REVIEW ARTICLE

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Killing One's Own Baby: A Psychodynamic Overview with Clinical Approach to Filicide Cases

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SUMMARY

Objective: This review article discusses the multi-dimensional and complex pattern of filicide from a psychodynamic perspective with reference to the recent publications. Creating awareness to filicide among professionals will help to the correct assessment of the cases, recognition of and intervention on filicide before the act, and the development of preventive mechanisms.

Method: Published articles between January 1960 and March 2020 were searched using the keywords 'filicide, infanticide, neonaticide, mother/ parent/ maternal/ paternal, psychodynamics' in the Google Scholar, EBSCHO-HOST, Science-Direct, PubMed and Web of Science databases.

Results: The term filicide refers to the murder of the offspring by the parent. Although it is a common belief that the children are murdered boy strangers, the reported figures may not be representing the truth. No families are detected in one fourth of all murdered infants within the first 24 hours. The death of abondoned children are classified as 'due to natural causes'. Some murders might not be reported properly and therefore, actual murders by own parents might have been missed on the records. It is known that filicide is a heterogeneous phenomenon requiring a multidimensional evaluation in being affected by cultural values, belief systems of the society as well as the bio-psycho-social and developmental variables. It is reported in the literature that filicide cases have a common profile and that training clinicians on this complex phenomenon would be effective on prevention strategies.

Conclusion: The concept of filicide is controversial in many aspects and mental health professionals tend to distance themselves since the concept is associated with 'crime'. However it is crucial to elucidate the psychodinamic background on violence and discuss the risk factors, triggers, background dynamics and psychopathologies underlying this phenomenon.

Keywords: Family violence, child mortality, homicide, parent, psychopathology

INTRODUCTION

Child murder is a tragic event with serious effects on families and communities in being the extreme form of violence against children. Approximately 95,000 children are killed every year worldwide (Unicef 2014). Epidemiological data show that more than half of child deaths are caused by parents and that the officially reported filicide incidence ranges from 2.4 to 7.0 per 100,000 residents of industrialised countries (Flynn et al. 2013, Barone and Carone 2020). In general, it is stated that the records on the details of child murder and victim-perpetrator relationship are inadequate and that the actual number of children killed is not known (Stöckl et al. 2017).

Filicide generally refers to the killing by the parent of the offspring older than 1 year of age. Killing an offspring in the first postnatal 24 hours and of the offspring below the age of 12 months are respectively referred to as neonaticide and infanticide. Adults under severe stress may fail to control their negative emotions and behaviours. Depending on the severity of the trauma experienced and the individual's mental strength or resilience, the unrestrained emotions can turn into destructive, aggressive behaviours (Spinelli 2010).

The factors and dynamics underlying the proneness to filicide gain much importance when parents, regarded as the caregivers responsible for the survival and development of their children, direct aggressive and destructive behaviour to the offspring. At a time when the development of secure attachment is expected in the mother-baby relationship, multiple intertwined causes makes the baby an easy prey of the caregiver. It is known that filicide should be evaluated

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in many dimensions including the societal influences, cultural values, belief systems as well as bio-psycho-social and developmental variables.

The cause of death of many children have not been identified and not recorded officially. Therefore, the reported child murders do not reflect the actual incidences (Velluta et al. 2012). Investigations on neonaticide are known to include mostly the cases of secret pregnancies and of labouring and giving birth alone without references to the act of killing. It has been especially difficult in suspected cases of neotaticde to distinguish normal death from sudden death, the neglected, beaten or shaken baby syndrome or death due to Factitious Disorder (of the caregiver) Imposed on Another (FDIA). Also, the number of the babies abandoned with intent to kill is not known and the cases are not included in records (Velluta et al. 2012, Spinelli 2010).

It is emphasized in the literature that filicide is a heterogeneous phenomenon which can be prevented as the cases show a consistent profile. It is noteworthy that while some researchers emphasize the psychopathology and psychodynamic factors seen in filicide, others argue that these factors are rarely detected and complicate the legal processes of filicide cases. However, there is the consensus that filicide cannot be explained on the basis of a single reason and that the cases have a common profile which should be known by the clinicians for development of effective prevention strategies. Therefore, despite the distanced stance of many professionals to the controversial topic of filicide, it is quite important to discuss in the literature the risk factors, triggers, underlying dynamics and psychopathology in order to understand the role of psychodynamic effects in the formation of violence.

In this article, it has been aimed to discuss from a psychodynamic perspective the multi-dimensional and complex pattern of filicide in reference to the recent findings in the literature with the belief that raising the awareness of the clinicians will contribute to the recognition, accurate evaluation of the cases and early interventions with preventive measures.

METHOD

The Google Scholar, EBSCHO-HOST, Science-Direct, PubMed and Web of Science databases were searched using the keywords "filicide, infanticide, neonaticide, mother/ parent/ maternal/ paternal, psychodynamics". The articles published between January 1960 and March 2020 were examined with weighting especially for research findings and review articles on the definition and psychodynamics of filicide.

General Assessment of Filicide

Evaluation of the data on child murder in 44 countries shows that 56.5% of the parents were found responsible for the killing of children and 77.8% of infants were killed by their parents. In the total of these children, 58.4% were girls and 46.8% were boys; and murderers were not identified in nearly 10% of the cases. The risk of being killed by the parent is highest during and immediately after birth. The vulnerability of children to their parents at later ages is due to the nature of the parent-offspring relationship (Stöckl et al. 2017).

Filicide, especially of the offspring under the age of 5 years, is mostly committed by mothers and hence the coining of the term maternal filicide (Resnick 1969), whereas older children are mostly killed by the father, referred to as paternal filicide (Spinelli 2010, Putkonen et al. 2011). Unlike in cases of maternal filicide, there is the possibility of more than one offspring being killed by paternal filicide (Léveillée et al. 2007). The graphics of child murder in reference to age is U-shaped, with 20% of the cases involving those under the age of 5 and increasing again towards puberty and reaching an incidence of 57% at the ages of 15-19 (Stöckl et al. 2017). It was reported that since the responsible families have not been found, 1 out of 4 neonaticides have not been recorded as victims of murder (Velluta et al. 2012). Given the widespread thinking that parents would not harm their offspring and regarding the deaths of abandoned neonates/infants as natural outcomes, although most are murdered by their parents, it is now recognized that infant killings are rarely reported.

A closer look shows that neonaticides are the most missed cases due to the denial of pregnancy and concealment of the delivery despite a degree of awareness by the parent about both situations. Questioning the subjective awareness of pregnancy up to the 20th week indicated that denial of pregnancy in this period was 1/475th of the denial at the stage of birth. Querying the denial until the term reduced this ratio to 1/2500, the difference between the 20th week and term indicating that mothers denying pregnancy were aware of their pregnancy at term (Wessel 2002). This finding showed that, as well as consciously concealing their pregnancy, the mothers actively try to conceal the death their babies for a short time, fearing the legal process ensuing after suspected neonaticide, but that this behaviour does not exclude the cases of widespread rejection of pregnancy (Stenton and Cohen 2020, Vellut et al. 2012). Neonaticide is mostly committed by suffocation or drowning, the latter cases often occurring after giving birth in the toilet (Gökler et al. 2011, Kunst 2002, Oberman 2003, Meyer et al. 2001). The mothers involved in these cases are mostly primipar adolescents living alone and the aim of killing is to get rid of the unwanted baby (Stanton and Simpson 2002, Resnick 1969, Vellut et al. 2012). However, Stenton and Cohen (2020) found that in more than 50% of the neonaticide cases the mothers were young adults living in middle-term or long-term relationships, one-third of whom were multigravida. This leads to the conclusion that neonaticide has a heterogeneous profile with the common

features being unwanted and unplanned babies, lack of prenatal care in pregnancy and nearly 95% of the deliveries occurring out-of-hospital (Resnick 1969, Vellut et al. 2012, Miller 2003).

Paternal filicide is much less researched, having been ignored despite the reports in the literature that the incidences may be as much as one half of those observed in maternal filicide. There also exists a difference in the judicial processing of these acts, with the mothers being mostly hospitalized after the filicide while the fathers are usually sent directly to prison (West et al. 2009). These approaches suggest that the less well known nature of paternal filicide is being considered in the same framework as homicide.

It is seen in the literature that there are variations in the characteristics of the victims, killing methods and motivations of the perpetrators in.paternal filicide. Filicidal fathers were reported to be generally unemployed with low level of education and tendencies to violence and substance/alcohol use (Putkonen et al. 2011, Bourget et al. 2007, Bourget and Gagné 2002). Cases of 'filicide-suicide' combination is frequent in paternal suicide and, in comparison to homicide cases, these fathers do not have a significant criminal history (Declercq et al. 2017). This shows that the paternal filicide is not comparable to homicide and stresses the importance of questioning the factors predisposing the fathers under increased emotional burden and stress to develop thought contents on harming their children and spouses, suicidal ideation and the act of filicide (Putkonen et al. 2011, Bourget et al. 2007). Fathers, in comparison to the mothers, are more frequently under the effect of substance/ alcohol at the time of the act that is committed with impulsive violence by using violent methods, such as stabbing, using firearms and causing head trauma. Also, 1 in 3 of these fathers have a history of abusing their children (Putkonen et al. 2011, Bourget et al. 2007, West et al. 2009). Paternally committed neonaticide is rare and these fathers do not try to get rid of the child's body after the act. It has been reported that domestic violence and paternal abuse of the children may be an indicator for paternal filicide (Bourget et al. 2007, Bourget and Gagné 2002).

The generalised prototype for paternal filicide was ascribed to the combination of filicidal and suicidal ideation and revenge under the effects of difficulties in social relationships, separation, divorce, deception, halplessness, anger and burnout (Putkonen et al. 2011, West et al. 2009). However, paternal filicide may not have been adequately researched as demonstrated in the case report on a father with schizoid personality in regular employment, without known history of psychopathology, crime, violence or alcohol/substance use, who committed together the acts of filicide and suicide (Declercq et al. 2017). The necessity for careful assessment of ruminative thinking on filicide-suicide before the acts, which the father may seek help for, has been emphasized (Bourget et al. 2007, Declercq et al. 2017).

Classification of Filicide

Maternal filicide cases have been classified in the literature on the basis of the trigger and the cause of the killing, presence or absence of intention to kill, the underlying motivations, impulsiveness in the act, parental psychopathology and the relevant clinical features (Bourget and Gagné 2002, Simpson and Stanton 2000). The approaches to classifications can be cited according to the researchers. Resnick (1969) classified child deaths after the first 24 hours postpartum in 5 categories. D'Orban (1979) placed maternal filicide action into 6 categories among the mothers who killed or attempted to kill their offspring. Details of these frequently cited classifications by Resnick (1969), D'Orban (1979) and Bourget and Bradford (1990) are given in Table 1.

Filicide can be an act with diverse motivations aiming to solve a problem. It may aim to prevent harm to the child, include motivations of revenge or jealousness in the marital relationship or see the child as a hindrance to desires/goals (Friedman et al. 2008). More boys were killed in the cases of spousal revenge and more girls were killed in altruistic cases

Table 1. Frequently Used Classifications of Maternal Filicide

Resnick's classification (1969)
1. Alturistic killing
2. Psychotic filicide
3. Unwanted child
4. Accidental filicide
5. Spousal revenge
D'Orban's classification (1979)
1. Beating-abusing mother; action develops suddenly, it is associated with anger,
2. Mother with mental illness such as psychosis, suicide-related depression,
3. Filicide-neonaticide- within the first 24 hours of life,
4. Avenger mother; aims to take revenge on her husband,
5. Unwanted child,
6. Alturistic filicide; it is the mother's behavior believing that the child is suffering and tries to prevent this.
Bourget and Bradford's classification (1990)
1. Pathological filicide, including altruistic features and extended homicide-suicide,
2. Accidental filicide, including battered-child syndrome,
3. Retaliation,
4. Neonaticide,
5. Paternal filicide.

(Bourget et al. 2007). Cases of familicide or killing of the entire family and subsequent siicide by the father, caused by divorce, separation or multiple motivations including revenge, retaliation or self sacrifice have been described (West et al. 2009, Léveillée et al. 2007, Declercq et al. 2017, Lucas et al. 2002). It is seen in these studies that despite the wide overlaps, there is not a consensus on whether the classification should be based on the motivation of the individuals, the contents of the act or the data on child/parent demographics.

Risk Factors and Triggers in Filicide

For better understanding and prevention of filicide, it is necessary to understand the effect of the traumatic experiences of parents on the relationship with their children, the risk factors that form the ground for the filicide act. The history of the parent may include previous exposure to sexual/ physical/ emotional abuse/ neglect, mental illness, paternal substance use, poor parenting and coping skills, parent disapproval of the child, lack of appropriate parental modeling and of social support as well as triggers including weak/absent interpersonal relationships, marital problems, domestic violence, destructive relationships with the opposite sex, losses and separations, adverse living conditions, traumatic experiences and financial difficulties (Foto Özdemir et al. 2019, Kauppi et al. 2008, Spinelli 2010, Kunst 2002, Meyer et al. 2001, Jackson 2011, Mugavin 2008, Simpson and Stanton 2000). It was reported that almost all mothers were involved in domestic abuse, marital conflict, the presence of an abusive partner/father, loss of partners due to death, divorce, separation or imprisonment and poor social support (Fonagy and Target 1995, McKee and Shea 1998). The risk of filicide is seen to increase in the absence of the needed support for heavy stress due to difficulties of childcare, social isolation, history of sexual abuse and family problems. Mothers, who typically experience severe deprivation and stress after conflicts, may get decompensated with simple ordinary stress and commit the act of filicide (Bourget and Gagné 2002, Lucas et al. 2002, Simpson and Stanton 2000, Smithey 1997, Spinelli 2010). A study conducted in Turkey reported the underlying motivations and triggers in filicide as getting rid of unwanted children, the pity motive, protecting the only offspring before the act of suicide, psychotic disorder, desire for revenge on the spouse and fatal child abuse and neglect (Eke et al. 2014).

Another important risk factor in the act of filicide is the victim's age; with the probability of harm increasing inversely to the victim's age. Evaluating the filicide is difficult when the victim is too young with limited social interactions outside the home and the inadequacy of self expression. Presence of physical, metabolic, neurological, genetic or mental diseases that make child care difficult also increase this risk. It is known that the mother experiencing difficulties in coping with the care needs of a child with infantile colic, restlessness, difficult temperament, autism or developmental retardation tends to feel rejected due to her inadequate relationship with the child (Smithey 1997, Lucas et al. 2002). It was observed that developmental disorders, especially autism, increased the stress of the parent and very frequently triggered the filicide-suicide act. Autism, characterized with impulsive behaviours, tantrums and the limited attachment to and interaction with the parents, increases the parental emotional burden, causing separation and particularly increasing the susceptibility to paternal filicide (Estes et al. 2009, Declercq et al. 2017). Increased emotional burden, burnout, parenting difficulty and suicidal ideation are seen in 40% of filicide cases. Therefore when these conditions are noticed by the clinicians, the parents should be questioned on having thoughts of harming the child (Pukonen et al. 2011, West et al. 2009).

Concealment or denial of pregnancy are critical factors that increase the risk of neonaticide. The mother may either conceal the pregnancy and its evidences from her physician, partner, family and social circle despite her awareness of her condition or otherwise may be unaware of her pregnancy and the relevant physical changes and persistently deny it (Stenton and Cohen 2020). Although the mental processes and awareness levels differ in concealment and denial, they are both expected to be associated with having experienced rape, unintentional pregnancy, fear of rejection by the husband and or family, ignoring pregnancy to continue with habits, risky pregnancy without clinical follow up, intrauterine death/ stillbirth, abandonment or neonaticide. In the environment of conflict, the mother is under stress and experiences the pregnancy alone, in isolation from people without the relationships to share her feelings and disclose her problems (Beyer et al. 2008, D'Orban 1979).

The diagnosis of psychopathology is also a critical risk for filicide. The parent is seen to seek psychological support before the act which should be detected to prevent possible filicide (Aho et al. 2017). It is known that depression and psychosis are more common disorders, seen especially after giving birth, that pose a risk for filicide (Kauppi et al. 2008, Jackson 2011, Friedman and Resnick 2007). Mental illness per se does not explain filicide since it is also common among parents in the community who do not attempt filicide (Kunst 2002). Mothers with psychopathology ae likely to have a history of abusive parent relationship, with insecure/ disorganized attachment such that the resultant low mentalising capacity increases the risk of filicide (Barone and Carone 2020). Hence, it is believed that parents with psychosis, depression and a history of substance use should be screened for childhood traumas of deprivation, abuse, parental loss or abandonment, as an approach to prevent filicide (Papapietro and Barbo 2005).

Filicide and Psychopathology

Although it is difficult to determine the profile of filicide in terms of psychological characteristics or psychopathological diagnoses, psychopathology of the parents perpetrating filicide has been frequently emphasized in the literature. Data on the psychiatric disorders most frequently diagnosed in filicidal parents varies between studies, with the incidences ranging as 9-54% and 7-52%, respectively, for maternal and paternal depression, as 3-55% and19-67%, respectively, for maternal and paternal personality disorder and as 2-82% and 6-48%, respectively, for maternal and paternal psychosis (Putkonen et al. 2009, Léveillée et al. 2007, Flynn et al. 2013, Aho et al. 2017). Studies focusing on mood disorders in mothers detected depressive symptoms in 60-85% of the cases (Bourget and Gagné 2002, Friedmanve et al. 2008, Friedman and Resnick 2007). Reports show that after long term frustration, lack of help, low self-esteem, hopelessness, depression and despair filicidal mothers develop suicidal ideation before the act they commit with the motive to protect their children from adversity (Kauppi et al. 2008, Oberman 2003, Resnick 1969, Smithey 1997). Intense suicidal ideation predicts the frequently completed acts of planned filicide and suicide (Schlesinger 2000, Simpson and Stanton 2000, Debowskave et al. 2015).

Despite the emphasis in the literature on the involvement of psychotic disorder in cases of filicide, there are also reports showing this disorder has low incidence or is not at all detected. Psychopathology was found to be rare in maternal filicide. The mothers instead had characteristics of immaturity, dependences, negative emotions, jealousy, hostile thoughts, negative self-perception and anxiety which underlied the displayed neurotic personality (Vellut et al. 2012). These contrasting observations may have resulted from the heterogeneity of the groups included in the reported meta-analyses and reflect the lack of consensus on the definition of filicide.

Papapietro and Barbo (2005), on the other hand, emphasized the importance of knowing the psychological symptoms that lead to violence and recommended the investigation of psychodynamic factors for predicting filicide. Since the majority of filicidal mothers have childhood traumas, limited relationships, personality disorders and susceptibility to psychiatric disorders, it is crucial to evaluate their developmental characteristics. Similarly, Willemse (2007) stated that filicidal parents have low emotion regulation skills and borderline personality traits. However, some mothers, without a history of agression, psychosis, mania or suicidal attempt may experience a clinical psychotic attack prior to the filicide act (Papapietro and Barbo 2005).

Kunst (2002), defended the opinion that filicide can not be associated only with neurobiological or psychosocial problems; pointing out that not every schizophrenic, traumatized, deprived and abused mother kills her child. Structural disorders of the mother prevent normal ego development leading to the development of psychotic defenses and, hence, to easy decompensation. The abusive conditions of the unprotective early stage environment makes the management of psychological threats difficult. However, in neonaticide, experienced as a secret event, psychological and physical changes are not noticed (Beyer et al. 2008, Oberman 2003). The passive, immature, dependent, and inhibited personality, low self-esteem, sense of worthlessness, isolated life style of the mother has been reported (Beyer et al. 2008, D'Orban 1979). Hence, especially in mothers with a history of childhood abuse or mental illness, depersonalization and dissociative amnesia can be observed when giving birth (Stenton and Cohen 2020, Gökler et al. 2011). After committing neonaticide, the mother may continue her life without any sense of guilt, embarrassment, mental burden or discomfort as if nothing had happened (Beyer et al. 2008, Kaye et al. 1990).

The Psychodynamics of Filicide

The distanced stance of physicians and avoiding to understand the underlying causes of killing one's own offspring are based on the widespread perception that filicide is the outcome of violent child abuse and a crime. Even if this were the case, given the nature of the parent-child relationship, filicide cannot be evaluated as other homicides. It is observed that filicide is too complex to be attributed to a single cause, and that the psychodynamics underlying the traumatic events of the developmental stages increase the effects of the risk factors, almost creating a butterfly effect (Glasser 1986, Brothers 2009).There are referencdes in the literature to psychodynamics in relation to filicide including the attachment, object relations, separation-individualization and self-psychology theories with emphasis on the mother-infant relationship. As the outcome of childhood traumas of neglect and abuse, maternal filicide cases are associated with the frailties of impeded emotion and behaviour regulation, poor impulse control, poor skills of coping with stress and appropriate expression of anger that turn to destructive and agresive behaviours under heavy psychological tension (Willemse 2007). Hence, in maternal filicide, the mother cannot support the natural separation/individuation process in development of the infant. Over-attachment, as against dissociating the infant slowly to support independence and the autonomous functions, blurrs the roles and boundaries of mother-infant relationship. As the mother becomes dependent on the infant, the roles are reversed such that the infant who needs love, attention and support starts to function as a self-object for the mother (Korbin 1989, Resnick 1969). Overloving and preventing the healthy dissociation of the infant is related to the maternal inability to discriminate other

objects, and hence the infant, from her own self and seeing the infant as an extension of herself (Willemsen 2007). Here the mother actually harms herself by perceiving her infant as an object or as lifeless toy (Kunst 2002, Oberman 2003).

Analysis of maternal filicide in terms of the self-psychology indicates that the mother lacks the empathetic approach of her own mother, which has disrupted the processes of mirroring, internalization and separation. This malfunction of non-integration causes the constant need for a self-object leading to dependence on transition objects in order to sustain the functions of the self. Such an individual feels helpless, worthless, and incomplete, out of control and threatened if she is not supported by an external self-object. Kohut (1978, 1988) referred to this threat perception as the disintegration anxiety; in such a situation, the infant acts as a mirror for the mother. Over-attachment to self-objects and integrating with them may be ideal for the mother to achieve self-integrity. However, the inability of the infant to perform the "ideal self-object" function causes many disappointments to the mother whose need for the self-object and inadequacy as a parent continue. The violence directed at the self also includes the 'self-object' which may result in filicide. Considering that filicide and suicide are intertwined, the act of killing her infant by the mother who cannot distinguish between the self and the other may on the one hand be a suicidal attempt, while on the other hand, these intense destructive feelings may be directed to another object or the infant.

Kunst (2002), in reference to the object relations theory, argued that maternal over identification with the infant can cause filicide. The mother, who cannot tolerate inner mental pain and fears, can turn this conflict into a physically violent act. The inability to distinguish the infant from herself causes destructive emotions, thoughts and behaviors towards the infant. Contrarily, it was argued that the failure of the mother to attach the infant posed a risk for filicide (Willemsen 2007, Mugavin 2008), and that secure attachment, as a model for all future attachments, would protect the infant from abuse (Kauppi et al. 2008, Mugavin 2008). Unwanted pregnancies, prolonged hospitalization of the infant after birth and perceptions of developmental problems in the child adversely affect attachment and may cause filicide (Mugavin 2008).

Attachment also plays a key role in the development of mentalization skills of the mother such as understanding and predicting the intentions, emotions, thoughts, desires and beliefs of her own self and of others. For a mother who had parents with deficits in reflective functions or lacked a mentalising caregiver, it becomes difficult to develop the required mentalising capacity and prevents the formation of an integrated self-perception (Fonagy and Target 1995, 1997). Traumatic childhood experiences of parental abuse/neglect cause the development of disorganized attachment strategies and insufficient mentalizing skills which underlie the inability to perceive the mental/emotional needs of her own infant, the distorted attributions to the mental state of 'the other-infant' and the inability to react appropriately (Barone and Carone 2020). Presence of a psychiatric disorder in mothers with limited attachment and mentalizing capacity increases the risk of filicide.

Another psycho-dynamic approach evaluates the scenarios related to filicide in two broad conceptual categories of psychopathic or psychotic mothers. The psychopathic mother with antisocial or narcissistic personality traits deliberately designs the filicide act to cause physical and emotional pain (Glasser 1986). These mothers never want the child, and commit filicide either unintentionally during violent child abuse or as retaliation against their husbands. The psychotic group of mothers are included in the category of "pathological filicide" (Bourget and Bradford 1990). Here, violence has a protective function against the perceived threat to herself or her child (Fonagy and Target 1995, Glasser1986, Mitchell 1993, Kunst 2002).

Kunst (2002) identified organized and disorganized personality structures by closely monitoring the mothers placed in the 'pathological filicide' category. The filicidal mother with disorganized personality has a fragmented ego, chronic psychiatric disorders based on genetic, structural, phenotypic, biochemical characteristics and also early experiences of destructive life events. With a history of inappropriate parental care and toxic maternal experiences which have prevented the development of mentalization skills also limit the parenting capacity or cause distorted perceptions of the mothers in this category. A mother's inability to mentalize her past experiences prevents understanding her child's mental world and also causes her child to fail to develop the mentalizing skills and to lack the ability to make mental attributions on herself and her infant and either to have distorted mental attributes about herself and her infant or to lack these completely (Barone and Carone 2020). Kunst (2002) argued that these mothers are unaware of the presence of a live infant, perceiving the infant as a second thought. This perception of the mother about the lifeless object infant reflects the divided and unwanted parts of her fragmented ego. This category of mothers, not having formed internalized objects, lack the sense of attachment, anxiety and emotion and are too disorganized to grieve the loss of the baby. The method of killing involves severe violence and the filicidal mother continues as if nothing had happened.

On the other hand, the 'organized' mother with integrated personality, shows structural fragility with an easily disintegrated ego under intense stress. This easy decompensation is attributed to the mother's past experiences including abuse and neglect, inconsistent and insufficient parentage, loss of parents and especially maternal loss due to death or abandonment, weak bondage with her own parents,

despite having been able to withstand stress from time to time with the help of substitute parents. Nevertheless, the organized type mother is believed to sustain a basic attachment to her parents that allowed the realisation of projection and introjection processes enabling the construction of the ego and the internal object designs. Unlike the 'disorganized' type, the 'organized' mother shows not the clinical signs of real schizophrenia but the mixed psychiatric signs of personality disorder, temporary psychotic attack or episodes of depression as reactions to environmental stress. Having developed an ego on relatively normal lines, most of them exhibit psychotic symptoms for the first time at the time of the crime, which, unlike the fragmentation of the poorly shaped ego of the 'disorganized' type, reflects a pathologically organized ego with defences (Kunst 2002, Papapietro and Barbo 2005, Jackson 2011). The early stage deprivations and the successive traumas during development are believed to lead to feeling that the self is in constant danger and therefore perceiving physical violence as a protective mechanism for the future (Fonagy and Target 1995).

Unlike the withdrawal of the 'disorganized' type of filicidal mothers from object relations, the 'organised' mothers tend to be very oriented to their objects and seek desperately to satisfy the need for addiction. Throughout their lives, these 'organised' mothers go from one object to another to seek trust and love. Many endure their spouse's infidelity, addiction, financial difficulties, long-term separation or irresponsibility to meet their primitive addiction needs (Kunst 2002, Foto Özdemir et al. 2019). It is not surprising that the mother, who has been disappointed many times, eventually turns to her child to cope with deprivation. In the histories of these mothers who develop a feeling of disintegration after their losses, a search for help is often seen before the act of filicide (Aho et al. 2017). There are reports about mothers expressing fear of the possibility of killing their offspring. Here, it becomes difficult to discriminate the concern for self from that for the offspring. However, given the continual subconscious fantasy of uniting with the infant, the expressed anxiety may be about disappearance (Fonagy and Target 1995, Mitchell 1993). The mother commits both filicide and suicide to protect herself and her baby from the dangers of this world through death, expressessing her internal chaos by stating "I did not kill my baby, I killed myself" (Kunst 2002).

According to Bollas (1987) a mother may regard her offspring as a transformational object for herself, by rating the offspring as a safe and spiritually relaxing early period object having all that she needs for regaining the sense of trust she had lost. This illusion about getting a last chance to meet unsatisfied dependence needs prevents the mother, preoccupied with her inner world and her needs, from seeing the child as a real individual with specific needs and indicates the reversal of roles with the mother searching for a mother in her own child. The impossibility for the offspring to compensate for early deprivations of the mother by maintaining the idealized relationship in the mother's fantasy creates bilateral psychic pressure and disappointments, and is ultimately ineffective and destructive when the mother is overdependent on the offspring.

Resnick (1969) had argued that mothers commit filicide in a catathymic cirisis with the loss of logical thinking after emotional experience due to perceiving trauma in events. Such perceptions exacerbate emotional tension, the development of a delusional, obsessive way of thinking and seeing violence as the only way out. Behavioral and emotional blockage of an individual and the coexistence of disappointments and catathymic thought processes may be effective in perceiving the act of murder as a punishment to establish justice. Especially the acts of familicide-suicide and filicide-suicide are argued to be motivated by this psychological process (Aho et al. 2017, Resnick 1969, Schlesinger 2000, Jackson 2011, Spinelli 2010).

Spinelli (2001) stressed the concepts of denial, dissociation and depersonalization in explaining the act of filicide, arguing that close to 80% of the maternal filicide cases he studied involved dissociative experiences such as identity division, dissociative amnesia, unrealization, trans state, self-alienation, and numbness. This is not surprising after considering the traumas experienced by the mother in her own childhood and during the act (Mugavin 2008). The presence of a foetus and giving birth are believed to revive and trigger the traumatic childhood memories related to sexuality and sexual pleasure (Spinelli 2010). Killing her own offspring is a very severe trauma for the mother and dissociative experiences during and after the act are therefore natural (Jackson 2011, Foto Özdemir et al. 2019).

The psychodynamics of pregnancy rejection is evaluated on the basis of the affective denial, widespread denial and psychotic denial mechanisms that allow the mother to ignore pregnancy. In affective denial, the expectant mother perceives her pregnancy but does not experience the expected emotional and behavioral changes, does not receive medical care and does not get prepared for childbirth. Affective denial is associated with the mother's detachment or the inability to attach to and the emotional withdrawal from the infant. In widespread denial, the expectant mother does not have cognitive awareness of the pregnancy and often cannot understand the pregnancy related physical developments and misinterprets the existing changes. The physical symptoms of the unwanted pregnancy, such as perception of the intrauterine foetal movements may be attributed to bowel movements or food poisoning. Mothers with this type of denial are usually seen to have given birth in the toilet by misinterpreting the uterine contractions as bowel movements

and to have commited neonaticide after the neonate is born (Gökler et al. 2011).

In psychotic denial; physical symptoms and pregnancy related changes can be attributed to unusual and even bizarre reasons with the mother making strange interpretations and explanations about her pregnancy (Miller 2003, Spinelli 2010). It has been argued that any denial requires the awareness of what is denied. Given that pregnancy and birth are social processes, the mother in denial prevents the social existence of pregnancy by not speaking about it. Ignoring pregnancy and not sharing it with any one causes these mothers to end up as victims of their own deception when giving birth secretly and in panic (Velluta et al. 2012). The uncertainty of the physical signs of pregnancy in adolescents and the failure of the family to notice them supports the denial (Gökler et al. 2011). In many of these cases the pregnancy related amenorrhea does not develop.It was as reported that pregnancy was not noticed by the partner, the family and even the physician who had seen the mother-to-be before the neonaticide, which facilitated the denial of pregnancy. There are cases when the partner had not understood the pregnancy after sexual intercourse hours before the birth; or when the physicians consulted for reasons of amenorrhea attributed it to stress without attempting the physical check up for pregnancy (Miller 2003, Beyer et al. 2008, Vellut et al. 2012, Spinelli 2001, 2010, Stenton and Cohen 2020).

Denial of the pregnancy by the family under any circumstances constitutes emotional neglect and abuse. The reasons for this vary from family to family, but when behaviours that reinforce the denial of the patient are displayed, the message "Pregnancy is not a life option with conditional probability" is conveyed to the patient. Hence, denial is not solely the product of the individual's psychopathology (Stenton and Cohen 2020). Riley (2005) defined the behavioral and psychological processes accompanying the act of neonaticide after pregnancy denial by the 7 phases comprising 1) fearfulness, 2) hiding the pregnancy, 3) emotional isolation, 4) denial, 5) dissociation, 6) panic and 7) homicide. Dissociation experiences and depersonalization are frequently expressed in the cases of mothers denying their pregnancy. Autoscopic delusion or the perception of separation from the body and being the self-observer of the birth, alienation of the body, feeling like someone else, temporary amnesia, depersonalization, not feeling pain immediately after the event have been reported (Spinelli 2010).

Another subject to be emphasized is the cycle of violence. Most of the mothers are exposed to neglect and/or abuse early in their lives. It has been reported in the literature that 90% of the filicidal mothers have histories of early childhood traumas involving exposure to emotional abuse, rejection, neglect and violence which are associated with the defects in ego and superego development (Kauppi et al. 2008). Psychological mechanisms such as role-modeling, learning, identification with the aggressor or the abusive mother, cycle of violence seen in filicidal mothers underlie the tendency to violence in the face of stress, fear and frustrations creating the susceptibility to filicide (Jackson 2011, Mugavin 2008). Exposure to childhood abuse has stronger effects on the parenting behaviours of mothers in comparison to early loss of parents. For example, a wrongly perceived-threat from the infant's signs during the mother-infant relationship may trigger painful memories, early injuries and adverse feelings of helplessness, which may give rise to violent behavior and filicide (Barone and Carone 2020).

CONCLUSION

Research has shown that inability to cope with difficulties, despair, limited object relations, inadequate parenting skills, as well as various psychopathologies such as depression, psychosis and personality disorder are associated with filicide. Although the general term filicide is used for the act of killing one's own child, there are subtypes and classifications most of which overlap with the classification made by Resnick (1969). Problems in the design of classifications have attracted attention. Debowska et al. (2015) have pointed out that the term filicide is being used both as an upper title for the killing of children in all age groups and as a subtitle in reference to the killing of children over 1 year of age, Another problem is using the paternal filicide as a subtitle in some classifications which gives the impressions that paternal filicide is a subcategory of maternal filicide and that the other categories given for maternal filicide do not apply to paternal filicide. Bourget and Bradford (1990) argued for the necessity of separating paternal and maternal filicide to bring a solution to the differentiation of filicide. Another problem is related to placing in the same category the similarities of motivation or modes of action valid for neonaticide and filicide. This leads to acceptance of neonaticide as a separate category suggesting that factors expressed in the other categories are not valid for neonaticide. Finally, as Lewis and Bunce (2003) pointed out, it is very difficult to place a large number of filicide cases in a single category.

Referring to a case seen in our clinic, the pregenancy of the sexually abused 15-year old female patient 'A' was not understood by herself and those around her for 9 months. She was prescribed an enema when she consulted a hospital for abdominal pain at term, and gave birth in the toilet. Initially perceiving the baby as a defecated object, she came round with the baby's voice when she blocked the baby's mouth and nose to prevent audability. She feared the resultant cyanosis as death and and caused the baby's death by throwing the baby in the toilet. (Gökler et al. 2011). This case thus fits both the accidental filicide and the unwanted pregnancy categories.

There are not sufficient data in the literature on paternal filicide. Although mothers are generally implicated in cases of filicide, there are publications indicating that the prevalence of paternal filicide is considerably high and its properties are not well known. It is understood that researchers, clinicians and lawyers do not see significant differences between paternal filicide and other homicides such that prevention studies have been insufficient. The majority of reports have been on maternal filicide cases. Therefore, the role of psychodynamic effects in filicide has been discussed over the mother-infant relationship in this review article. In the literature there are examples of accidental filicide cases resulting from the physical violence of the parents. It is seen that accidental filicide due to care giver violence directed to children under the age 3 are quite common.

However, our clinical experience shows that the incidences of child death in this category due to the Shaken Baby Syndrome and sometimes due to the Factitious Disorder Imposed on Another (FDIA), formerly known as the Munchausen Syndrome by Proxy, are considerably high (İşiyel et al. 2018). We therefore believe that there are many cases of filicide in our country that have been camouflaged as sudden infant death. It should also be emphasized that filicide and FDIA have significant similarities with respect to familial characteristics, parental characteristics, triggers, conditions creating susceptibilities, some psychodynamic properties and in the abuser being the caregiver in both conditions. Since there is not the aim to kill a child in FDIA which involves a mother making up an illness in her child and cheating the healthcare workers to prevent or make difficult a definitive diagnosis. Reports of death in FDIA that may have resulted from some interventions of the mother have been subjects of debate in the literature since it is difficult to differentiate the event from filicide. Recurrence of child deaths in the same family more often than possible in filicide, frequent hospital admissions, the motvation being not to get rid of the child but to create the image of a 'self sacrificing and prfect mother', the mother's satisfaction in being in the hospital and creating a social environment with the treatment team and patient's relatives and displaying symptoms of personality disorder are the features differing from filicide. In FDIA the object of the mother's pathology is the baby needed in order to maintain the disease fiction (Foto Özdemir et al. 2015).

In filicide, generally there are not incidences of hospital consultation before the act, but, on the contrary, evasion of medical care after the unwanted pregnancy is a typical feature. The filicidal mother finds herself inadequate, has negative self perception and low self esteem (Kauppi et al. 2008). In contrast to the psychotic personality structure, psychosis, depression, and mental disorders that are frequently reported in filicidal mothers, narcissistic and borderline personality disorders are emphasized in mothers of FDIA cases. Hence, despite the similarities of the triggers, conditions underlying the susceptibility and the psychodynamics, the scenes presented by the caregivers are very different.

In conclusion, given the quite high incidences of mortality and morbidity in filicide cases, it is very important to understand all aspects of filicide. Evaluation of the risk factors during periods of high dependence such as infancy and early childhood and awareness of complex psychodynamic and familial features that may cause susceptibility to filicide or accidental filicide are very important for the prevention of filicide. In cases of incomplete filicide, evaluating the patient and the situation correctly and seeing the risks can save the life of the child intervened with and the other siblings. Understanding that the act was committed by parents in cases of completed filicide and detecting the underlying psychopathology or psychological triggers that push the parent to this act contributes not only to the protection of the other children but also to providing more effective and permanent interventions to the involved family.

Comprehensive and detailed evaluation of these cases with a multidisciplinary approach is required through investigation of the family's belief systems and culture, the developmental levels of the individuals, the mother-infant relationship and the baby's relationship with the other members of the family as well as the bio-psycho-social dimensions. Observing the best interests of the child, conducting the judicial processes meticulously by a team, and collaboration with the social workers if placing the child under proection is necessitated is vital for conducting the process appropriately.

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