Journal of Forensic and Legal Medicine 39 (2016) 91–99

Contents lists available at ScienceDirect

Journal of Forensic and Legal Medicine

journal homepage: www.elsevier.com/locate/jflm

Original communication

Intra- and extra-familial child homicide in Sweden 1992–2012: A population-based study

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ARTICLE INFO

Article history:
Received 14 September 2015
Received in revised form
9 December 2015
Accepted 18 January 2016
Available online 25 January 2016

Keywords:
Child homicide
Filicide
Filicide–suicide
Infanticide
Neonaticide
Familicide

ABSTRACT

Previous studies have shown decreasing child homicide rates in many countries – in Sweden mainly due to a drop in filicide–suicides.

This study examines the rate of child homicides during 21 years, with the hypothesis that a decline might be attributable to a decrease in the number of depressive filicide offenders (as defined by a proxy measure). In addition, numerous characteristics of child homicide are presented. All homicide incidents involving 0–14-year-old victims in Sweden during 1992–2012 ($n = 90$) were identified in an autopsy database. Data from multiple registries, forensic psychiatric evaluations, police reports, verdicts and other sources were collected.

Utilizing Poisson regression, we found a 4% annual decrease in child homicides, in accordance with prior studies, but no marked decrease regarding the depressive-offender proxy. Diagnoses from forensic psychiatric evaluations ($n = 50$) included substance misuse (8%), affective disorders (10%), autism-spectrum disorders (18%), psychotic disorders (28%) and personality disorders (30%). Prior violent offences were more common among offenders in filicides than filicide–suicides (17.8% vs. 6.9%); and about 20% of offenders in each group had previously received psychiatric inpatient care. Aggressive methods of filicide predominated among fathers. Highly lethal methods of filicide (firearms, fire) were more commonly followed by same-method suicide than less lethal methods. Interestingly, a third of the extra-familial offenders had an autism-spectrum disorder.

Based on several findings, e.g., the low rate of substance misuse, the study concludes that non-traditional risk factors for violence must be highlighted by healthcare providers. Also, the occurrence of autism-spectrum disorders in the present study is a novel finding that warrants further investigation.

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1. Introduction

Child homicide is a rare, yet tragic, event that occurs at rates of 2.0 per 100 000 inhabitants globally[1] with intra-familial cases far outnumbering extra-familial ones.[2,3] Filicide, which denotes the parental killing of a child, comprises the major part of the intra-familial cases and has existed for centuries in many socio-cultural contexts.[4,5] Historically, the disposing of unwanted children has been a more or less accepted way of ensuring survival of more fit family members during times of famine or poverty.[5] Although of questionable generalizability, a recent study has found thoughts of committing filicide followed by suicide to be fairly common, at rates of nearly 15% among parents to school-aged children in rural Taiwan.[6] In a seminal article from 1969, Resnick proposed a classification system for filicide based on apparent motive in five separate, although not mutually exclusive, categories[7]: (i) the *altruistic* filicide, which is characterized by the urge to relieve (real or imagined) suffering; (ii) the *acutely psychotic* filicide, in which the offender is acting under the influence of psychosis; (iii) the *unwanted child* filicide, in which the offender primarily strives to get rid of the child; (iv) the *accidental* filicide, which is characterized by the unintentional use of excessive violence by a battering parent; and, last, (v) the *spouse revenge* filicide, in which the offender kills primarily to retaliate against a former or current

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http://dx.doi.org/10.1016/j.jflm.2016.01.011
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intimate partner. Although still generally regarded as valid, Resnick's work has been augmented by several other typologies, with a view both to overcome problems with overlapping categories and to understand other aspects of the phenomenon (see, for instance Refs. 5,8–10).

The topic of child homicide and filicide has been well researched,[10–12] albeit often with small and inherently biased samples, which frequently are drawn from correctional facilities or forensic-psychiatric units or from populations still awaiting trial.[13] Unfortunately, findings from such studies have limited generalizability owing to biased inclusion criteria. Moreover, studies with larger sample sizes often lack detailed case characteristics, thereby precluding in-depth analysis.[13–16]

In addition, the research field is plagued by inconsistencies regarding the definition of filicide. The upper age limit for victims is commonly set to be below 15[17] or 18 years[18,19] or sometimes even omitted so as to include adult victims.[13] Two subcategories of filicide are commonly acknowledged: *neonaticide*, which denotes homicide during the first 24 h of life, and *infanticide*, which denotes homicide during the first year of life with the exclusion of the first 24 h.[18] The term infanticide, however, should not be confused with the criminal charge with the same name, whereby a mother, in the grip of post-partum mental instability, takes the life of her small child.[12] Further, the term *familicide* is frequently used to describe the joint killing of at least one child and one other family member; in the vast majority of cases the perpetrator is male and the victims include his female spouse.[20] Neonaticide and infanticide rates are believed to be underreported, partly as a consequence of the fact that many presumptively filicidal mothers are young and prone to conceal their pregnancies and to eschew contact with prenatal care.[14,21–23] Thus, some of the youngest victims are born in seclusion and remain unrecognized by society.

In several European countries, infanticide rates have steadily declined,[21] as have overall child-homicide rates in Sweden and Finland.[17,24] A number of factors have been proposed as central to these decreases during their earlier phases in the 1960s and 1970s, e.g., improved birth control, legalization of abortion, increased societal acceptance of single mothers and a growing female emancipation movement.[24]

Moreover, a recent Swedish study found a 4% annual decrease in child homicides when data from two seven-year periods in the early 2000s and the 1990s were compared.[17] The authors found that the overall decrease was chiefly attributable to cases of filicide–suicide (i.e., filicide followed by offender suicide), which led them to speculate that increasing sales of modern antidepressants may have lowered the child homicide rate by way of reducing suicidal outcome of depression.[17] Filicide–suicide is a distinct subcategory of homicide that seems to display fairly constant characteristics over time and that – in comparison with filicide only cases – more commonly is associated with paternal offenders, multiple and older victims, as well as older offenders.[25–27] However, detailed data on such perpetrators are difficult to obtain, since they are deceased. Furthermore, the filicide–suicide time interval is problematic and varies considerably in the literature,[28] although a maximum time frame of 24 h has been employed by influential theorists.[27] Because of its unfathomable nature, child homicide is seemingly instinctively associated with mental disorder; whenever a filicide case is reported in the media, harsh comments are usually made regarding the need of adequate psychiatric care for parents with filicidal ideation. Indeed, recent studies have shown psychiatric morbidity among almost half of filicide offenders, with elevated rates of affective disorders, personality disorders and psychotic states.[19,29,30] In addition, a Danish cohort study has shown an increased relative risk of becoming a homicide victim in children whose parents have received inpatient psychiatric care.[31] To the best of our knowledge, no studies have examined the presence of autism-spectrum disorders in child homicide offenders. The topic is intriguing, however, given previous findings of violent behaviour among individuals with such disorders.[32,33]

2. The present study

The present study aims at adding to prior scholarship by utilizing a medium-sized population-based sample of both extra- and intra-familial cases, in parallel with a comprehensive dataset collated from multiple sources. Drawing on Sturup's and Granath's recent study,[17] we hypothesize that (i) there has been a decline in the rate of child homicides between 1992 and 2012; and, more specifically, that (ii) there has been a drop in the number of depressive filicide offenders. Further, we aim to examine offender-specific factors – e.g., psychiatric morbidity and health-care consumption – as well as other characteristics of offenders, victims and offences in filicides, filicide–suicides and extra-familial child homicides.

3. Methods

3.1. Design and material

The study has a retrospective, registry-based case-series design and encompasses all child homicides during the period January 1, 1992, to December 31, 2012. All individuals below 15 years of age, who were adjudged as victims of homicide upon forensic-pathological examination, were identified in the National Board of Forensic Medicine's in-house autopsy database ($n = 116$). Cases were then compared with data from a police-report-based registry administered by the National Council of Crime Prevention (www.bra.se) – and previously used in homicide research[34] – to minimize the risk of eligible cases being misclassified or overlooked. At that stage, four victims were excluded, since the police later in the process had not been able to prove that a crime had taken place. Conversely, an additional three victims were included, yielding a total of 115 child homicide victims.

In the present study, filicide is defined as the death of a victim aged 0–14 years following a violent act committed by one or both biological parents, stepparents, foster parents, adoptive parents or any other person *in loco parentis*. In non-offender-suicide cases, court verdicts were collected to confirm that victims had died as the result of a criminal act. Accordingly, a court ruling of homicide, manslaughter, infanticide or involuntary manslaughter by assault, was required for inclusion. Offenders who were below the age of 15 years ($n = 4$) at the time of the offence, and thus not criminally responsible according to the Swedish law, were nevertheless included provided that the case was considered solved by the police. In cases of multiple child homicide, the eldest victim was considered the primary one.

3.2. Registries

Comprehensive data were retrieved from the National Register of Criminal Convictions, the National Patient Register and the Swedish National Tax Agency. Medico-legal autopsy reports, forensic psychiatric evaluations, files from the social services and police reports were also collected. Occasionally, police reports included additional information such as suicide notes, files from psychiatric clinics, interviews with relatives or statements from eyewitnesses. The National Patient Register (administered by the Swedish Board of Health and Welfare, www.sos.se) includes information on all admissions to psychiatric hospitals in Sweden

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