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The Infanticidal Attachment

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Kahr's article introduces the concept of an infanticidal attachment relationship in infancy as a potential precursor to the development of schizophrenia. He argues that the infanticidal attachment is characterized by all of the failures and inconsistencies of caretaking so prevalent in the classic disorganized attachment state of mind, but would contain, as well, one or more specific experiences of deadliness that would have made the infant fear for his or her life on one or more occasions. He goes on to propose that the further presence of experiences of premature morbidization and psychological infanticide - early near-death experiences and early death threats - creates an infanticidal introject which may play a role in the aetiology of schizophrenia. He identifies five different forms of premature morbidization that include actual parental death threats, the replacement child syndrome, aborted abortions, and murder of pets and death of a twin *in utero*. He illustrates this proposal with a clinical account of the ways in which the infanticidal introject may feature in the developmental history of Vita, who eventually receives a formal diagnosis of schizophrenia.

Keywords: Infanticidal attachment, disorganized attachment, schizophrenia, psychological infanticide, replacement child, infanticidal introject

'A thing which has not been understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been solved and the spell broken.'

(Freud, 1909b, p. 122)

Introduction: What Causes Schizophrenia?

In 1979, as a young psychology student, I began to work on the back wards of a decrepit, foetid nineteenth-century psychiatric hospital, which served, quite literally, as a warehouse for elderly men and women who had received a diagnosis of schizophrenia. Only moments before my fellow trainees and I met these psychogeriatric patients for the very first time, the Chief Psychologist warned us - and I do believe that I remember his precise words nearly thirty years later - 'These people are different from us. They have twisted brains and faulty biochemistry.' He then produced a huge ring of keys, thereby resembling a Dickensian gaoler, and with a dramatic flourish in his otherwise flattened voice, the Chief Psychologist intoned, with a trace of menace and a hint of excitement, 'Welcome to Never-Never Land.' This earnest man wanted his students to know that we would not be encountering fellow human beings, but, rather, some very bizarre creatures from a faraway fictional world.

Although I received a very solid education in experimental psychopathology, and I studied the literature on the genetics, biochemistry, neuropathology, and psychophysiology of schizophrenia with Talmudic fervour, I also steeped myself in the writings of the classical Freudian psychoanalysts as well as those of the Laingian antipsychiatrists, all of whom claimed that schizophrenia could be conceptualized in rather different terms. As I persevered with my training,

I worked with a growing number of schizophrenic patients, and for more than one year I even lived with psychotic men and women in two community-based psychiatric halfway house facilities. I soon learned that whatever genetic, biochemical, or neuropathological vulnerabilities these individuals may have had to endure, they certainly had experienced a great many interpersonal traumas in their early developmental histories, ranging from abandonment and bereavement to physical abuse and rape. In fact, I cannot recall a single person diagnosed as schizophrenic who had not suffered from one or more psychosocial traumas.

As my psychotherapeutic work began to broaden, and I started to treat people who had never suffered from schizophrenia or from other varieties of psychosis, I soon learned that they too had been abandoned, abused, raped, and so forth, and yet mercifully, did not suffer from the hallucinations, delusions, and thought disorder so characteristic of the typical schizophrenic condition. Psychosocial trauma and psychosocial stressors could function as contributory factors in the aetiology of schizophrenia, but such external impingements would not, in all likelihood, serve as the sole explanation of the origins of such an excruciatingly crippling psychological illness.

All of my mentors in clinical psychopathology and behavioural genetics conceded that psychosocial factors might play a role in the developmental trajectory of schizophrenia, but only if the patient already had a genetic predisposition. In other words, most investigators subscribed to the fashionable 'diathesis-stress' models of schizophrenia, which viewed psychosis, essentially, as a genetically transmitted brain disease that could be 'kick-started' by some amorphous set of life stressors.

Although the so-called diathesis-stress models have proved ongoingly attractive, representing a veritable psychiatric equivalent of 'having one's cake and eating it too', these traditional conceptualizations, however, falter on at least two crucial dimensions:

1. If schizophrenic individuals really suffer from genetically heritable neuropathology, how can one explain the cases of carefully diagnosed schizophrenic people who reveal no abnormalities on brain scans, or who reveal the same abnormalities detected in alcoholics, depressives, and, *inter alia*, combat veterans **(Andreasen, 1986)**?
2. If schizophrenic individuals really suffer from a genetically-transmissible illness, how can one account for the literally hundreds and hundreds of case reports of patients whose schizophrenia remitted successfully as a result of intensive psychotherapeutic treatments (Boyer, **1967a**,**b**; **Karon & VandenBos, 1981**)?

Although investigators have implicated a number of chromosomes, neurotransmitters, and subcortical brain structures in the pathogenesis of this

psychotic condition, none has, as yet, established a definitive causal relationship between somatic anomalies and the subsequent development of schizophrenia **(Sullivan, Owen, O'Donovan, & Freedman, 2006)**.

Elsewhere, I have surveyed the growing body of research on the role of intrafamilial traumatization (especially sexual abuse) in the aetiology of schizophrenia, as well as the much-

neglected research on the role of the Nazi concentration camps in producing documentable cases of schizophrenia in Jewish internees **(Kahr, 2007)**. The debate about causation in schizophrenia, yet another chapter in the centuries-long battle between the naturists and the nurturists, will continue to rage, no doubt, for some time to come. In the meantime, I wish to add a small puzzle piece to the question of the aetiology of schizophrenia, and in particular, to its possible psychogenesis.

Over nearly thirty years of work as a clinician, as a clinical supervisor, and as a clinical lecturer, I have now encountered over 150 cases in which schizophrenic patients have reported the presence of parental death threats or parental death wishes in a clear and undisguised manner. In my experience, these events create a toxic style of insecure, disorganized attachment which, when combined with other traumata, may, in certain instances, serve as the necessary precondition for the development of the schizophrenic psychoses. I refer to this style of adult-child interaction as The Infanticidal Attachment.

Psychological Infanticide and Schizophrenia

Shortly after I had begun to work with schizophrenic patients in hospital, I became increasingly aware of the sheer amount of stories that I had heard about early experiences of death threats, often perpetrated by parents. As I listened to these tales of horror, I learned that virtually all of my schizophrenic patients had experienced what I have come to refer to as 'premature morbidization', an early exposure to death, to deadliness, and, in particular, to threats of death, usually at the hands of caretakers. Fortified by Dr Donald Winnicott's **(1949)** important work on 'Hate in the counter-transference', in which he carefully delineated the many ways in which even ordinary, healthy parents will hate their children, unconsciously singing murderous lullabies such as 'Rockabye Baby', and then, subsequently inspired by Lloyd deMause's **(1974)** ground-breaking work on the ubiquitousness of actual infanticide of babies in the ancient world, I learned only too clearly about the ways in which mothers and fathers transmit death-related messages to their children, sometimes consciously, but often unconsciously **(Kahr, 1994)**.

I first began to appreciate the possible connection between murderous parental wishes and psychiatric illness after reading the 1967 Thomas William Salmon Memorial Lectures on schizophrenia, delivered at the New York Academy of Medicine by the pioneering American psychoanalyst Professor

Theodore Lidz of the Yale University School of Medicine, one of the leading researchers on the psychogenesis of schizophrenia, whose work focused predominantly on the disturbed patterns of communication and the disturbed patterns of misalliances within the families of schizophrenic patients. In a chilling case report, Professor Lidz described his work with an overtly delusional young woman, a university-aged student who suffered from clinical schizophrenia. Lidz (**1973**, pp. **99-100**) reported on a meeting with the patient and her family:

The mother did all the talking, while the father, a wealthy art dealer, remained silent. When I directed remarks to him, I gained a response from his wife. When I purposefully turned my back

on her and asked the father a question, the mother intruded before he completed a sentence. It was difficult to learn much about the patient for the mother talked about herself, her Pilgrim ancestry, and her ambitions as a writer. When I finally interrupted and asked about the daughter's college career and her interests, I learned that the girl's whole life revolved around becoming a novelist; she had a passion for Virginia Woolf. Her mother hoped her daughter would follow in the footsteps of her idol. I hesitated before commenting, 'But Virginia Woolf had psychotic episodes and committed suicide.' The mother did not hesitate when she replied, 'It would be worth it.' Six weeks later, while making rounds of the in-patient hospital rooms, Professor Lidz noticed a brace of novels by Virginia Woolf newly despatched by the young girl's mother. The patient explained to Lidz, 'Mother sent them - she has a thing about Virginia Woolf.' (Lidz, **1973**, p. **100**)

Eventually, Lidz discharged the patient, who returned home to continue her treatment on the West Coast of America, where her parents lived. Heart-breakingly, Professor Lidz subsequently discovered that the patient eventually killed herself, just as Woolf had done, thereby enacting her mother's all too powerful injunction.

This vignette from Lidz's casebook, first described in lecture form in 1967, and then in print in 1973, has received scant attention from psychological scholars and researchers, in spite of the pre-eminence of Lidz, and of his much-publicized work on the families of schizophrenic patients. Indeed, although this clinical example has formed a part of the psychiatric record for nearly fifty years, I have never seen this story cited in the clinical literature, except, on one occasion, by myself **(Kahr, 2001)**. Although one might dismiss this particular example of a patient whose mother wished her dead as but one brief illustration which defies replication - after all, how many schizophrenic patients believe themselves to be Virginia Woolf? - Lidz's report does, I propose, actually provide evidence of a more widespread phenomenon, for I would regard this interaction between the patient and her mother as a profound instance of the role of both conscious and unconscious parental death wishes

in the aetiology of the schizophrenic illness, the very type of threat that would prompt patients to kill themselves, or, as **Dr Ronald Laing (1960)** and others have noted, to experience 'petrification' and become catatonic.

As my sensitivity to the murderous subtext of interactions between psychotic patients and their families became increasingly acute, I eventually began to realize that large numbers of the patients with whom I had worked both wanted and needed to tell me important stories of near-death experiences, death threats, and other types of premature morbidization. Indeed, I started to conceptualize these episodes as instances of what I have come to call psychological infanticide, the transmission of a death wish, either directly or indirectly, from caretaker to child. As my thinking developed, I published a short, preliminary communication on this topic entitled 'Ancient infanticide and modern schizophrenia: the clinical uses of psychohistorical research' **(Kahr, 1993)**, in which I reviewed data on both the history of actual, concrete infanticide in the ancient world, and the ways in which it became transmuted into psychological infanticide, so prevalent in the psychiatric population.

In this brief communication, I identified three principal subtypes of psychological infanticide, experiences which would leave the preschizophrenic child feeling persecuted, terrorized,

tormented, and in many cases, delusionally dead or completely catatonic. I described these principal subtypes as follows:

1. *Actual parental death threats* in which a parent, through deeds or words, either attempts to kill a child, albeit unsuccessfully, or threatens to do so.
2. The *replacement child syndrome* in which the preschizophrenic child enters the world in the immediate aftermath of the death of an elder sibling, and then the replacement child ultimately realizes that he or she can never satisfy the grieving, bereaved parents, and becomes mad in the process.
3. *Aborted abortions*, whereby a parent, usually a mother, informs her child directly that she had planned to abort the foetus during pregnancy, but that for some unpreventable, external reason, the termination could not be carried out.

I shall now provide a more detailed description of the three principal subtypes of psychological infanticide.

With respect to actual parental death attempts or death threats, I have encountered numerous instances of near-death experiences perpetrated by parents towards children who eventually became formally diagnosed with schizophrenia. These include parents shouting 'I wish you were dead', parents chasing their children with knives or other dangerous implements, parents locking children in darkened cupboards for more than twenty-four hours, thereby depriving the child of food or sufficient oxygen, or depriving the child of necessary medical attention. One schizophrenic woman, whom I shall call Jemma, told me that during her childhood her Orthodox Jewish parents would

always refuse to telephone for medical assistance on the Sabbath (Friday nights after sunset, and all day Saturday until sunset), as the use of the telephone would be considered a contravention of Jewish law. I can think of few rabbis who would endorse this as a feasible interpretation of Judaism, but Jemma's parents often allowed both her and her brother to suffer without the ministrations of a physician during periods of illness. Both children, in fact, became schizophrenic in adult life, and the brother ultimately committed suicide.

As for the replacement child syndrome, it staggers me how many psychiatrically compromised individuals had to endure the experience of following a dead elder brother or sister into the world. Both Vincent van Gogh and Peter Sellers, two rather different personalities, yet both highly distressed, troubled, and deeply self-destructive - van Gogh psychotically so - entered the world in the wake of a dead sibling. In the case of van Gogh, he replaced an elder brother called, unsurprisingly, Vincent. Of course, not all replacement children become schizophrenic by any means, but I encountered a number of cases of schizophrenic patients who became replacement children and, crucially, whose parents had not even begun to mourn the loss of the earlier child. In my clinical work, I had never met a woman more ill than Karina (not her real name), a sixty-five-year in-patient who became diagnosed as schizophrenic at the age of nineteen. Karina spent all day walking up and down the corridors of the psychiatric hospital wailing in an uncontrollable manner, begging to die. She had done this for years, and eventually, the staff became numb to her rantings, and no one would work with her. When I sat down with Karina and attempted to learn something about her history, I soon discovered that her mother had had a depressive breakdown only days after Karina's birth. When I asked Karina why she imagined her mother had

become ill, Karina replied, 'She never got over the other Karina.' Naturally, I looked perplexed, and I soon came to understand that exactly nine months before Karina's birth, her elder sister died from diphtheria at the age of ten years. Her name? - Karina. Apparently, the elder Karina had beautiful blue eyes and wavy blonde hair. My patient, the replacement Karina, had muddy brown eyes and kinky black hair. Whenever she compared herself to her deceased sister, Karina the younger felt deeply, bodily inadequate. She constantly wondered why her parents had given her the same name as her dead sister, exactly as Vincent van Gogh's parents had done. Of course she could never compete with the cherished, idealized, unmourned older Karina, and, hence, my patient soon sensed that her parents had wished her dead, and often told her so.

With reference to the category of psychological infanticide known as 'aborted abortions', I recall a schizophrenic gentleman I shall call Manfred, a gay man who cheerfully admitted how much he found the sight of women's bodies revolting. During my first assessment interview with Manfred, I soon learned that his mother had experienced a traumatic delivery of her son. When

I asked Manfred what he knew about his own birth, he said, 'Oh, apparently, I ripped my mother open.' I then asked for clarification, whereupon Manfred replied, 'Yes, that's right, all my life my mother kept telling me how I ripped her body open, and that she regrets not having aborted me.' Another schizophrenic man, 'Nesbitt', explained that his mother also told him of her plans to have him aborted, but that their general medical practitioner, a fervent practising Catholic, refused to authorize such a procedure.

Of course, none of these experiences - whether being threatened with death, whether being a replacement child, or whether being an aborted abortion - provides complete evidence of traumatogenesis, at least not sufficiently so that one could comfortably attribute the aetiology of schizophrenia to one or more of these sub-categories of psychological infanticide. In fact, we all know of many people whose parents threatened them, of many replacement children, and of many aborted abortions, who did not become schizophrenically psychotic in any way.

Nevertheless, as I began to encounter more and more schizophrenic patients, first as an assessor, next as a psychotherapist in both individual and group contexts, and next as a clinical supervisor of the work of younger colleagues, I discovered at least two other subtypes of psychologically infanticidal experiences which appeared and reappeared with increasingly regularity in the life history stories of schizophrenic men and women. In addition to the aforementioned categories, I also catalogued numerous instances of the murder of patients' pets during early childhood, as well as the experience of having one's co-twin die in the third trimester of pregnancy, while still *in utero*:

1. *The murder of pets* occurs with surprising frequency in the childhood histories of preschizophrenic patients. I know of at least five schizophrenic patients who reported memories of parents burning their teddy bears in a dramatic manner, throwing their childhood dolls and toys away, and, in the more extreme cases, killing an actual pet, sometimes in the presence of the child, and sometimes not. Most horrifyingly, I recall the case of a twenty-something schizophrenic patient, whom I shall call Oona, whose mother wrenched her favourite childhood transitional object from her hands shortly after Oona's sixth birthday, explaining in a sneering tone, 'Big girls like you shouldn't play with teddies', and then proceeded to tear the bear's head off in front of Oona's eyes. **Dr Valerie Sinason (2001)**, pioneering psychoanalyst, child psychotherapist, and

traumatologist, has identified a similar phenomenon in her chillingly revealing essay 'Children who kill their teddy bears', based on her work with patients suffering from all manner of psychiatric illnesses, including dissociative identity disorder. In Sinason's work with an eight-year-old mutistic, psychotic, and handicapped boy called 'Steven', she observed him engaging in a repetitive ritual of drowning a toy

teddy bear in the clinic sink during child psychotherapy sessions. On one occasion, Steven rifled through the dressing-up cupboard and emerged in adult, female clothing, resembling an older woman. Steven announced, quite eerily, that he had become a 'mummy', and that he wanted to kill the teddy-baby. Steven intoned 'Kill, kill, kill', and 'I'm my mummy' (Sinason, **2001**, p. **45**), revealing, only too clearly, the ways in which the child will often identify with the murderous mother and repeat inexorably the death wishes and death threats absorbed during the pre-oedipal period of development. Such early childhood experiences may not occur exclusively in the backgrounds of the preschizophrenic child, but may ultimately prove pathogenic, in fact, in a number of different psychopathological syndromes.

2. *Death of a twin* in utero may also feature as a potentially toxic agent in the development of adult schizophrenia. During my working life I have encountered three floridly schizophrenic patients whose co-twins had all died *in utero* during the third trimester of pregnancy. 'Percy', a forty-something schizophrenic male, told me that his twin brother had died shortly before his birth. A conversation with a family member confirmed the truth of Percy's assertion. Deeply tormented by hallucinations of being murdered by a giant hand, Percy could not fall asleep at night unless he could go to bed, on his hospital ward, clutching an enormous teddy bear, approximately five feet in height, to which he would cling with symbiotic tenacity. A tall, fully grown man in his own right, Percy would intone, before bedtime, 'This is my brother.' Episodically, Percy would lapse into deep catatonic states, pretending to be dead, and claiming that someone had sucked all of the blood from his body. I suspect that from an unconscious point of view, Percy entered into a state of identification with his dead twin brother, and he used the five-foot tall teddy bear as a desperate means of both enlivening himself and shielding himself from the trauma of having had a dead co-twin as his very first object relation.

I have now identified five different, though interrelated, varieties of premature morbidization that one will encounter all too regularly in the biographies of men and women who eventually receive a psychiatric diagnosis of schizophrenia. All of these individuals have survived in a bodily sense - none became the victim of forensic infanticide - but all have suffered from what I have identified as psychological infanticide, having become recipients of one or more variants of parental death threats, or, in the case of those born with dead co-twins - a situation that can be blamed unconsciously on mother - recipients of other types of premature morbidization. As a result of becoming a victim of psychological infanticide, the young child in question will internalize a state of deadliness, which I have come to call the infanticidal introject,

which functions, rather like a cancerous tumour in the mind, and which will remain toxic unless defused by a psychotherapeutic process or some other form of healing.

Those people who have internalized an infanticidal introject through psychological infanticide and other types of premature morbidization will, in my experience, develop a disorganized attachment style, and in particular the one that we may identify specifically as an infanticidal attachment. To date, I have never met a schizophrenic patient with a secure attachment, and I have, by now, met many, and supervised or consulted to the treatment of many more.

Although I shall not attempt to discuss the ways in which one might begin to work psychoanalytically or psychotherapeutically with the psychologically infanticided schizophrenic patient, I do wish to remark that the dynamics of someone who has grown up with infanticidal attachments will invariably be relived in the treatment situation; and clinicians ought to become increasingly vigilant to the possibility of what I have come to call an *infanticidal transference* and its correlate, the *infanticidal countertransference*. I can recall patients who, upon first meeting me, instantly thought that I had plans to kill them. One hospitalized patient, whom I had not met previously, ran into my consulting room at the beginning of our first session and, before I could even introduce myself by name, catapulted himself out of the window, fearful of being killed. Fortunately, the patient landed on a ledge and did not harm himself. Another hospitalized patient ran into my room and, before I could introduce myself to this man, he hid under a table, cowering in fear of being murdered. Yet another schizophrenic patient, with whom I worked in a music therapy group, used to fantasize that I wanted her dead when, in fact, I often regarded her as one of my favourite patients, as the others all suffered from catatonia and only this particular woman would sing out loud! Still others will threaten the life of the psychotherapist as a desperately creative attempt to protect themselves from the even more terrifying fear of being killed by the clinician. For those who work with such patients, an infanticidal countertransference will be inevitable, and therapists of all backgrounds regularly report fantasies of hurling these understandably demanding and frightening individuals out the window, which represents both the objective burden of working with such people, and also an unconscious communication of a deadly quality within the original intrafamilial environment.

Other mental health professionals have, of course, written about the possible aetiological role of the death threat in the backgrounds of psychotic individuals. Professor **Bruno Bettelheim (1956)**, for example, reported several cases of psychotic boys who had suffered either death-threats or near-death experiences; but, as yet, no clinician has attempted to theorize the relation between infanticidal experiences and schizophrenic symptoms in a more systematic manner. In an era dominated by biopharmacotherapeutic approaches to severe

mental illnesses, one can readily understand our reluctance as psychotherapeutic practitioners to share these arguably unpopular clinical observations

I now present some more detailed clinical material illuminating, I trust, the ways in which the infanticidal introject may feature in the developmental history of the patient who eventually receives a formal diagnosis of schizophrenia.

Clinical Material: The Case of Vita

I have met few patients more distressed and crazed than ‘Vita’ during nearly thirty years of work in the field of mental health. One of my senior colleagues, who knew Vita very well, described her

as a veritable ‘museum of psychopathology’ because she displayed so many symptoms, including auditory hallucinations, delusions of being murdered, anorexia nervosa, bulimia, multiple suicide attempts, self-cutting of the face, arms, legs, and genitals with a razor blade, self-inflicted burning of the skin, sexual promiscuity, drug abuse, alcohol abuse, chronic smoking of cigarettes, and trichotillomania (hair-pulling). Although the large range of symptomatology might lead a traumatologist to suppose that Vita might better be diagnosed as a case of complex post-traumatic stress disorder, one must realize that she met all the formal *Diagnostic and Statistical Manual of Mental Disorders* requirements for a diagnosis of schizophrenia, and had received this diagnosis from one of the world's leading experts in the field of psychiatric diagnosis, one of the many, many psychiatrists who had evaluated Vita over the years, all of whom agreed on the schizophrenia diagnosis. I shall not dwell upon the full details of Vita's history, except to report that she suffered from gross early abandonment, as one month after her birth Vita's mother became ill with lymphoma from which she eventually recovered, but which necessitated the mother spending a full year in hospital so that she could receive very primitive chemotherapy. Vita's father attempted to look after the newborn baby, rather unsuccessfully. A paedophile of long-standing, the father abused Vita sexually, and he eventually became embroiled in a child pornography ring and used Vita as one of the so-called ‘models’. She believed that this abuse took place between the ages of eight and eleven. Unsurprisingly, Vita became a psychiatric in-patient at the age of twelve, and lived in many adolescent units, heavily medicated, and deeply despondent.

Although I did not work with Vita in long-term psychotherapy, as she joined the institution where I worked shortly after I had already announced to colleagues that I would be leaving in a year's time to take up a new job, I did have the opportunity to offer time-limited family work to Vita and her parents. The Consultant Psychiatrist in charge of Vita's case asked me to meet with the family, as Vita had begun to express a ‘delusion’ that her parents wanted her

dead, and so, as a result, she began to acquire large carving knives, stolen either from local shops, or from the hospital kitchen, or from other sources unknown to staff, threatening to use these knives to stab her parents to death. On more than one occasion, colleagues and I had to confiscate these knives and attempt to convince Vita that murder would not be the best of ideas. At this time, Vita began using razor blades, and would make light tracings on her belly, often drawing blood.

One afternoon, Vita's rather frightening parents did not arrive for the family session, and I met with Vita alone. She told me that she had just remembered an episode that had occurred sometime during her childhood. Vita could not recall her exact age, possibly five, or six, or even seven years. It seems that Vita had a favourite transitional object, a teddy bear called ‘Harry’. Vita loved Harry greatly, and she carried him everywhere. At one point, Vita became distressed because one of the old-fashioned wire coils inside Harry's tummy became loose, and began to protrude through the fabric of the soft toy. Vita brought Harry to her mother who, according to Vita, feigned sympathy, and mockingly announced, ‘Oh, dear, poor Harry, he is very ill, isn't he? It looks as though we shall have to operate’, whereupon the mother then took Vita and Harry into the kitchen, seized a large carving knife, and sliced open the teddy bear's stomach from sternum to abdomen. Vita began to scream hysterically at the sight of her mother mutilating her bear, and eventually, the mother taped the wire coil back inside, and sewed Harry together again. Vita shook demonstrably as she told me this tale.

Some weeks later, Vita's mother arrived for a family therapy session. Vita could not attend, as she chose to go to the cinema with the nurses and some of the other patients; and father, too, did not attend, as he had a cold. Mother seemed very uncomfortable meeting with me by herself, as did I, but somehow we survived the meeting. I asked mother whether she might be able to tell me something of her background, because I realized that I knew little about her history prior to Vita's birth, and prior to her own quite awful struggle with lymphoma and her ultimately successful treatment with chemotherapy.

Grudgingly, the mother offered some skimpy details, and I asked a raft of clarificatory questions. 'What did your mother do?' I wondered. 'Oh, just a housewife,' replied Vita's mother. 'And what about your father?' I asked. 'Ah, yes, he was a doctor, in the country,' she answered. And then Vita's mother began to look away, and she turned her eyes towards the ceiling, as if concentrating very hard upon some newly formed thought or newly retrieved memory. 'It's funny,' she mused, 'I haven't thought about this in decades, but I suddenly remember that my father was not only a doctor, he was *my* doctor too, even though he wasn't a paediatrician.' I looked quizzical as Vita's mother continued with her free associative recitation. She then explained that once during her childhood - she could not recall the age - she suffered from

crippling stomach pains, and her father diagnosed a burst appendix and knew that an immediate appendectomy would be needed. Unfortunately, the family were holidaying on a remote Scottish island at the time, far away from the mainland, and so could not access medical help in time. I worked with Vita in the early 1980s, at which time the mother must have been already sixty years old; therefore, I quickly estimated that this appendix crisis would have occurred in the 1930s, when being stranded on a remote Scottish island, with no mobile telephones or helicopters, would indeed have constituted a grave emergency. In the absence of any other qualified practitioner, the father announced, 'We shall have to operate.' With no anaesthetic other than chloroform available, and no operating theatre, Vita's grandfather actually performed surgery upon Vita's mother, and, quite miraculously, she neither died nor developed an infection in the process.

I shall restrain myself from discussing more of the details of Vita's case in this limited context, but, rather, I wish only to underscore at this juncture the role of intergenerational trauma as a possible aetiological component in the development of Vita's symptomatology, and of her fear of being murdered. One might imagine that having her own mother hospitalized with lymphoma for the first year of Vita's life would, in and of itself, provide a serious risk for a disorganized attachment later, but when one combines the maternal abandonment with the sexual abuse perpetrated first by father, and then by father's child pornography accomplices, one wonders why Vita did not become schizophrenic much sooner, or indeed, commit suicide. Furthermore, when one considers the impact of mother committing an act of psychological infanticide on the teddy bear, Harry, and through identification, on Vita herself, one begins to wonder whether schizophrenia, especially paranoid schizophrenia, becomes the inevitable outcome of such a set of childhood impingements and intrusions.

I have called this patient Vita as a testament to her desperate struggle to cling to life in the face of so much traumatic reliving, across the generations, from the knife-wielding grandfather, to the knife-wielding mother, to the knife-wielding part of Vita herself. Heart-wrenchingly, I learned that years after I had left the psychiatric hospital, Vita did indeed kill herself, although the nurse who told me about Vita's death, did not know whether Vita used a knife, as I suspect she might have

done. But whatever the cause of her death, I have a strong suspicion that her mother's unanaesthetized surgery became replayed on Vita's teddy bear decades later, and that Vita became understandably fearful of being murdered by a mother. Then, when mother failed to protect her from the grotesque abuses of father and his confederates, murder, suicide, or madness became Vita's only options for survival. In the end, though she tried to kill her parents and become a murderess, she succumbed to madness and suicide, unaided by the literally hundreds of staff members across different hospitals and clinics who tried to rescue her.

Conclusion: The Infanticidal Attachment

In the preceding pages, I have identified a new subtype of attachment style between caretaker and child - the infanticidal attachment. But do we really need yet another type of attachment in an increasingly lexicographically crowded literature? We already have many highly useful categories: secure attachment, secure-autonomous attachment, insecure attachment, detached attachment, enmeshed attachment, disorganized attachment, avoidant attachment, anxious-ambivalent attachment, dismissing attachment, preoccupied attachment, fearful attachment, fearful-avoidant attachment, dismissive-avoidant attachment, resistant attachment, unresolved attachment, disorientated attachment (**Levy & Blatt, 1999**; **Holmes, 2001**; **Rholes & Simpson, 2004**), not to mention passionate lethal attachment **(Sinason, 1990)**, violent attachment **(Meloy, 1992)**, and traumatic attachment **(de Zulueta, 2006)**.

I wish to propose that the infanticidal attachment be categorized as a variant of insecure attachment and, specifically, as a subtype of the disorganized and disorientated division of insecure attachment. We know, of course, that infants who have experienced insecure, disorganized attachment relationships in their earliest months and years of life will be more prone to psychiatric illness in adulthood, more likely to develop criminality, more susceptible to dissociation and dissociative identity disorder, more vulnerable to aggressive conflict in intimate relationships, and more impaired on a welter of cognitive and academic measures. Similarly, those with disorganized attachment histories will be more likely to have experienced loss and trauma, will have higher cortisol levels, will be less competent at conflict resolution, will reveal greater inhibitions in play, will demonstrate a preoccupation with thoughts of catastrophe during free play, will manifest controlling behaviours and helpless behaviours often in alternation, and will have a more immature ego structure (**Fonagy, 2001**; **Strathearn, 2007**; **Sinason, 2002**; **Steele, 2002**). Those who have worked with psychotic patients will recognize that all of the above-mentioned symptoms and characteristics will be found not only in people with classic disorganized attachment, but in those with a diagnosis of schizophrenia as well.

But the schizophrenic also suffers from additional symptomatology not found among ordinarily disorganized individuals. I suggest that the further presence of experiences of premature morbidization and psychological infanticide - early near-death experiences and early death threats - creates an infanticidal introject that might play a role in the aetiology of schizophrenia. The infanticidal attachment would therefore be characterized by all of the failures and inconsistencies of caretaking so prevalent in the classic disorganized attachment, but would

contain, as well, one or more specific experiences of deadliness that would have made the infant fear for his or her life on one or more occasions.

There can be few questions more pressing in contemporary mental health care than the conundrum of schizophrenogenesis. Somatic theories prove increasingly attractive to investigators, to families, and to patients alike, holding out hope of a magic bullet or antibiotic that will eradicate this dreadful form of human suffering. Psychological theories, by contrast, evoke anxiety, and threaten to activate conscious or unconscious guilt, especially among parents. The fear of blaming parents, so regnant among professionals, has created a veritable writers' block within the psychotherapy profession, preventing colleagues from publishing pertinent findings about the role of noxious experiences within the intrafamilial fold. If such a 'shared writers' block' remains unresolved, this may actually cause more suffering to patients and their families in the long run. In documenting cases of infanticidal attachments, I wish to avoid any notion of blame; by contrast, I have endeavoured to report my findings in the hope that subsequent investigators will share their personal experiences, their clinical experiences, and their research experiences, whether confirmatory or disconfirmatory in nature. Only in this way will we be able to test the hypothesis that infanticidal attachments contribute to the cause of schizophrenia, an hypothesis which, if supported, will have clear implications not only for the psychotherapeutic treatment of schizophrenia, but also for its prevention through greater support for expectant parents who struggle with often overwhelming ambivalences towards their babies.

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