Infanticide secrets

Qualitative study on postpartum depression

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ABSTRACT

OBJECTIVE To explore thoughts of infanticide that did not lead to the act among mothers with postpartum depression.

DESIGN A phenomenologic hermeneutic study in which women were invited to share their experiences of having thoughts of infanticide.

SETTING Community setting in a large metropolitan city, Brisbane, Australia.

PARTICIPANTS Fifteen women who had been diagnosed as clinically depressed with postpartum onset whose babies were 12 months of age or younger.

METHOD Audiotaped, in-depth interviews were transcribed verbatim. Thematic analysis commenced immediately after the first interview, and data collection continued until saturation was achieved. A questioning approach that reflected hermeneutics was facilitated by use of journals by the researchers.

MAIN FINDINGS Six themes emerged from the data: imagined acts of infanticide, the experience of horror, distorted sense of responsibility, consuming negativity, keeping secrets, and managing the crisis.

CONCLUSION Women who experienced nonpsychotic depression preferred not to disclose their thoughts of infanticide to health professionals, including trusted general practitioners or psychiatrists. These women were more likely to mention their suicidal thoughts than their infanticidal thoughts in order to obtain health care. General practitioners and other health professionals should directly ask about whether a woman has been experiencing thoughts of harming herself or her baby, regardless of the reason why she has presented.

EDITOR'S KEY POINTS

- During a larger study of women with postpartum depression, some participants unexpectedly disclosed that they had experienced thoughts of infanticide. This study was implemented in order to explore the characteristics of infanticidal thoughts experienced by women with nonpsychotic postpartum depression.
- The researchers found that although the women were unlikely to disclose their infanticidal thoughts to health care professionals, they did often realize that they needed help. In such cases, women were more likely to mention thoughts of suicide than thoughts of infanticide in order to receive the needed medical care.
- The authors recommend that health care professionals use direct but sensitive questioning to explore whether mothers have thoughts of infanticide, especially when suicide is mentioned.

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Pensées secrètes d'infanticide

Étude qualitative de la dépression post-partum

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RÉSUMÉ

OBJECTIF Examiner les idées d'infanticide sans passage à l'acte chez des mères en dépression post-partum.

TYPE D'ÉTUDE Étude phénoménologique herméneutique dans laquelle des femmes ont été invitées à partager leur expérience concernant le fait d'avoir eu des idées d'infanticide.

CONTEXTE Contexte communautaire de la grande ville de Brisbane, Australie.

PARTICIPANTS Quinze femmes avec un diagnostic clinique de dépression ayant débuté durant le post-partum et dont les bébés avaient au plus 12 mois.

MÉTHODE Interviews en profondeur enregistrées sur bande magnétique et transcrites mot à mot. L'analyse thématique a commencé immédiatement après la première interview, et la collecte des données s'est poursuivie jusqu'à saturation. Une façon de poser les questions respectueuse de l'herméneutique a été facilitée par l'usage de journaux par les chercheurs.

PRINCIPALES OBSERVATIONS Six thèmes sont ressortis des données: représentation de l'acte d'infanticide, horreur ressentie, faux sentiment de responsabilité, négativité envahissante, secret bien gardé et gestion de la crise.

CONCLUSION Les femmes souffrant de dépression post-partum préféraient ne pas parler de leurs idées d'infanticide aux professionnels de la santé, même à l'omnipraticien ou au psychiatre en qui elles avaient confiance. Pour recevoir les soins appropriés, elles avaient tendance à parler d'idées de suicide plutôt que d'infanticide. Les omnipraticiens et autres professionnels de la santé devraient demander directement aux femmes si elles ont eu l'idée de s'en prendre à elle-mêmes ou à leur bébé, quelle que soit la raison de la consultation.

POINTS DE REPÈRE DU RÉDACTEUR

- Dans le cadre d'une grande étude chez des femmes souffrant de dépression post-partum, certaines participantes ont révélé de façon inattendue avoir eu des idées d'infanticide. Cette étude a été entreprise pour examiner les caractéristiques des idées d'infanticides qu'avaient eu les femmes en dépression post-partum non psychotique.
- Les chercheurs ont observé que même si elles étaient peu susceptibles de révéler ces idées d'infanticide à des professionnels de la santé, ces femmes avaient souvent conscience d'avoir besoin d'aide. Dans ces circonstances, elles avaient tendance à mentionner des idées de suicide plutôt que d'infanticide, de façon à recevoir les soins appropriés.
- Les auteurs recommandent aux professionnels de la santé d'interroger directement mais avec délicatesse les mères pour savoir si elles ont des idées d'infanticide, notamment lorsqu'elles parlent de suicide.

***Le texte intégral est accessible en anglais à www.cfp.ca.**
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Infanticide is the term used to denote child murder in the first year of life.[1] Denial of pregnancy and a period of psychosis appear to be strongly associated with the act of killing one's infant.[1,2] Adolescent mothers who have a history of mental illness are more likely to kill their infants than mothers 25 years of age or older are.[3,4]

Chronic mental illness, such as a history of schizophrenia, is a substantial risk factor for infanticide.[5] A pattern of delusions that leads to the mother's feeling suspicious and having homicidal thoughts (controlled by outside forces or where the infant is seen as the devil incarnate) is of particular concern.[2] Hallucinations often involve themes about death, particularly of the infant.[2] Delusional altruistic homicide—where the mother aims to save someone from the "evil" infant or to spare the suffering of the infant (as well as herself) due to the lack of hope—that might include an associated parental suicide attempt has been noted as significant.[3]

Mothers with no psychotic symptoms have a lower risk of acting on their thoughts to harm their infants.[6] Abuse-related infanticide, however, has predictable and identified patterns of increased risk of death by homicide at demanding times of the day, like mealtimes and bedtime. These times appear to be associated with impulse killings.[7,8]

Fortunately, it is rare for mothers to kill their infants.[9] In addition to the concern that mothers might act on their thoughts of harming their infants, however, the suffering of these women is also worthy of attention. Little is known about the characteristics of infanticidal thoughts when the mother has no intent to act. This project was implemented to contribute to the current body of knowledge by examining the characteristics of infanticidal thoughts experienced by women with postpartum depression.

METHODS

Study design

In-depth interviews were conducted and audiotaped in this hermeneutic study. Theories of hermeneutics[10] argue that to obtain a true interpretation of an experience, one must obtain the meaning through those that have lived such an experience. The researcher must continually question the evolving interpretation in order to present an accurate picture of someone else's experience.

Ethics

Ethical approval was obtained from Queensland University of Technology in Brisbane, Australia. A number of key strategies were put in place in recognition of the sensitive nature of such a study. The research included guidelines to be followed in certain circumstances, such as offering to stop the interview if any woman became distressed, and researchers were able to refer women for counseling if required. Two women were referred back to their psychiatrists. All reports of study findings include fictitious names to protect the anonymity of participants.

Setting, sample, and data collection

The study was conducted in the large metropolitan city of Brisbane, Australia, in a community setting. During a larger study, women were identified by either a psychiatrist or psychologist on the project team as being depressed with postpartum onset according to the criteria set out in the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition, text revision.[11] As some women in this larger study admitted to experiencing infanticidal thoughts, a smaller qualitative study was implemented to collect descriptions of such thoughts.

At a single recruiting site—a community support group that was associated with the first project—a snowballing recruiting technique was used. This technique was successful once the women starting telling each other that the researchers could be trusted. Eighteen women expressed interest in the project. The first phase involved confirming the diagnoses of depression with postpartum onset, as some time had passed since the original diagnoses. Of the 18 women, 2 were noted to have obsessive-compulsive disorder and were therefore excluded. Another woman was found on the day of her interview to have psychosis and was also excluded. All 3 of these women, however, were offered the opportunity to "tell their story" for ethical reasons. Women continued to be recruited until analysis was no longer producing new themes (saturation), resulting in a sample size of 15 women. Qualitative studies must have small sample sizes in order to obtain the desired depth of information shared by the participants.[12]

The women who participated in the study were between 20 and 34 years of age. Some additional participant characteristics are presented in **Table 1**. The

Table 1. Participant characteristics: *N* = *15.*

CHARACTERISTIC	N (%)
Marital status	
• Married or common-law	14 (93)
• Separated	1 (7)
No. of live babies	
• Mother of 1 living child	7 (47)
• Mother of 2 living children	5 (33)
• Mother of 3 or more living children	3 (20)
Episode of depression (diagnosed in the first 4 wk postpartum)	
• First	7 (47)
• Second	6 (40)
• Third (or more)	2 (13)

duration of the current episodes of depression from the first clinical diagnoses ranged from 2 to 11.5 months.

The first 2 interviews were used as pilots to refine the interview question. Asking a direct question about infanticide did not produce the necessary rapport or create an environment of trust, resulting in minimal depth to the data. Therefore, the question was refined, and subsequent interviews commenced successfully with "Can you tell me about the distress you felt having postpartum depression?"

Data analysis

Data analysis was informed by the philosophical guidelines of Heidegger[13] and Gadamer.[10] The researchers needed to be aware that presuppositions (otherwise termed by Gadamer as *prejudices* or commonly known as *personal opinions* and *beliefs*) can influence interpretation of the data. Therefore, the researchers had to note personal opinions and knowledge held about infanticide before collecting any data. This became a point of comparison to inhibit the researchers from imposing personal biases onto the interpretation of the data.

After the interviews were completed and transcribed, the researchers had to become familiar with the stories from the participants by reading and rereading the transcripts of each story. Words and phrases that appeared to be important within the story were highlighted. These data were clustered to become units of meaning, then given a name that described the meaning. Similar units of meaning were compared or were contrasted until the researcher noted patterns within the data. Once there were enough data to confirm a particular unit of meaning, the hermeneutic circle[10] was implemented. The researchers purposively returned to their previous assumptions (prejudices) to compare that personal knowledge and understanding with the new conclusion. The researchers adopted a cynical and questioning stance and challenged the new units of meaning to evaluate whether they were the same as or different than the prejudices. When the units of meaning did not have sufficient evidence to confirm the suggested meaning, then the researcher re-engaged with the raw data and began the process again. Once the evidence confirmed a unit of meaning, then the researchers applied the hermeneutic circle, which is used to compare an aspect of a story (part) to the entire story (whole) in order to ensure that the part "fits" with the whole account as told by the research participant. This process was facilitated by the use of journals.

Frameworks for evaluating truthful and authentic findings of qualitative studies were used.[14-17] This included attending to personal and professional biases that could influence the interpretation. Also, 2 women with past experiences of infanticidal thoughts who were not participants of the study critiqued the analysis and confirmed that they could relate to the descriptions and that the interpretations were plausible, thus demonstrating transferability.

FINDINGS

Six themes emerged from the interviews.

Imagined acts of infanticide

The first theme related to women imagining acts of infanticide. Descriptions included throwing the baby off the balcony or dropping the baby onto the cement. One woman, Kathy, said she would sit for hours trying to determine if just dropping the baby from a standing position would be sufficient to kill the baby. She said that she would then speculate about what the baby would look like and how much blood would be present, and she also wondered how she would know that the baby had died. Kathy explained that she always carried her baby carefully, and yet these "silly thoughts kept happening."

The experience of horror

Horror relates to the women's responses to having thoughts about harming their babies. Women were shocked at having such thoughts and horrified by the nature of the thoughts. Sue explained:

> It is shocking really, wishing he was dead. Sometimes I would imagine things as I do things. I do a lot of things in the microwave, reheating things up, and I would suddenly stop seeing the food and see the baby going into the microwave, or I would be bathing him and realize how easy it would be to push him under the water. I used to have this overwhelming feeling of wanting to push something over his face as he screams. Shocking, isn't it?

Distorted sense of responsibility

A distorted sense of responsibility occurred when women felt despondent and believed that the situation was hopeless. They felt they could not endure their suffering anymore. In such situations, the women described having suicidal thoughts. For these women suicidal thoughts often occurred at the same time as the thoughts of infanticide. The associated meaning appears to be related to feelings of distorted responsibility toward their babies. Jane articulated this in the following manner:

> I worried about the baby, as he was only 3 months old. Far too young to be left without a mother. So I use to plan the suicide and intended to take him with me. I believed that he was my responsibility and he would be disadvantaged by not having a mother, so it was better to take him with me.

Julie too felt this form of responsibility.

> There were times when I thought I was such a terrible mother that he would be better off without me, and so I imagined him with someone else; and there were times when I thought that I would have to take him with me. I felt that it wasn't fair on [the baby] to have a terrible mother, but it also wasn't fair on him not to have a mother. And so, to take him with me was the only option.

Consuming negativity

A consuming negativity reflected the anger and hate that was described by most of the women as being associated with having thoughts of infanticide. As Jill explained clearly:

> You are so angry it's like a rage, it's all consuming, like a furry, like a volcano, you know, when it erupts. You feel like the lava as it starts at your feet and flows through your veins, rushing, and you can't stop it. It's so frightening and you can't stop it.

Grave consequences of such anger could have resulted for some of the participants, especially when the anger was directed at the babies. Julie's baby would not stop crying. She acted spontaneously:

> The way I felt about [the baby], the frustration, I could have strangled him at times [pause]. I put a teddy bear over him and could have easily suffocated him [pause]. I don't know, maybe I meant to [pause]. How can I tell him [looking toward her husband who is outside] that? What sort of a person would he think I was? [She begins to cry.]

The baby ceased crying, and Julie said she "snapped out of it" and gave the baby mouth-to-mouth resuscitation for a brief period. She did not know if he was breathing or not when she commenced resuscitation.

Keeping secrets

Of the 15 participants, all admitted to feeling ashamed and unable to share these thoughts with family and health professionals. All the women were afraid that they would be judged to be inappropriate mothers and their babies would be taken away if they told people about their thoughts of infanticide. The women described how tiring it was to keep such information secret.

According to Jill, she never told any health professional about her thoughts of infanticide. This is what she said about a recent episode:

> I had suicidal thoughts and plans for 3 weeks. I would think about it all day and I knew that was bad. I couldn't think what to do with the baby and so I thought I had to take the baby with me. Suddenly I knew there was something wrong with that picture. I knew I had to do something. But you know, you don't come straight out with it to your GP or your psychiatrist. I just say things are bad.

Kate provided a plausible reason for keeping such secrets:

> How I imagined hurting the baby was awful … you really don't want anyone to know … if they did they would want to put you away or take the baby away [pause]. I mean to say, why would you leave a baby with a mother who is thinking about putting him in a microwave. I used to see, in my mind, a pillow going over his head. So easy … the doctor says it's only thoughts. I get that, but what sort of a person am I even to imagine such things? … I have cried and cried over this [pause]. It was easier when I was numb and didn't feel at all. At least I didn't have these awful thoughts.

Sue said how easy it is for health professionals to assume you are suicidal:

> My GP and psychologist always know when things are bad, as they ask me if I am going to harm myself. I always tell the truth as I trust them, you know. But don't tell them the whole truth. They change my medication so that helps my thoughts about the baby anyway.

Managing the crisis

Some women reported how fearful they were of opportunistic harm when they could not stop their babies from crying. Two mothers had organized paid help in the evenings at mealtimes and confirmed how this reduced the tension they felt in the house at this time of the day when the baby was restless. Others would delay bath time until their partners came home from work. Julie was different from other participants, as she used daily goals to ensure that she did not act on the thoughts of infanticide again after she placed the teddy bear over her 3-month-old baby. The researcher asked Julie what these daily goals were:

> They were that he would not be damaged, he'd be normal, and he wouldn't get hurt, because as a mum you feel like you've achieved nothing, so I could say he wasn't hurt today and so I had met a goal.

Some of the women found it helpful to avoid or use distraction when thoughts of harming the baby occurred. As Joy said:

> After a while you know you are not going to do anything. You kind of get use to them, even though I still

feel guilty [pause] and ashamed [pause] I don't feel so afraid anymore. I just try to think of something else, you know, if I can't sleep and they pop into my head I then get up and watch the [television].

DISCUSSION

Momentary but recurring obsessional thoughts of harm to an infant, such as those described in this paper, are commonly experienced by depressed mothers.[6,18] In many cases, the infants of nonpsychotic depressed mothers might not be at any increased risk of harm compared with those infants of women who are not depressed, even if the women are experiencing obsessional thoughts about their infants.[6] However, a health assessment to confirm that there is no presence of psychotic symptoms (like a delusional system) or at-risk behaviour (like caregiving failure or neglect) is advised, as these have been previously identified as potentially harmful.[6,18]

Feelings of disgust and guilt about having such thoughts are common in women who have depression.[6] Greenland[19] claims that even those with the urge to kill or to severely injure family members likely also feel the opposite urge of restraint. Greenland does warn that this conclusion is dependent on anecdotal reports; but research conducted in this area to confirm or discount such a claim would be difficult.

Our study validates that women experiencing thoughts of infanticide might come to realize that they need to seek help. Seeking behaviour has previously been noted as important.[19] The findings of this project provide some insight into how women with depression who have infanticidal thoughts might seek help, such as sharing with a health professional that they are feeling suicidal not that they are experiencing infanticidal thoughts.

Our finding that women did not mention thoughts of infanticide to health professionals has also been noted by Meyer and Spinelli.[5] When infanticide has occurred, nearly half the parents had recently visited medical professionals. Therefore, when suicidal thoughts are mentioned, health professionals should probe further for the possibility of thoughts of infanticide. We suggest that health professionals use direct but sensitive questioning about harm of self and baby, including questions about hoping that the baby dies, regardless of the reason why mothers have presented.[6]

Limitations

Unfortunately, it is not possible to generalize our findings. The detailed descriptions of infanticidal thoughts found in this paper will aid health professionals in interpreting and making clinical judgments about patients' intent to undertake infanticide and in understanding the suffering that women who have depression face. However, our findings do not reflect the situations of women with different diagnoses, such as obsessive-compulsive disorder, or coexisting conditions, like schizophrenia. Therefore, further research about infanticidal thoughts in women with different diagnoses would be useful for comparison. Improving health professionals' awareness of the diversity of infanticidal thoughts with differing diagnoses would help to ensure that these women receive appropriate treatment.

Additionally, large studies to determine the prevalence of these types of thoughts would be useful. Unfortunately, such large studies might not be feasible, considering the sensitive nature of these thoughts and the trust issues that these women experience. Studies that explore descriptions of such thoughts from different cultural perspectives will also be necessary.

Conclusion

Women who experienced nonpsychotic depression preferred not to disclose their thoughts of infanticide to health professionals, including trusted general practitioners or psychiatrists. These women were more likely to mention their own suicidal thoughts than their infanticidal thoughts in order to obtain help. The morbidity and quality of life issues surrounding these distressing thoughts are key issues for depressed mothers. Our findings contribute to the current understanding of the nature of obsessional thoughts experienced by women with postpartum depression. Raising awareness helps to assist with early detection and assessment of infanticidal thoughts, resulting in effective treatment and support as required for recovery.

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Contributors

Drs Barr and **Beck** contributed to concept and design of the study; data gathering, analysis, and interpretation; and preparing the manuscript for submission.

Competing interests

None declared

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