

CASE REPORT

PSYCHIATRY & BEHAVIORAL SCIENCES

J. Reid Meloy,^{1,2,3} Ph.D.

A Catathymic Infanticide

ABSTRACT: A case of infanticide committed by a 37-year-old married man, and the father of three sons, is reported. Clinically depressed since adolescence, and also diagnosed with obsessive-compulsive disorder and a dependent personality, the subject began to worry about killing someone a decade before the homicide. Increasingly disabled by his major depression, unable to work, and confined in his home, the idea that his only recourse was to kill one of his sons became fixed and frequent. Following his fourth psychiatric hospitalization, he took his 13-month-old son home from day care and drowned him in the bathtub. He then called the police and reported his crime. This sudden act of intentional killing was followed by a period of emotional relief and calmness, clearly illustrating the three stages of chronic catathymic homicide.

KEYWORDS: forensic science, forensic psychiatry, forensic psychology, catathymic process, homicide, infanticide

The intentional killing of a young child evokes disgust and horror in most, but it is even more deeply disturbing when it is inexplicable. The usual biopsychosocial conditions that can facilitate homicidal behavior—situational factors, psychosis, a toxic state, or rage—are absent, yet the intent is evident. In some such cases, the cause of the homicide is found in the faint recesses of the individual's mind, and if one looks closely, the idea of homicide has emerged slowly, almost imperceptibly, over the course of days, weeks, months, or even years, a tension filled by-product of emotion and perception that is transference-based, yet remains out of conscious awareness of the individual.

This particular motivation for homicide was originally identified by Wertham (1), who relied on earlier clinical work by Maier (2). It was called catathymia, from the Greek kata and thymos, and is most readily translated, "in accordance with emotion" (3). In a forensic context, the term refers to a motivational pattern for homicide wherein a fixed idea, often rather obsessional, grows in intensity over the course of time until the person feels compelled to kill to alleviate such psychic tension. In its chronic form, there are three clearly identifiable stages: an incubation period during which the idea, initially unwelcome, becomes fixed in the mind of the person over the course of time; a sudden, homicidal act, usually in the absence of any history of violence; and a postoffense period of relief during which memory is fully preserved for the event (4). There is usually no evidence of any conscious anger toward the victim, often an intimate or family member, yet the killing itself is a testament to the capacity for extreme aggression by the perpetrator.

There have been a number of case studies of catathymic homicide published during the past 60 years (5,6), although its rarity has precluded any large, comparative investigations. This is a case of

catathymic infanticide, and to the author's knowledge, the first such study presented in the scientific literature.

The Offense

Mr. L awoke on a warm spring Monday morning and realized that the day had come when he would kill his 13-month-old son. He had stayed in bed most of the morning, as he usually did, and his wife had left much earlier to drop two of his three sons in day care. The second son was four, and the oldest son, who was eight, had left for school.

Mr. L dutifully took his medication cocktail of olanzapine, bupropion, venlafaxine, and lorazepam—it seemed as if they were throwing medications at him now—and continuously thought about the desperate state he was in. He had not worked for a year, he slept most of the day, he could not function as a parent, his wife was increasingly angry at him, and the mental health professionals were not helping. He was hopeless, helpless, humiliated, and felt almost paralyzed by his disorders. He had been diagnosed with major depression since mid-adolescence and had been treated by the same psychiatrist for 20 years with mixed success. His major depressive disorder—he knew the diagnostic terms quite well—did not seem to respond to the pharmaceutical efforts of his doctor, and his belief that he might benefit from psychotherapy appeared to fall on deaf ears. His course of treatment had been medication visits about once a month, and four hospitalizations: two in his late adolescence and two within the past 6 months. His second diagnosis, obsessive-compulsive disorder, did not appear until a decade ago when he was unable to decide whether he had mixed the cement correctly for his bricklaying. His productivity in the masonry company that had employed him for 13 years collapsed, but they generously continued to keep him on the payroll for his health insurance coverage. The other symptom that emerged was his fear that he "would hurt someone." He would arrive at a stop sign and not be able to venture forth in his auto until he had checked the cross traffic multiple times, often sitting at the stop sign for 10 min. He was compelled to return to the stop sign hours later to make sure he had not caused an accident from which he

¹Clinical Professor of Psychiatry, University of California, San Diego, School of Medicine, San Diego, CA.

²Adjunct Professor, University of San Diego School of Law, San Diego, CA.

³Faculty, San Diego Psychoanalytic Institute, San Diego, CA.

Received 30 May 2009; and in revised form 13 July 2009; accepted 19 July 2009.

had fled. Although his wife continued to tolerate his symptoms and emotionally support him, she found some of the repetitive behaviors benign, such as checking to see if the boys' milk had spoiled; and some of the behaviors quite bizarre, such as visiting the neighbors' home to see whether a stairway had collapsed, which he had built years earlier.

But the idea of killing was different. He had attempted suicide when he was twelve by swallowing his mother's psychiatric medication, and he had most recently gestured suicidally by taking a large amount of clonazepam, which precipitated his fourth hospitalization. When he was twenty, however, he had been "born again" as a Christian, and actual suicide was no longer an option. He would be consigned to Hell if he did take his own life. When his first son was born, moreover, he began to worry that he would not choose Jesus as his Savior when he grew up, and when he died, he would also go to Hell. This concern surfaced with the birth of each of his three sons, and he contemplated killing them through suffocation—as he put it, both a fear and an urge to do so—during their first year of life to ensure that their innocence would take them to Heaven. His desire to suffocate was most apparent when he held the infant and had the thought of squeezing his face into his upper arm. He never told anyone of these urges, including his psychiatrist, and never acted on his idea. His wife, however, vividly remembers occasions when he would be intensely concerned if he saw another infant with a blanket too close to his face.

During his third hospitalization 6 months before the homicide, a nurse recorded for the first time his desire to kill his youngest son: "complains of homicidal thoughts toward 9 month old son for 3 min last night. Depression. Feels hopeless." His worries about hurting someone were becoming more detailed and focused, and 2 months before the homicide he told his treating psychologist, "I've had thoughts of killing my son and going to prison." This time the target was his middle child. The psychiatrist and spouse were immediately informed, and a contract was signed by Mr. L agreeing that he would tell his wife and his professional treaters if he had any thoughts of hurting someone. There was also agreement that he would not be left alone and responsible for the children.

A new psychiatrist was now treating Mr. L after his fourth hospitalization 3 months before the homicide, and the diagnosis was changed to schizoaffective disorder. Personality disorder was also diagnosed for the first time in 20 years. Medication dosages were increased to no avail, and Mr. L continued to be socially withdrawn from both his family and friends, and virtually bedridden. ECT was considered, but Mr. L refused this treatment alternative.

The frequency and intensity of the fixed idea to kill his youngest son hounded Mr. L through the month of May. Although he did not tell anyone of these continuous thoughts, and he was resisting them less, his father was concerned enough to accompany him to his last psychiatric visit 18 days before the killing. It was a medication management visit, and the psychiatrist wrote in his note, "looking better to me, starting to function better. Brighter affect, more animated, appropriate, no thought disorder or suicidal ideation. Here with his dad, they both think he's doing better. Followup in 6–8 weeks." The psychiatrist did not ask him about any homicidal thoughts. His last psychotherapy session was 2 weeks earlier. He told his psychologist then, "My relationship with God is not terrific," and he did not return for any subsequent psychotherapy visits.

Mr. L got dressed, drew a tub of water, and drove the short distance to the day care where his two sons were. He lied to the young woman in charge, telling her he needed to take his youngest son to a doctor's appointment. He then drove home, making sure

his infant was secure in his car seat. He took him to the bathroom and submerged him face down in the tub until he stopped struggling and was dead. He then called 911, told them he had drowned his son, and began administering CPR. When the police arrived, he initially lied again, telling them his son had fallen. He then confessed. They also found a handwritten note to his wife: "I'm sorry I killed John. I couldn't do anything else. I'm not a man. I am a coward. John is lying on the bed. Here is the key to the mower. Don't let the boys have it." When asked by the police why he had killed his son, he variously stated that he was confused, he did not know, he was depressed, and that it freed him of all the pressures in his life. What was most notable to the officers on the way to jail was his composure; they wrote that he seemed quite calm. His wife also noted his relief when she visited him a week later. That first evening in jail he asked God to forgive him and he slept well through the night.

Clinical Interview and Testing

Mr. L presented as a medium height, mildly obese, 37-year-old Caucasian male, neat, clean, cooperative, and eager to please 5 months after the homicide. Clinical interviewing was completely consistent with a diagnosis of major depressive disorder, recurrent, without psychotic features; and obsessive-compulsive disorder. He still reported intermittent symptoms while in custody, including a preoccupation that he would bite the television cord and a fear that someone would break out of jail because the brick mortar was not appropriately applied. He was being medically treated by the same psychiatrist who had seen him prior to the homicide and was taking venlafaxine 300 mg, bupropion 300 mg, olanzapine 10 mg, and lorazepam 2 mg as a prn for anxiety. He showed no evidence of psychosis and stated that he was "doing alright." There was no significant medical history other than asthma as a boy and a period of hypoxia when he was born.

Mr. L's history was negative for any antisocial behavior or conduct disorder prior to the crime, but he was medically treated for ADHD as a child. He had been an introverted boy growing up, largely ignored by his father who may have consumed alcohol excessively, and cared for by a mother who was clinically depressed. He was teased at school for his shyness and social awkwardness and adapted by pleasing people and staying in the background. He was an average student with an average IQ. He completed 1 year of college prior to his first psychiatric hospitalization, and then did not return.

The maternal side of the family was significant for severe depression. Clinical interview and review of records confirmed that his mother had been clinically depressed since Mr. L was at least 6 years old, had been hospitalized for the first time at age 44, had at least two subsequent hospitalizations, and two trials of ECT with some positive effects. Her most acute period of psychiatric decompensation occurred at the same time her son became severely depressed in adolescence, and culminated in the parents divorcing and the mother abandoning the family to live elsewhere. Archival records indicated that her father had committed suicide "by hanging induced by worry" and her mother walked in front of a train 1 month later. Mr. L's mother was 5 years old at the time. There was also credible historical evidence that her grandfather committed suicide and her grandmother died in a mental hospital. Mr. L's two siblings, however, appeared to have escaped this genetic sword of Damocles.

Psychological testing, moreover, confirmed the findings of the clinical interview and the review of records. The Millon Clinical Multiaxial Inventory III suggested a personality disorder diagnosis

of Dependent Personality Disorder (BR 85) with additional avoidant (BR 84), schizoid (BR 83), depressive (BR 82), and masochistic (BR 78) features and traits. There were no elevations on the modifying indices. The Minnesota Multiphasic Personality Inventory-2 suggested a chronically anxious and depressed individual (72 Codetype) who naively attempted to put his best foot forward (L = 78). He evidenced low self-esteem (LSE = 75) and was hungry for reassurances (Dy = 68). To satisfy such neediness, moreover, he rigidly controlled and constricted his emotions (R = 81), particularly his angry and aggressive thoughts and feelings (OH = 69, ANG = 36, Sc2 = 78, Pa3 = 75). Both of these self-report measures suggested the intrapsychic conflict most central to his crime: he could not bear to risk abandonment by those he depended upon by allowing into his awareness—and God forbid expressed through his behavior—his anger and aggression. Instead, he turned his fury on himself, only to be projected outward when he held a helpless and dependent object, his infant son, in his arms.

The Rorschach provided additional psychostructural information. Although Mr. L produced a normative amount of responses (R = 25), he was highly defended against his own affects (L = 5.25) and evidenced a complete affective shutdown (FC + CF + C = 0). His attachment capacity and anxiety were normal (T = 1, Y = 1). Most notably he produced only one human detail response, an indication of his lack of whole object representations, a likely inability to mentalize (7), and the absence of empathy toward others (M = 0). He was bereft of any aggression responses (Ag = 0) and showed no expectations of cooperative interactions with others (COP = 0). The only significant clinical index elevation was a maximum score of 5 on his Coping Deficit Index, suggesting global deficiencies in social and interpersonal skills. His reality testing was within the normal range (X-% = 20, XA% = 80), and there were no indications of psychosis. There was no suggestion of chronic impulsivity (AdjD = 0).

4 Mr. L's PCL-R (8) score, a measure of psychopathy, was 4, indicating no evidence of psychopathic traits. There were also no indications on mental status exam of a need for further neuropsychological testing.

His recounting of the facts of the crime was very consistent with police reports and investigative findings. He stated that his first thoughts of homicide occurred a decade earlier, about the time of the onset of his obsessive-compulsive disorder. He found that his conversion to Christianity, and his born again experience, were initially quite moving, but he then began to worry that each subsequent son would make bad decisions when he grew up, not follow Jesus, and be consigned to Hell when he died. His first homicidal thoughts were documented 8 years before the killing in a psychiatric hospital note, "worries whether he will kill anybody or not." Such reports continued to intermittently appear in various psychiatric records for a decade until 3 weeks before the killing. The target of his homicidal fantasies moved from son to son, finally settling on his third and youngest. He deliberately chose to not tell anyone of his final decision to kill and reported that the thoughts occupied him all day long during the final weeks. The last homicidal thoughts he reported to anyone were directed toward his second oldest son 2 months before the killing. The specificity of his plan did not crystallize until the morning of the murder. After the homicide, Mr. L reported, "I was relieved at that time. It felt like a burden was lifted off of me. It was there for a couple of hours. Then at the jail I asked God to forgive me for killing me. I realized what I did. Not a lot of emotion. A little guilt. I felt God has forgiven me. I know by faith and his Word he will forgive us our sins and cleanse us from all unrighteousness. I slept that evening." His conscious motivations reported to me were attention-seeking,

confusion, not knowing, and depression. His most plausible conscious motivation was that by killing one of his children, he "would be free of all the pressures in life," and his state of mind, which included feelings of desperation, humiliation for failing as a father and breadwinner, guilt, and paralysis, would be relieved.

The unconscious motivation was transference-based, and closely tied to his own mother's chronic depression. Very early in life, and for a number of years, Mr. L felt he was a burden to his mother and believed he was causing her suffering—a typical belief when a child has a mother who is chronically ill. By killing his own infant son, he was trying to annihilate the helpless dependency in himself. This reflects both self-loathing and guilt and is captured in his parapraxis (slip of the tongue) to the evaluating forensic psychologist, "to forgive me for killing me." His ability to mentalize—to reflect upon his own mind and the mind of another—was grossly impaired, and instead he projectively identified with, and hated, the dependency he witnessed in his own sons when they were infants.

The mental health professionals also failed him. His best treatment occurred during his four brief acute hospitalizations beginning in adolescence and extending over the next two decades. His outpatient treatment was inadequate for at least three reasons: (i) there was the assumption that medications alone, and brief monthly psychiatric medication consults, would be sufficient to address an individual with chronic familial depression, a personality disorder, and increasingly obvious failures to function at home and at work; (ii) there was no evidence that his last psychiatrist had reviewed the extensive psychiatric records from his past; and (iii) the last psychiatrist relied solely on the patient and his father's self-report during his last visit and made no inquiry concerning homicidal ideation or urges.

Mr. L's fundamentalist religion also contributed to the homicide. It provided him a religious sanction for the killing: if he murdered his son while an innocent, he could guarantee his ascension to Heaven when he died. Religious approval for homicidal violence, no matter how perverted the personal theology becomes, brings with it a resolve and the blessing of an ultimate authority—one who can also confer forgiveness once the act has occurred. The more fundamentalist the belief system, the more aggression can be sanctified, because unquestioning belief negates critical thought and typically breeds intolerance for others' opinions—and sometimes an utter disregard for their lives.

Mr. L pled guilty to the murder of his infant son. At his sentencing hearing, following the testimony of a forensic mental health professional and his spouse who continued to support him, Mr. L tearfully apologized to the community. He was sentenced to life in prison and is eligible for release in 25 years.

Discussion

This is a prototypical case of chronic catathymic homicide. The court appointed psychiatrist who evaluated Mr. L 6 weeks after the murder wrote in his report, "I have done forensic evaluations for nearly 30 years...I have never seen a case quite like this...His reasoning does not explain an act that was totally out of character for him." That is the point. The motivational dynamics for catathymic homicide are often transference-based and not consciously understood by the perpetrator, the act is inexplicable by those who investigate it, and the prior absence of any violence completely obliterates the usual phenomenological explanations for intentional killing.

In chronic catathymic homicide, the choices are reduced, often in the dismal tunnel of depression, to either homicide or homicide/suicide. Other more reasonable choices cannot be considered, despite the lethal risk posed toward self or others. The finality,

narrowness, and intense drive of the catathymic process were captured most poignantly in this case when Mr. L left a note for his wife at the crime scene, "I'm sorry I killed John. I couldn't do anything else."

The chronic form of catathymic homicide is recognized by a lengthy incubation period, a sudden act of killing, and a period of relief (4). The victim is usually an intimate (mother, spouse, and in this rare case, a biological child). Acute catathymic homicides, on the other hand, are usually perpetrated against complete strangers, there is no incubation period, and the unconscious, transference-based motivation is usually uncovered by the painstaking elimination of all other motives for the crime (5). Although depression figured prominently in this case, it is usually not associated by professionals with risk for homicide, and the literature relating the diagnosis and intentional killing of another is scant (9–11). This case, however, illustrates once again the importance of inquiry concerning thoughts of *both* suicide and homicide in the evaluation of clinically depressed patients, particularly if their depression is treatment resistant. Most men who commit familicide are clinically depressed (11), and depression often figures prominently in males who commit mass murder (12).

This case also illustrates the contribution that religious belief can make to homicidal acts. Such beliefs are particularly relevant when they are unquestioned and absolute and provide a supreme being's sanction for the killing, at least in the mind of the perpetrator. This is superego aggression—the polar opposite of psychopathic aggression which is devoid of any internalized value—yet both can be planned, purposeful, and emotionless in their expression. The study of religious belief and homicide is beginning to receive some scientific attention through the scrutiny of extremely aggressive forms of martyrdom, such as suicidal-homicidal acts by Islamist true believers (13).

Most infanticides and child homicides are perpetrated by a family member and are the result of psychosis, intoxication, abuse, or neglect. None of these factors play a role in catathymia, hence the befuddlement of professionals who examine such cases.

Although individual studies such as this contribute little to scientific understanding because of their anecdotal nature, the

accumulation of such studies often advance understanding through the aggregation of data. Catathymia, despite its discovery nearly a century ago, continues to be rarely understood and appreciated by forensic mental health professionals. Yet it remains an important concept for understanding homicides that first appear to be without motivation.

References

1. Wertham F. The catathymic crisis: a clinical entity. *Arch Neurol Psychiatry* 1937;37:974–77.
2. Maier H. Ueber katathyme wahnbildung und paranoia. *Ztschr f d ges Neurol u Psych* 1923;82:193.
3. Revitch E, Schlesinger LB. Murder: evaluation, classification, and prediction. In: Kutash IL, Kutash SB, Schlesinger LB, editors. *Violence: perspectives on murder and aggression*. San Francisco, CA: Jossey-Bass, 1978;138–64.
4. Revitch E, Schlesinger L. *Psychopathology of homicide*. Springfield, IL: Charles Thomas, 1981.
5. Meloy JR. *Violent attachments*. Northvale, NJ: Aronson, 1992.
6. Schlesinger LB. The catathymic crisis (1912-present): a review and clinical study. *Aggress Violent Behav* 1996;307–16.
7. Allen J, Fonagy P, Bateman A. *Mentalizing in clinical practice*. Washington, DC: American Psychiatric Publishing, 2008.
8. Hare RD. *Manual for the psychopathy checklist-revised*, 2nd edn. Toronto: Multihealth Systems, 2003.
9. Goldney RD. Family murder followed by suicide. *J Forensic Sci* 1977;9:219–28.
10. Rosenbaum M, Bennett B. Homicide and depression. *Am J Psychiatry* 1986;143:367–70.
11. Marzuk OM, Tardiff K, Hirsch CS. The epidemiology of murder-suicide. *JAMA* 1992;267:3179–82.
12. Hempel A, Meloy JR, Richards T. Offender and offense characteristics of a nonrandom sample of mass murderers. *J Am Acad Psychiatry Law* 1999;27:213–25.
13. Meloy JR. Indirect personality assessment of the violent true believer. *J Pers Assess* 2004;82:138–46.

Additional information and reprint requests:

J. Reid Meloy, Ph.D.
PO Box 90699
San Diego, CA 92169
E-mail: reidmeloy@gmail.com

Author Query Form

Journal: JFO

Article: 1414

Dear Author,



During the copy-editing of your paper, the following queries arose. Please respond to these by marking up your proofs with the necessary changes/additions. Please write your answers on the query sheet if there is insufficient space on the page proofs. Please write clearly and follow the conventions shown on the attached corrections sheet. If returning the proof by fax do not write too close to the paper's edge. Please remember that illegible mark-ups may delay publication.

Many thanks for your assistance.

Query reference	Query	Remarks
Q1	AUTHOR: A running head short title was not supplied; please check if this one is suitable and, if not, please supply a short title of up to 40 characters that can be used instead.	
Q2	AUTHOR: Please define CPR.	
Q3	AUTHOR: Please define ADHD here.	
Q4	AUTHOR: Please define PCL-R if applicable.	
Q5	AUTHOR: Please provide the volume number for reference [6].	

Proof Correction Marks

Please correct and return your proofs using the proof correction marks below. For a more detailed look at using these marks please reference the most recent edition of The Chicago Manual of Style and visit them on the Web at: <http://www.chicagomanualofstyle.org/home.html>

<i>Instruction to typesetter</i>	<i>Textual mark</i>	<i>Marginal mark</i>
Leave unchanged	... under matter to remain	<i>stet</i>
Insert in text the matter indicated in the margin	^	^ followed by new matter
Delete	Ʒ through single character, rule or underline or Ʒ through all characters to be deleted	<i>e</i>
Substitute character or substitute part of one or more word(s)	Ƶ through letter or — through characters	new character Ƶ or new characters Ƶ
Change to italics	— under matter to be changed	<i>ital</i>
Change to capitals	≡ under matter to be changed	<i>Caps</i>
Change to small capitals	≡ under matter to be changed	<i>sc</i>
Change to bold type	~ under matter to be changed	<i>bf</i>
Change to bold italic	~ under matter to be changed	<i>bf+ital</i>
Change to lower case	Ɔ	<i>lc</i>
Insert superscript	√	√ under character e.g. √
Insert subscript	^	^ over character e.g. ^
Insert full stop	⊙	⊙
Insert comma	↵	↵
Insert single quotation marks	↵ ↵	↵ ↵
Insert double quotation marks	↵ ↵	↵ ↵
Insert hyphen	=	=
Start new paragraph	¶	¶
Transpose	┌┐	┌┐
Close up	linking  characters	
Insert or substitute space between characters or words	#	#
Reduce space between characters or words	˘	˘