REFLECTIONS ON THE CARE DELIVERED IN A SUSPECTED CASE OF INFANTICIDE

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Scherer EA, Scherer ZAP. Reflections on the care delivered in a suspected case of infanticide. Rev Latino-am Enfermagem 2007 julho-agosto; 15(4):692-8.

This study resulted from the experience of supervising a suspected infanticide case hospitalized at a psychiatric ward. We aimed to find support in scientific literature about infanticide, point out an interdisciplinary health team's affliction and uncertainties when faced with this kind of case and suggest strategies for dealing with these feelings and their possible consequences in dealing with this case. Professionals involved in this case observed their discomfort about the situation and difficulties caused by feelings of guilt about the child's death, whether intentional or not. Specialists suggests that the relation between psychiatry and the law should be facilitated by "demedicalizing" the crime, including socioeconomic factors, comorbidities, domestic violence, cultural norms etc. The team must try and learn from these mothers, overcoming their anger or repulsion with compassion and courage to understand infanticide.

DESCRIPTORS: infanticide; domestic violence; depression, postpartum; infant mortality

REFLEXIONES SOBRE LA ATENCIÓN DE UN CASO DE SOSPECHA DE INFANTICIDIO

El presente estudio resulta de la experiencia del trabajo de supervisión de un caso de una persona sospecha de haber cometido infanticidio internada en una Enfermería de Psiquiatría. El objetivo fue buscar respaldo en literatura científica sobre infanticidio, denotar las aflicciones e incertidumbre que un equipo psiquiátrico interdisciplinario puede encontrar cuando colocada frente al acompañamiento de un caso como este y sugerir estrategias para lidiar con tales sentimientos y sus posibles consecuencias en el manejo del caso. Profesionales envueltos en el atendimiento denotaran desaliento frente a la situación y dificultades con sentimientos relacionados a la culpabilidad en la muerte del niño, intencional o no. Estudiosos sugieren facilitar la relación entre psiquiatría y ley a través de la "desmedicalización" del delito, incluyendo factores socioeconómicos, comorbidad, violencias domesticas, normas culturales y otros. El equipo debe procurar aprender con estas madres, superando la rabia o la repulsa con compasión y coraje para entender el infanticidio.

DESCRIPTORES: infanticidio; violencia domestica; depresión postparto; mortalidad infantil

REFLEXÕES SOBRE A ASSISTÊNCIA DE UM CASO DE SUSPEITA DE INFANTICÍDIO

O presente estudo resulta da experiência do trabalho de supervisão do caso de uma pessoa suspeita de ter cometido infanticídio, internada em uma enfermaria de psiquiatria. O objetivo foi buscar respaldo em literatura científica sobre infanticídio, denotar as aflições e incertezas que uma equipe interdisciplinar psiquiátrica pode encontrar quando colocada frente ao acompanhamento de um caso como esse e sugerir estratégias para lidar com tais sentimentos e suas possíveis conseqüências no manejo do caso. Profissionais envolvidos no atendimento denotaram desconforto frente à situação e dificuldades com sentimentos relacionados à culpabilidade na morte da criança, intencional ou não. Estudiosos sugerem facilitar a relação entre psiquiatria e lei através da "desmedicalização" do delito, incluindo fatores socioeconômicos, comorbidades, violências domésticas, normas culturais e outros. A equipe deve procurar aprender com as mães, incluídas em situações semelhantes, superando a raiva ou a repulsa com compaixão e coragem para entender o infanticídio.

DESCRITORES: infanticídio; violência doméstica; depressão pós-parto; mortalidade infantil

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INTRODUCTION

Aggressiveness is understood as part of the human instinct, that is, it is something innate to the human being. Its manifestation under the form of an action configures an aggression that can be considered violence. It has increased both in frequency and in type or form of presentation. It appears in the communication media represented by domestic violence, and also in large armed conflicts. New forms of manifestation in which man is victimized have emerged, following evolution and technological progress.

Diseases caused by the inadequate use of resources made available by so called "modernisms", sometimes confounded with "fashion" have been increasingly studied and detected. The growing stimulus to apparently harmless virtual relationships can entail consequences for the way the individual relates with others. In addition, the increase in mental disorders like anxiety and depression has already been perceived in people who live in constant stress, always in a hurry and "plugged or connected" the whole day. There is no room for contact with nature or for leisure time with friends and family anymore. A characteristic of these violent behaviors is the lack of knowledge, that is, the victim's lack of awareness that (s)he is being or is becoming the target of an aggression. Self-aggression is not uncommon either.

Thus, the human being has become solitary, disperse and confused and can even lose the capacity to recognize what is considered normal or abnormal behavior. Some violent acts start to be accepted by "common sense", that is, their meaning becomes understood in terms of the cultural context. The moral principles seem to support these explanations. Hence, homicides can be justified by potential personal gains and, although not accepted, are a part of daily events[1].

There is an issue that deserves attention amid this threatening reality. The different forms of violence elect the weakest as victims. This category includes children, who are born totally defenseless and live during long periods depending on others (adults)[2].

The relation between Mental Health, Crime and Justice can generate discomfort when one analyzes a determined situation, besides arousing doubts in its management. One circumstance that illustrates these difficulties is related to cases of suspicion, or even confirmation, that the person who was supposed to be responsible for care actually caused his/her own child's death.

Mistreats against children[2] in their diverse manifestations, that is, from psychological violence to those that culminate in death, exist since the genesis of the human being. In ancient civilizations, infanticide was considered a means to eliminate all those little ones who, by misfortune, were born with physical defects. Children were killed or abandoned to die undernourished or devoured by animals, for reasons like: balance of genders, economic measures in great calamities, not being able to bear long travels, religious reasons, the father's right to recognize his child's right to live or not ("Jus vitae et nasci" - Rome).

With the development of civilizations in successive stages, the motivation and methods to abuse or kill children have diversified. Motivations include economic, political, ideological, war, educational, insanity and religious justifications. There seems to be an agreement that children are propriety to be disposed of by their own parents. For some experts, the child has a minor "status" in society, which ends up reflecting in infanticide laws, which enforce lesser punishments than those for homicide and allow for defense based on insanity. On the other side, when the child's minor social status is questioned, there is no ambivalence or mercy standard in terms of the punishment[3] for the parent who kills a child.

In psychiatric clinical practice, professionals can be confronted with violent situations that involve the client in many ways. This person can be the victim of mistreats in childhood or even a perpetrator of violence against children. Handling such situations arouses discomfort in those responsible for care delivery.

In this study, motivated by the follow-up of a case in which a mother was suspected of having killed her eight-month-old son, the authors present considerations about the theme infanticide and filicide. What caught the attention of the professionals involved in care for this case was the reason why this person was taken to the service. It is a situation of a woman with a long history of untreated psychotic symptoms, who was not brought to the service for being sick, but rather for having been found in the street with her dead baby in her arms. The difficulties that might emerge in the follow-up and management of this kind of cases like this one and specific literature data are presented, in order to serve as a source for other professionals who might face similar situations.

OBJECTIVE

Describe the afflictions and uncertainty an interdisciplinary psychiatric team might face when confronted with care delivery to a suspected case of infanticide and suggest strategies to deal with these feelings and their potential consequences in case management.

Seek support in scientific literature about infanticide.

METHOD

This study results from the experience in the supervision of a person suspected of having committed infanticide, hospitalized in the Psychiatric Ward of the *Hospital das Clínicas* at the University of São Paulo at Ribeirão Preto Medical School (PW). This nursing ward is characterized by the tertiary service it delivers to people with psychiatric disorders.

Therefore, this work is a reflection by a psychiatric assistant physician and a psychiatric nursing faculty, responsible for the supervision of this case. Hence, this study follows the case study method[4], in which a discussion (reflection) is performed, based on relevant literature in the face of a case report.

The PW[5] psychiatric care team is composed of a fixed group (physicians, nurses, psychologists, social workers, occupational therapists and nursing aids) and another floating one (resident physicians, specialization course students in psychology, social service and occupational therapy and undergraduate students) in an in-service learning scheme. The work model is the interdisciplinary team, so that the fixed and floating professionals participate actively in the discussions, therapeutic planning and implementation of treatment techniques. Because it is a teaching hospital, activities are supervised by faculty members and technicians with a college degree.

The service offers 14 beds for full-time hospitalization, eight for women and six for men. During their stay at the nursing ward, the users participate in a treatment program that includes pharmacotherapy, daily operative groups (according to the therapeutic community), physical and leisure activities, individual psychotherapy sessions, occupational therapy groups and family meetings. These approaches follow the precepts of the therapeutic environment model[5].

For the bibliographic review, publications in national and international journals cited in LILACS (Latin American and Caribbean Health Sciences) and PubMed (National Library of Medicine) and the Brazilian Penal Code[6] were selected.

Following the ethical and legal precepts, the authors consulted the Ethics Committee of the institution where the study was performed. In order to preserve the client, this Committee suggested she should sign the free and informed consent term, which the authors requested. Regarding the care team in the situation presented, the referred committee suggested that the authors should present them their results, aiming to provide an instrument to guide their actions in similar situations they might encounter in the future.

RESULTS AND DISCUSSION

Case synthesis

Woman, 29 years old, white, married, two children (four-year-old daughter and eight-month-old son), housewife, Pentecostal religion, and unfinished basic education.

Accompanied by the police for psychiatric care when found sitting on the sidewalk with her eight-month-old son “unconscious” in her arms. The child’s death was confirmed (Report from the Ribeirão Preto Legal Medicine Center - CEMEL) - cause of death: mechanical asphyxia, without possibility of knowing the motive, that is, it was not possible to characterize intention or guilt).

She revealed to be anxious and restless during the care, talking about fear of death, asking for a knife to kill herself. Reported having left the house with the child, at midnight, for having heard voices that said they wanted to kill her. Alternated reports that, guided by voices, she asphyxiated her son, pushing him against her breast, or that she had covered his mouth and nose to warm him, or that she had found him dead (in the cradle) and ran away, afraid that her husband would blame her.

When she was 13 years old she started to hear voices talking to her or among them, judging her attitudes, producing offenses or orders, especially when she was in stressing situations. She tried to commit suicide twice while adolescent. However, up to the moment of this care, she had not sought medical help.

The psychiatric diagnostic hypothesis was Paranoid Schizophrenia (ICD 10: F 20.0).

Contextualizing the infanticide

The case reported in this study motivated the researchers to seek clarification on situations in which parents cause the death of their children. After the literature review, participating in forum discussions about domestic violence and discussing the management of this case with other professionals of the area, including psychiatrists, social workers and psychoanalysts, it could be perceived that the questioning of such occurrences starts with the denomination of the fact itself, that is, is it infanticide or filicide?

In Brazil, the term infanticide is described in the Penal Code[6], under article 123, as "kill, under the influence of the puerperal state the own child during delivery or right after". The expected punishment is detention of two to six years. Filicide would be the act of killing one's own child[7], which fits in the same category as homicide crimes, established in article 121 of the Penal Code[6], with punishment of reclusion from 6 to 20 years. Article 26 of the same code also determines a reduction of penal capacity in cases of mental disease, incomplete mental development or mental retardation of the aggressor, previewing a punishment reduction by one to two-thirds.

There exists specific legislation about infanticide in countries like New Zealand, England, Australia, Canada, Austria, Colombia, Finland, Greece, India, Korea, Philippines and Turkey. There are differences in these legislations regarding the determination of the child's age, although the provision of guilt reduction in these cases is common when compared to homicide. However, in the United States and Scotland, the legislation does not provide for any distinction between homicide and infanticide[3].

The controversy regarding the denomination of the act of killing one's own child appears in specialized literature. There is criticism regarding the legal use of the term infanticide, which is generally based on the existence of a mental disorder in the mother, due to the puerperal or lactation period, or even a disorder presented by women and linked to reproduction[8]. According to researchers, there is no sufficient evidence that confirms the existence of such disorders[8-9]. There are indications of a relation with bipolar affective disorders and of a wide range of disorders, including psychogenic and organic psychoses[9]. Experts also question the fact that such cases are treated differently from other crimes committed by people with mental disorders, that is, through specific legislation[3,8,10]. Data are presented supporting this position, showing that 50% of women who commit infanticide do it in the context of undesired or occult pregnancies[7-8]. Other factors like social and economic situations can also increase infanticide rates[7-8].

In a Cuban research[11] about violent deaths in infants, twelve cases of infanticide were found in the period between 1981 and 1990. In these cases, more than half of the mothers had no occupation, were between 16 and 20 years old, had only finished basic education and the main cause of death was suffocation. This is the most known cause of infantile death in so-called "hidden homicides". Deaths by suffocation might not present signs or evidence pathologists can diagnose. The diagnosis is reached when mothers confess or when they are surprised by hidden camera records[12].

The articles referring to the study theme consider infanticide as the death of a child younger than one and caused by the own mother. Filicide would be the death of a child older than one. Yet, there are authors who characterize the death of an infant in the first 24 hours of life as neonaticide[3,7,9-10,13-14].

After the case *Yates*[13], in which a woman drowned her five children, the American Psychiatric Association published a note about defense based on mental disease and insanity. In this note, it manifests the expectation that both society and its legal system will discuss how to deal with criminals with severe mental disease. It is known that advances were made in neurosciences, increasing the understanding of how the mental functioning is altered by mental disease and how a psychosis can distort reality. However, so far, popular understanding has not been affected by these advancements. The decision to punish mentally sick people has been influenced by the lack of awareness of how the disease can affect reasoning and behavior. Prisons are full of mentally sick people, most of whom do not receive adequate treatment. People whose crimes occurred due to their disease should be referred to specialized psychiatric services and treated, not locked in prisons and even less condemned to death.

Still based on the referred case, a review of the legislations and the psychiatric perspective on infanticide[13] mentions factors considered triggers or lost opportunities in the prevention of such infractions. These include the previous mental disease history;

labor conditions; family history of mental disorder; stigma or family disbelief due to religious beliefs (it is the devil's thing). Regarding the conduct of health professionals involved in post-delivery care, psychoeducation and management are sometimes appointed as inadequate. In the same article, the author concludes that the majority of cases of infanticide and suicide occur outside media spotlights. Diagnostic criteria for post-delivery disorders are crucial for the security of both mother and child.

Aiming to describe maternal characteristics preceding the act of killing one's own child and to suggest preventive strategies, a retrospective study[15] of the forensic hospital records of 39 mothers with severe mental disorder who were considered not guilty by insanity was performed. Around two-thirds of these mothers were having hearing hallucinations, especially commanding voices; half of them were depressive when they committed the infraction and three-quarters had already received previous psychiatric treatment. Almost three-quarters of these women had gone through stressors in their development, such as the death of their own mother and incest. The reasons include "altruism" (to alleviate some real suffering in the child or the mother's delirious belief) and "acute psychotic episode". The authors call for psychiatrists' attention in order to carefully evaluate the risk of filicide in mothers with mental disease.

The interface between health and justice is perceived in a case of infanticide. Thus, there is a need for integrated work between these two entities. Scholars suggest that a closer relation between the psychiatry and law would be favored through the "demedicalization" of the infraction, that is, health professionals should not be restricted to medical-clinical care interventions. When attending and evaluating cases, health technicians are expected to observe socioeconomic factors, comorbidities, domestic violence, cultural norms and others, among the possible causes of this kind of infraction[3,7-8,14].

Another aspect that deserves attention refers to prevention policies. Implementing them requires psychiatry, public health and social sciences to collaborate with their competencies, providing information on people at risk of committing infanticide or filicide. Therefore, researchers are expected to change the way they collect data in order to include specific data about perpetrators of homicide against children and follow-up of mentally-ill mothers, questioning filicide intentions. In order to prevent these events[7], a systemized and focused research program on reliable markers for maternal filicide is necessary.

The health team in care for a case of infanticide

Maternal infanticide or the mother killing her child in the first year of life is a situation that causes embarrassment and repulse. For society in general, it is crime, requires punishment and law. On one side, the defenseless child, killed by the person on whom s(he) depended to live. On the other side, the image of an insane mother, imprisoned for a crime that is unthinkable for most people. It shows the ambivalence of the situation, a contradiction[13].

During care to the case presented here, the (fixed and floating) professionals at the PW showed discomfort and difficulty in dealing with the feelings aroused by delivering care to a person unable to manifest feelings of guilt or not about the death of her own son (intentional or not).

One of the factors that can have influenced or even generated discomfort in the team is related to the closeness between the client and the professionals, which might have aroused mechanisms of identification between them and the case, arousing doubts and difficulties to handle it. Some technicians, women and men, were around the patient's age, had or were planning to have children. There were verbal and non-verbal manifestations of non-conformism, repulse, indignation and anger.

There were frequent questionings during the follow-up about how a person could live with the suffering of a loss in such circumstances, especially by the patient's apparent affective indifference. The indication of contraception was also a motive of several discussions about this case. The professionals manifested countertransference* regarding the patient. It occurred despite the team's awareness that the indifference could be justified by the psychotic condition the patient presented.

Thus, if identification or even countertransference attitudes are detected, it is expected that co-workers help the person to understand what is happening and to acknowledge and respect his(er) own and the other person's limit (patient). It is expected that a help process is

* Countertransference constitutes a phenomenon described by psychoanalysis. It can be understood as a set of the professional's emotions, representations or acts, aroused by the interaction with the patient's psychic ingredients. It is an unconscious phenomenon, that is, occurs despite the therapist's wish.

established and, if necessary, advice to seek individualized support for this professional.

Another relevant aspect in this situation is the human being's tendency to seek and punish a culprit. Another risk was related to punish the family, considering them omissive or even responsible for the disturbed history of the patient's life. The difficulty is to understand the situation and not make judgments.

Mental health professionals are aware that they can face new and uncommon situations at any moment in their practice. Each care delivery can be a motive of uncertainty and affliction. Confronting domestic violence is perhaps one of the most challenging situations, in requiring the technician to remain attentive and loyal to his(er) role. Especially in cases of infanticide (or suspicion), many times, hospitalization is indicated to evaluate and treat the mother who committed the infraction. When it occurs, the care is delivered by a team, which is expected to be exempt, impartial, not judging or "condemning" the client. Curiosity and empathy, in the attempt to understand and even to learn from the patient, besides facilitating the group to perceive the suffering that is not always revealed in a clear way, favor bonding and a therapeutic alliance between mother and team.

In Brazil, like in most countries, there are no public policies or strategies related to mental health care in the perinatal period. The primary care focus is the biology of the pregnancy and puerperal period, while aspects related to mental health are secondary. The mental health team, on the other hand, focuses on cases of more severe mental disorders. In addition, there is also the belief that women with psychotic disorder are less fertile. In London, an active approach is found in the *Maternity and Perinatal Partnerships in Mental Health (MAPPIM)*[16], in St Thomas Hospital, which offers: training for the maternity team in mental health issues, information on perinatality issues, *liaison* consultation between professionals involved in perinatal care and mental health, as well as care and treatment to pregnant women with mental disorders.

CONCLUSION

Questions emerge related to the education of professionals involved in mental health care. Do they receive training that addresses domestic violence in their undergraduate or even in trainee or graduate programs? Is specialized professional education necessary? As shown in this case, the team, composed by experienced technicians from several mental health areas and inserted in a university service that offers in-service training and specialization, is not prepared for an encounter with the reality of infanticide, nor perhaps with other situations in the scope of domestic violence. It reflects the need to invest in the education, training and follow up of professionals. One possible suggestion is to implement permanent education programs accessible to all professionals who might have to deal with this kind of situations.

Another field that deserves attention relates to prevention and clarification to the population itself, aiming to expand the number of notifications and care for cases, since many of them happen out of the care network scope. Perhaps through open discussion forums and with judicial participation, the theme, which is still seen with a certain prejudice and censorship, can be perceived as a problem of the whole society, and not only in the domain of health and legal power.

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Recebido em: 15.5.2006
Aprovado em: 6.10.2006