

Post Partum Depression, Psychosis and Infanticide  
(in press, *Encyclopedia of Domestic Violence*)

Postpartum mood disorders are more common than we realize: Up to 80 percent of new mothers experience mild depression within a year of giving birth. If the “baby blues” persist, depression can escalate to dangerous levels, influencing some women to experience psychosis and—in rare and tragic cases—to kill their offspring.

As many as 50 to 80 percent of all women experience some degree of emotional “letdown” following childbirth—the so-called “baby blues.” Fortunately, its more extreme sister disorder, postpartum psychosis, is rare, affecting only about one or two in 1,000 new mothers.

The baby blues, though, are common for numerous reasons. The baby’s crying and the mother’s interrupted sleep and soreness from breast-feeding are enough to make any woman feel irritable, if not overwhelmed and tearful. These feelings typically begin three to four days after the baby is born but normally dissipate on their own within a few weeks.

### Postpartum Depression and Psychosis

Women are more likely to experience psychiatric illness after childbirth than at any other time in their life (Kendell et al, 1987).

If the blues last for more than two weeks, however, the new mother may be suffering from a condition of intermediate severity, postpartum depression (PPD), a mood disorder on par with other forms of clinical depression. Ten to 22% percent of women experience PPD before the infant’s first birthday (Stowe et al., 2001). PPD is characterized by feelings of despondency, inadequacy as a mother, impaired concentration and memory function as well as loss of interest or pleasure in activities that were formerly enjoyable. In addition, the mother experiences excessive anxiety about the infant’s well-being. Mothers with postpartum depression are reluctant to share their upset emotions because they do not want others to think of them as a bad mother.

Some women also become paralyzed with fear and concern for the baby’s safety. If such symptoms appear, it is important to seek professional consultation to help differentiate PPD from other conditions such as obsessive-compulsive disorder. Symptoms of anxiety are frequently an aspect of clinical depression, but true obsessive-compulsive symptoms signify a different disorder that needs proper diagnosis and treatment.

Though debilitating, the emotional reactions to being a new mom that signify depression are not as severe as those associated with postpartum psychosis, of which the predominant symptom is a “break” with reality—a loss of the ability to discern what is real from what is not. For instance, a woman with PPD may experience violent thoughts about her baby but recognizes that those thoughts are wrong and potentially dangerous. In that case, she will not act on them.

A woman with full-fledged psychosis, however, has temporarily lost the judgment needed to make this assessment. Very often, a woman with psychosis

experiences a frightening sense of merger with her infant — she can't differentiate between where she ends and where her baby begins. Psychotic merger is so terrifying that she may try to avoid losing her sense of self by either committing suicide or killing the baby or both. Infanticide refers to murder in which the killer is a parent of the victim.

In the month directly following child birth, women are 25 more times likely to become psychotic (Marks, 1996) than during other periods of their lives. Postpartum psychosis occurs in only one to two per 1000 births. However, the risk of infanticide associated with untreated puerperal psychosis has been estimated to be as high as 4% (Altshuler et al., 1998; Cohen and Altshuler, 1997; Carter et al., 2001.)

Women with puerperal depressive disorders experience a high relapse rate during subsequent pregnancies. Fifty percent or more of women who had a previous episode of postpartum depression experienced relapse following a subsequent pregnancy (Gold, 2001). For postpartum psychosis, the relapse rate is close to 80% (Stowe et al, 2001; Altshuler et al., 1998; Cohen and Altshuler, 1997; Nonacs and Cohen, 1998).

#### Filicide and Neonaticide:

There are two distinct types of infanticide. Filicide is the killing of a son or daughter older than 24 hours. Neonaticide, is the killing of a newborn before this age. Neonaticide is a separate entity, differing from filicide in the diagnoses, motives, and disposition of the murderer.

About 3% of all American homicides are filicides (Green, 1979). The reported rate of murder for children less than one year of age has remained relatively stable over the past 20 years ( Lewis and Resnick, 1999). The rate of killing children under one year is 4.3 per 100,000 live births.

Estimates of the annual occurrence of neonaticide in the United States range from 150 and 300 (Smith, T., 1998). The Uniform Crime Reports between 1976 and 1985 show that on average about 384 filicides of children up to age 18 are reported each year (Kunz and Bahr, 1996). Sixty-two percent of all homicides that occurred in children 0-5 years in the United States from 1976 through 1998 were committed by parents (U.S. Dept. of Justice, 2000). The risk of filicide is greater among younger than older children (Kunz and Bahr, 1996).

Nevertheless, infanticide is a very rare phenomenon; only about 4 percent of women who become psychotic kill their babies. Perhaps even fewer tragedies would occur, however, if proper education and treatment were more readily available.

According to one study, sixty-seven percent of women who kill their children are mentally ill, as opposed to only 6 % of those who kill their spouses (Silverman and Kennedy, 1988).

The risk of filicide is greater among younger than older children (Kunz and Bahr, 1996) and is greatest within the first year. Among infants in the first week of life, mothers are almost always the ones who commit the filicide (Kunz and Bahr, 1996).

The ages of the filicide victims ranged from a few days to as old as 20 years (Resnick, 1969). The most dangerous period for the victims is the first six months of life. This is the time of maternal post-partum psychoses and depressions. The younger the child, the more likely is the suicidal mother to think of the child as a personal possession and feel inseparable from the baby.

Comparing mothers who commit neonaticide with those who commit filicide, only a few of the women who commit neonaticide were psychotic but psychosis was evident in two-thirds of the maternal filicide group. In one study, serious depression was found in only 3% of the maternal neonaticide cases compared to 71% of the maternal filicide group. In contrast, suicide attempts accompanied more than one-third of the filicides, but none occurred among the neonaticide cases.

Although infanticide is now considered a crime by national governments all over the world, nevertheless, infanticide has been practiced on every continent and by people on every level of cultural complexity, from hunters and gatherers, to highly evolved civilizations. Rather than being an exception, sadly it has been the rule (Williamson, 1978).

Regarding motivation, reasons have included population control, illegitimacy, inability of the mother to care for the child, greed for power or money, superstition, congenital defects, and ritual sacrifice (Radbill, 1968). Researchers who study infanticide distinguish several different groups of parents who murder their offspring. Some kill as a result of psychotic delusions—the dread of parent-child merger or the belief that the child is trying to harm or kill them. Others murder their children out of profound depression and hopelessness. Often they carry strong religious ideas that killing their child will enable them both to enter an afterlife more peaceful than their current life.

The great bulk of neonaticides are committed simply because the child is not wanted due to the stigma of pregnancy out of wedlock. In keeping with this observatoin, the most common reason for neonaticide among married women is extramarital paternity. Neonaticide is especially common among teenagers who are overwhelmed by dealing with their pregnancy.

In most neonaticides, the perpetrators are young women who live with their families, but are psychologically isolated (Meyer and Oberman, 2001). Teenagers who commit neonaticide often lack relationships with open, caring, reliable adults who will recognize their pregnancy and initiate a conversation and resolution of the pregnancy (Oberman, 1996). Many girls feel ashamed of having engaged in sexual relations and are fearful that their pregnancies will disappoint and even humiliate their families.

Passivity is the single personality factor which most clearly separates women who commit neonaticide from those who obtain abortions. In contrast to women who seek abortions who recognize reality early and promptly and actively seek to address the danger of an unwanted pregnancy, women who commit neonaticide often deny that they are pregnant or assume that the child will be stillborn.

Neonaticide is not usually a premeditated act; frequently it is committed in the face of intense emotion such as shock, shame, guilt, and fear (Pitt and Bale,

1995). Generally no advance plans are made for the care or the killing of the infant.

The methods of neonaticide listed in order of greatest frequency are suffocation, strangulation, head trauma, drowning, exposure, and stabbings (Resnick, 1970). Suffocation is probably most frequent because of the need to stifle the baby's first cry in order to avoid detection. The crime is usually concealed. Following the murder the body is usually disposed of and the mother denies that it has occurred.

In contrast to neonaticide, the motives for filicide in order of descending order of frequency according to Resnick are "altruistic" associated with suicide (38%), or to relieve suffering (11%), acutely psychotic (21%), unwanted child (14%), fatal maltreatment (12%) and spousal revenge (4%).

The "altruistic" filicidal mothers see their children as extensions of themselves and do not want to leave them motherless in an uncaring world as seen through the eyes of their own depression. Varying degrees of pathological identification may exist between mother and child, ranging from the mother projecting her own suffering upon the child to psychotic merger.

The "altruistic" filicide raises particular medical legal issues. In most jurisdictions, the criteria for claiming "insanity" as a legal defense against the crime of murder are predicated upon the McNaughtan Rule: the defendant must prove that they did not appreciate the nature and quality, wrongfulness and criminality of their murderous act. Severe depression, even without psychotic features may distort thinking so that a mother believes her children will be better off in heaven with her. In these cases, it is usually clear that the mother knows the nature and quality of her act and that killing is legally wrong. However, the filicidal mother often believes that she is also doing what is morally right for her child by killing it. Finally, jury instructions in different jurisdictions vary on the meaning of "wrongfulness."

Acutely psychotic filicidal parents include who killed under the influence of hallucinations, epilepsy, or delirium. However, this category does not include all psychotic child murderers and is the weakest because it includes cases in which no comprehensible motive could be ascertained. One striking example quoted by Resnick from the historic psychiatric literature was that of an "epileptic mother (who) placed her baby on the fire and the kettle in the cradle (Hopwood, 1927)." Presumably she was suffering from a form of epilepsy now called psychomotor epilepsy or "Jacksonian" seizures. A new mother in a similar neuropsychiatric state observed by this author held her newborn at fully extended arms length and walked aimlessly around a room with one breast completely bared, oblivious to whether she was holding or dropping her infant.

Unwanted child filicide requires no further explanation.

Fatal maltreatment filicides are invariably the tragic outcome of child abuse such as "battered child syndrome." In these situations there was usually no clear homicidal intent and death is the unintended consequence of maltreatment that was intended to stop the child's "bad" behavior. Indeed, child abuse is the most common cause of filicide in the U.S. A variation on this pattern

includes child maltreatment with the participation of or coercion by a male partner.

"Spousal revenge" filicide is a final category that encompasses parents who murder their offspring in a deliberate attempt to make their spouse suffer. Infidelity, either proved or suspected, is a common precipitant for spousal revenge filicide (Wilczynski, 1997).

Paternal filicide is a related phenomena but one that is beyond the scope of this article. Suffice it to say that men are far more likely than women to commit familicide, killing the child's mother as well as the child, followed by their own suicide.

In one study from a psychiatric hospital, of ten paternal filicides, more than half attempted suicide after the offense (Marleau, 1999).

There are also characteristic reactions to the deed of filicide. According to Resnick, after the "altruistic" and "acutely psychotic" killings, there is often an immediate relief of tension. He notes that "this explains the failure of some parents to complete their suicide. Furthermore, after the murder, these parents usually run to seek help and make no effort to conceal their crime."

By contrast, the parent who commits "unwanted" and "fatal maltreatment" filicide often goes to great lengths to dispose of or conceal incriminating evidence and to deny the crime.

Regarding neonaticide, most of these murders fit into the unwanted child category. Furthermore, major mental illness in the mother is usually infrequent. These women tend to conceal the pregnancy, deliver the baby alone and dispose of the baby secretly.

In summary, there is a spectrum of puerperal mental illnesses, ranging from "baby blues" which is probably a normative response to rapid hormonal shifts immediately following delivery to postpartum depression and psychosis, including the rare and tragic outcome of infanticide by the mother. An effort has been made in this article to further delineate filicide from neonaticide, comparing and contrasting the two phenomena. It goes without saying that the best preventive measures to reduce the frequency of these tragic occurrences would be to increase the availability of educational and mental health services during pregnancy and the puerperal period.

Mark I. Levy, MD

*I wish to offer a particular expression of gratitude and acknowledgement to Phillip Resnick, MD, Professor of Psychiatry and Law and Director of the Forensic Psychiatry Fellowship at Case Western Reserve University School of Medicine, for his inspiring research and educational accomplishments, particularly in this area of forensic psychopathology. Dr. Resnick is a gifted and truly extraordinary educator.*