

Suicide, homicide and infanticide in depression

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Abstract

Depression is a common mental disorder that has a wide range of clinical severity. Suicide, homicide and infanticide are rare events with complex multi-factorial causes. However, when they do occur, they have a devastating impact on patients, relatives and the wider community; understanding the role that depression plays is critical from a clinical perspective.

1. Introduction

Depression is a common mental disorder worldwide (1), with a prevalence of 5 - 10% in primary care (2). More than 50% of individuals who have an episode of depression will experience recurrence after remission (3). The most serious consequences are suicide and, less commonly, infanticide. The link with homicide is less extensively researched. There are interesting parallels and differences between homicide and infanticide, especially with regard to the gender of the perpetrator.

2. Depression and suicide

Approximately 15 - 20% of depressed people die by suicide (4, 5) and depression is the most common mental disorder amongst the over 800,000 people who die globally by suicide every year (6, 7). Having major depressive disorder increases the risk of suicide by a factor of 20 (8).

The link between depression and suicide is important in several respects. First, early recognition and treatment of depression could prevent suicide (5); second, clinicians treating depressed patients must document each person's ongoing risk profile; and third, the understanding that, although a significant proportion do, most people who attempt suicide will not die by suicide (9). An attempted suicide may therefore be a critical opportunity to assess and treat what could be a lifelong, disabling disorder.

2.1 Suicide - risk factors

Identifying which depressed patients are most at risk is of major importance, with evidence suggesting that targeting high-risk patients can reduce suicide risk (10, 11). Completed suicide shows a gender bias, being nearly four times more common in men than women (12). Alcohol use and having the means to complete the act are key factors (5).

In the BRIDGE-II-MIX study (13), a major international study of depression and suicide, 2,811 patients with depression were evaluated, of whom 628 had already attempted suicide. Comparing those depressed patients who had attempted suicide to those who had not, the researchers found increased activation in the context of severe depression often preceded suicide attempts: this included risky behaviour (e.g. reckless driving, promiscuity), psychomotor agitation (pacing around a room, wringing of hands) and impulsivity (displaying behaviour characterised by little or no forethought, reflection or consideration of the consequences).

2.2 Suicide - mechanisms

The consensus is that depression is best considered using a biopsychosocial approach. A family history of suicide increases suicide risk, supporting the possible roles of both a potential genetic component and shared environmental factors (14). Whether the neurochemistry of depressed suicide completers

is different from non-suicidal depressed patients is a question of intense interest (15). There are several neurochemical theories of depressive disorder, with the serotonin theory being the most prominent. The serotonin transporter (SERT) has been the focus of this. Whether polymorphisms within the SERT gene are associated with suicide has not yet been shown unequivocally, although a recent meta-analysis of European and Asian populations does support an association (16).

2.3 Suicide - prevention

Most depressed people who die by suicide are not in contact with secondary mental health care in the period just before death (17), implying that primary care could have a key role (10). It has been shown that training primary care providers in recognising and treating depression reduces suicide rates (18-20).

Professional and societal attitudes must also be considered, as depression, along with mental health conditions in general, remains stigmatised and this represents a barrier to seeking timely treatment.

3. Depression and homicide

Rosenbaum and Bennett, writing in the mid-eighties, thought it unusual that psychiatrists had primarily been concerned with exploring the link between depression and suicide (representing internalised anger), rather than any link with externalisation of depressive anger as homicide (21). They also pointed out that exploring this link is difficult, because homicidal thoughts are rarely expressed spontaneously and not routinely asked about by clinicians. Furthermore, academic study of the role of mental illness is limited by the fact that homicide is usually investigated by police and related agencies, rather than by those with medical expertise.

In addition, it is generally considered to be an issue of stigma that mental illness has been strongly associated with violent crime. Much work has been done to reduce the automatic assumption that people who have mental health problems pose a risk to others. A seminal study of 1,594 homicide convicts in England and Wales (1996 - 1999) found only 10% had symptoms of a mental disorder at the time of the offence (22). The key issue, as the authors pointed out, is that the term 'mental illness' is often very broadly defined. The presence of mental illness at the time of a crime does not automatically lead to a verdict of diminished responsibility. In fact, in those with depression symptoms at the time (6%), it was only the added presence of psychotic symptoms that was associated with diminished responsibility (22).

It is important to define the nature of the homicide. Rosenbaum's group highlighted that, amongst homicides, there are several distinct groups; for example, murders committed in the context of other crimes, e.g. robbery, and 'domestic' murders. They found that, particularly in contrast to criminal-context murders, half of the perpetrators and all instigators of murder-suicide pacts had mental health problems, with depression being the most frequently detected illness (21). This association between murder-suicide pacts and depression was subsequently confirmed by others (23) and it is now posited that murder-suicides are a distinct paradigm (24).

Homicidal depressed patients also differed from non-homicidal depressed patients, being more likely to have a personality disorder, abuse alcohol and to have suffered childhood adversity (21), echoing what we know about suicide – a consideration of the context in which depression occurs, and thus a matrix of factors, is key to understanding what role depression plays in homicide.

4. Depression and infanticide

Infanticide is a subset of filicide (killing one's child): it is filicide within the first year of life. In contrast to general homicide, infanticide is much more common in women than men. An accurate estimate of prevalence is difficult. The literature on infanticide is limited (25), and complicated by the fact that infanticide is under-reported and subject to misclassification bias (26). A recent review reported the incidence in developed countries as between 3.1 to 6.9 per 100,000 (26).

Studies of infanticide cases indicate they can be broadly separated into five main groups (25): women who commit infanticide due to neglect; overly harsh chastisement of the child; following denial/concealment of the pregnancy; or in conjunction with a violent partner. Finally, there is an identifiable group who intentionally kill their infants, and it is for this group that there is an association with postpartum mental

disorders. Formal recognition of this link came in England in 1922, with the Infanticide Act (25) which introduced the idea that "...the balance of [the mother's] mind was disturbed by reason of her not having recovered from the effect of giving birth to the child ..." and was, as such, legally speaking, more similar to manslaughter than murder (27). Friedman and Resnik (28) pointed out that there is opposition to the acceptance of infanticide as a valid entity, with some groups claiming it "pathologises childbirth".

The link between childbirth and psychosis is clearly demonstrated, with postpartum psychosis affecting around 1 - 2 in 1000 women within 2 - 4 weeks of birth (29). Research indicates that, despite being presumed by many as a time of happiness, pregnancy can often be very difficult for women, and depression is common during both pregnancy and the postpartum period, and is similar in phenomenological terms to non-pregnancy-related depression.

How does depression lead a woman to such an extreme act in what is usually a loving dyad? Stanton et al. (30) have pointed out that it is a generally accepted tenet that "those at risk from mentally disordered killers are those of psychological significance to the perpetrator". The most common theme amongst reports of depressed women committing infanticide is "altruistic" reasoning. In the context of a depressive disorder, a woman might believe the world is so bad a place it is better for one's child, often the most significant person in a mother's life, not to be exposed to it. As such, she is 'lovingly' protecting the child by ending its life (30).

Filicides in the context of depression have been found in one small study to be pre-planned for some time, in comparison with filicides in the context of psychosis which were more sudden (28, 30, 31). In a qualitative study of six women who committed filicide while mentally ill, Stanton et al. (30) identified themes of self-induced pressure to be "good mothers". They noted another similar study, where mentally ill mothers did not describe any difficulties at all with mothering. They interpret this as a "desire to be seen in a positive light" and secondary to a "fragile investment in the mothering role whence ambivalence is too threatening to acknowledge".

Again, careful examination of the matrix of factors involved is key. Hatters Friedman and Resnick (28) caution that this must not over-simplify what is a complex area: mothers who kill for other reasons may have diagnosable depression and, conversely, very depressed women may kill for reasons other than altruism.

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