避免的婴儿惨死案件。要改变上述三个在中低等收入国家的农村贫困地区阻碍治疗的因素，我们必须共同应对这一挑战。任务紧迫！这一因精神疾病未得到治疗所致的弑婴病例为我们敲响了警钟。

关键词：精神分裂症；弑婴；高危母亲；印度

本文全文中文版从 2016 年 2 月 26 日起在
http://dx.doi.org/10.11919/j.issn.1002-0829.215058 可供免费阅览下载

References

1. Fazel S, Grann M. Psychiatric morbidity among homicide offenders: a Swedish population study. *Am J Psychiatry*. 2004; **161**: 2129-2131
2. Coid J. The epidemiology of abnormal homicide and murder followed by suicide. *Psychol Med*. 1983; **13**: 855-860
3. Wallace C, Mullen P, Burgess P, Palmer S, Ruschena D, Browne C. Serious criminal offending and mental disorder: case linkage study. *Br J Psychiatry*. 1998; **172**: 477-484
4. Large M, Smith G, Swinson N, Shaw J, Nielssen O. Homicide due to mental disorder in England and Wales over 50 years. *Br J Psychiatry*. 2008; **193**(2): 130-133. doi: http://dx.doi.org/10.1192/bjp.bp.107.046581
5. Walsh E, Buchanan A, Fahy T. Violence and schizophrenia: examining the evidence. *Br J Psychiatry*. 2002; **180**(6): 490-495. doi: http://dx.doi.org/10.1192/bjp.180.6.490
6. Large M, Nielssen O. Evidence for a relationship between the duration of untreated psychosis and the proportion of psychotic homicides prior to treatment. *Soc Psychiatry Psychiatr Epidemiol*. 2008; **43**(1): 37-44. doi: http://dx.doi.org/10.1007/s00127-007-0274-0
7. Chandra PS, Bhargavaraman RP, RaghunandanVNGP, Shaligram D. Delusions related to infant and their association with mother-infant interactions in postpartum psychotic disorders. *Arch Women Ment Health*. 2006; **9**(5): 285-288. doi: http://dx.doi.org/10.1007/s00737-006-0147-7
8. Altshuler LL, Hendrick V, Cohen LS. Course of mood and anxiety disorders during pregnancy and the postpartum period. *J Clin Psychiatry*. 1998; **59**(Suppl): 29-33
9. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry*. 1987; **150**: 782-786
10. Ryan D, Milis L, Misri N. Depression during pregnancy. *Can Fam Physician*. 2005; **51**(8): 1087-1093
11. Alder C, Polk K. *Child Victims of Homicide*. Cambridge: Cambridge University Press; 2001
12. Haapasalo J, Petaja S. Mothers who killed or attempted to kill their child: life circumstances, childhood abuse, and types of killing. *Violence Vict*. 1999; **14**(3): 219-239
13. Wisner KL, Gracious BL, Piontek CM, Peindl K, Perel JM. Postpartum disorders: phenomenology, treatment approaches, and relationship to infanticide. In: Spinelli MG, editor. *Infanticide: Psychosocial and Legal Perspectives on Mothers Who Kill*. Washington DC: American Psychiatric Publishing; 2002. p. 36-60

(received, 2015-05-21; accepted, 2015-10-12)

Dr. Saha obtained his Bachelor of Medicine and Bachelor of Surgery degree in 2005 from Maharani Laxmi Bai Medical College, Jhansi, Uttar Pradesh and an MD in Psychiatry in 2011 from King George's Medical University, Lucknow, Uttar Pradesh. He is currently working as a senior research associate in the Department of Psychiatry at the Post Graduate Institute of Medical Educational & Research (PGIMER), Dr. Ram Manohar Lohia (RML) Hospital, New Delhi. His research interests are the phenomenology of attention deficit hyperactivity disorder (ADHD) and schizophrenia. He is currently working on a project titled 'Follow-up study of phenomenology and functional impairment in ADHD children'.