Maternal Filicide

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Description of the Problem

Maternal filicide, the murder of a child by his or her mother, is a multidimensional phenomenon with various characteristics, motivations, and patterns. It transcends geographic boundaries, occurring in every country and culture (Friedman, Horwitz, & Resnick, 2005). And, although maternal filicide has been discussed in the medical, mental health, and child abuse fields, little research exists with a criminal justice or law enforcement perspective.

Cases in which mothers kill their children highlight the disturbing reality of the violence that women are capable of committing. In spite of this truth, society still tends to view violence as committed exclusively by males (Pearson, 1997). In fact, historically male aggression has often been encouraged, accepted, and/or condoned. On the contrary, female violence is seen as unfeminine and women often commit violence in private (e.g., at home) against themselves or their children (Robbins, Monahan, & Silver, 2003; Stangle, 2008). As Pearson (1997) noted, "Women commit the majority of child homicides, a greater share of physical child abuse, an equal rate of sibling violence and assault on the elderly, about a quarter of child sexual abuse, an overwhelming share of the killings of newborns and a fair preponderance of spousal assault" (Pearson, 1997, p. 7).

Only in the last few decades have we begun to understand that female violence has existed throughout history, and that women have harmed their children for many reasons, some of which reveal clear and lucid intent (Motz, 2008; Stangle, 2008). Historically, female aggression, especially toward one's child, has been typically perceived to be abnormal, and the result of a mental disorder (Pearson, 1997; Stangle, 2008). Silverman and Kennedy (1988) suggest that gender stereotypes, such as the tautology that "if they killed their kids they must be crazy," contribute to misconceptions about mothers. Historically, society has often viewed mothers who harm their children as either "mad" or "bad" which limits our comprehensive understanding of maternal filicide. The mad mother is described as afflicted by hormones; the bad mother is afflicted by evil or characterized as selfish, cold, and neglectful of her children or domestic responsibilities, and promiscuous (Wilczynski, 1991). Some argue that psychological perspectives of maternal filicide are often one-dimensional and explain the occurrence as primarily a result of mental illness

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(Smithey, 2001). There are studies which conclude that psychosocial stress, rather than mental illness, is the primary cause of filicide (Bartholomew & Milte, 1978; Resnick, 1969, 1970; West, 1966). The presence of significant life stressors, such as financial strain and/or discord/violence within a marriage or relationship, as well as a history of childhood abuse and parental separation, have been noted as common factors in women who kill their children, especially in fatal-abuse filicide cases (Cheung, 1986; d'Orban, 1979; Haapasalo & Petaja, 1999; Marks & Kumar, 1996; Scott, 1973).

Historical Background

Maternal filicide cases run counter to deeply ingrained views of motherhood and femininity; however, child homicide by mothers has not always been considered a crime worthy of a murder charge (Dobson & Sales, 2000). Illegitimacy, preference for male offspring, physical disabilities, population control, eugenics, religious beliefs, and poverty has been used to explain its occurrence throughout history[1] (Meyer, Oberman, White, & Rone, 2001). Prosecution of maternal filicide also has a rich history of ambivalence and inconsistent approaches. Furthermore, although viewpoints have changed over time and the punishment of mothers became more common, conviction rates remained low in cases wherein the victim was very young.

This precedent for leniency was set many years ago as nations began passing legislation on behalf of maternal offenders with the assumption that childbirth was a time of unique biological change which may lead to mental disturbance (Dobson & Sales, 2000). This sentiment was formalized by the English Parliament in the 1922 Infanticide Act which provided a partial explanation by assuming that infanticide offenders suffered from puerperal (post-partum) psychosis[2], the most severe form of mental disorder associated with childbirth (Oberman, 1996). In 1938, a modified Infanticide Act replaced the 1922 version and expanded the age of the victim from a newborn child to a child <12 months old. Lactation was added as a medical basis for a mental disturbance, most likely due to the exhaustion that may accompany nursing. Eventually, lactational insanity was discredited, though public sympathy toward maternal offenders continued.

England's Infanticide Act and similar legislation established in many other countries[3] gave formal legal recognition to a biological explanation for infanticide (Friedman & Resnick, 2007; Spinelli, 2003). Today, punishment under infanticide laws has been significantly reduced or eliminated. For example, in Canada, no mother convicted of infanticide has served more than 5 years in prison (Walker, 2006), and the overwhelming majority of infanticidal mothers in England have received probation and counseling rather than prison sentences (Spinelli, 2003).

Although other countries have identified special provisions for these offenders, the USA makes no such distinction (Dobson & Sales, 2000; Kumar & Marks, 1992; Resnick, 1970). Mothers who kill their children, regardless of the victim's age, are prosecuted under existing homicide laws (Dobson & Sales, 2000; Kumar & Marks, 1992; Resnick, 1970), and offenders have been charged with a variety of crimes including murder in the first, second, or third degree, manslaughter, gross abuse of a corpse, and concealment of death (Schwartz & Isser, 2000). American medical and legal experts do not agree on the nature of postpartum mental disorders and their capacity to cause a mother to kill her child(ren)

[1] Filicide dates back to ancient civilizations such as Mesopotamia, Greece, and Rome, and among the Vikings, Irish Celts, Gauls, and Phoenicians (Meyer et al., 2001).

[2] Puerperal (post-partum) psychosis is an abrupt onset of severe psychiatric disturbance that occurs shortly following birth. It is estimated to occur in 1–4 women per 1000 deliveries. Symptoms include hallucinations, delusions, loss of reality, illogical thoughts and behavior, and possible suicidal or homicidal tendencies (Chaudron & Pies, 2003; Schwartz & Isser, 2006).

[3] These countries included Australia, Austria, Brazil, Canada, Colombia, Finland, Germany, Greece, Hong Kong, India, Italy, Japan, Korea, New Zealand, Norway, Philippines, Sweden, Switzerland, Turkey, and the UK (Friedman & Resnick, 2007).

(Spinelli, 2003). Postpartum disorders do exist, but severe cases like postpartum psychosis are rare (Schwartz & Isser, 2006). Even so, the presence these disorders in any given filicide case does not necessarily indicate the woman is unable to control her behavior and/or did not appreciate the difference between right and wrong (Schwartz & Isser, 2006). However, past studies of filicide cases in this country indicate that even in the absence of US infanticide legislation, society continues to be ambivalent toward mothers who kill their children, especially when the children are young (Marks & Kumar, 1993; Oberman, 1996; Shelton, Muirhead, & Canning, 2010; Stangle, 2008). Several studies have highlighted the variability in conviction and sentencing, as well as the US's history of leniency (Oberman, 1996; Shelton et al., 2010; Spinelli, 2001).

Furthermore, analyses of insanity defenses in the US reflect that a maternal filicide offender's chances of successfully raising this defense in her case is far greater than those of any other criminal defendant (Bourget & Bradford, 1990; d'Orban, 1979; McKee & Shea, 1998). d'Orban (1979) reported that 27% of the maternal filicide defendants in their study were found Not Guilty by Reason of Insanity (NGRI). Bourget and Bradford (1990) reported that 15.4% of maternal filicide cases in their sample resulted in legally insane verdicts. These results indicate that insanity verdicts are much more frequent in maternal filicide cases than in general criminal cases, wherein defendants are found insane only 1% of the time (McKee, 2006).

Even in cases where a mental disorder is not noted, it appears courts take into account the stresses of a mother during her postpartum period and often take pity on her or use rationalization and denial to explain her homicidal actions (Kaye, Borenstein, & Donnelly, 1990; Perlin, 2003a, 2003b). Such actions indicate that there is a belief that mothers should be treated with leniency "simply because they are mothers" (Stangle, 2008). Also, jurors arrive in the courtroom fully loaded with stereotypes and myths about cases involving a mother killing her child stir up notions of femininity, childbirth, and depression (Finkel, 1995a, 1995b, 1996, 1997; Finkel & Groscup, 1997; Finkel & Sales, 1997; Perlin, 1990; Silver, 1995).

Shelton et al. (2010) analyzed 45 cases of neonaticide and found only one offender who was diagnosed with psychosis; yet, sentencing of the offenders remained relatively lenient. The authors presented several socially constructed factors to explain society's inconsistent legal response to non-psychotic neonaticide offenders, including the mother's reduced culpability, her "redeemable" qualities, and the age of the victim (Shelton et al., 2010).

Epidemiology

Young children are overrepresented in child homicide statistics, with over three fourths involving children under the age of four (US Department of Health and Human Services, 2009). According to the National Center for Injury Prevention and Control, homicide was the fifth leading cause of death for children under five years of age, and child maltreatment is the cause for almost half of the homicides in young children (Klevens & Leeb, 2010). Children in this age group consistently account for more than 80% of fatal cases of child maltreatment (Klevens & Leeb, 2010; US Department of Health and Human Services, 2009). Children under the age of one year are at an even greater risk for homicide; this is especially true during the first four months of life (Overpeck, Brenner, Trumble, & Trifilliti, 1998). In fact, the first day of life reflects the greatest risk for homicide, with rates at least 10 times greater than at any other time of life (Overpeck et al., 1998). In general, younger children appear to be at greater risk for fatal maltreatment as compared to older children, who more often die from purposeful homicide (West, 2007).

Not surprisingly, child abuse has the most direct impact on the occurrence of filicide, and the frequency with which children die from maltreatment is troubling. A 2009 US Department of Health and Human Services (US DHHS) report stated that over 10,000 children died from maltreatment over a 6-year period from 2001 to 2007, and the number of fatalities has consistently

increased each year, with the exception of 2005. These statistics translate to nearly five children dying every day as a result of maltreatment with one or both parents most often (69.9%) responsible, and mothers acting alone in more than one quarter (27.1%) of the cases (US DHHS, 2009).

Many believe these numbers are grossly underestimated because child abuse fatalities are underreported (US DHHS, 2009). Some studies have estimated that up to 60% of maltreatment-related child fatalities are not currently captured (Crume, DiGuiseppi, Byers, Sirotnak, & Garrett, 2002; Herman-Giddens, Brown, Verbiest, Carolson, Hooten, Howell, & Butts, 1999). Reasons for underreporting vary, but often include the lack of standardized national reporting systems, poor cooperation between investigating agencies, and the challenges of differentiating between inflicted trauma from accidental injury and deaths due to natural causes (US DHHS, 2009).

Additionally, previous filicide studies have highlighted high rates of victim abuse prior to the homicide (Crittenden & Craig, 1990; D'Silva & Oates, 1993; Wilczynski, 1997). For example, Wilczynski's (1997) analysis of nearly 50 cases of both paternal and maternal filicide revealed that half of the victims had been previously abused by the offending parent. Wilczynski also noted that filicide offenders with prior professional contact (e.g., Child Protective Services) were significantly more likely to have been violent toward the child before the filicide, indicating that previous intervention does not necessarily lessen the likelihood of reoccurring violence toward the child (Wilczynski, 1997).

Characteristics of the Offender

Neonaticide

Neonaticide refers to the killing of a newborn within the first 24 h of life by a biological parent. In almost all neonaticide cases, the mother is the perpetrator; fathers are rarely known to commit neonaticide as they do not typically possess the same access to newborns as mothers or the unique stressors associated with this crime (Beyer, Mack, & Shelton, 2008; Koenen & Thompson, 2008; Resnick, 1970). Prior research reveals that neonaticide offenders are typically women who are young, unmarried, of low socioeconomic status, and living with their parents or a relative at the time of the offense (Beyer et al., 2008; Meyer et al., 2001; Resnick, 1969; Shelton et al., 2010). However, more recent literature reveals that neonaticide offenders are of every race, age, and educational level, and marital and socioeconomic status (Oberman, 1996; Riley, 2005; Shelton, Corey, Donaldson, & Hemberger-Dennison, 2011). Women in their 30s and 40s commit neonaticide as do women who are married (Beyer et al., 2008). It appears women from a variety of ages and life circumstances are capable of committing neonaticide in response to a conflicted pregnancy (Riley, 2005).

Women who commit neonaticide share some common psychological features, but most do not suffer from significant mental illness (Cheung, 1986; Dobson & Sales, 2000; d'Orban, 1979; Haapasalo & Petaja, 1999; Meyer et al., 2001; Putkonen, Collander, Weizmann-Henelius, & Eronen, 2007; Resnick, 1970; Shelton, Hoffer, & Muirhead, 2014; Spinelli, 2001). Major psychiatric disorders are rare and it is more common for personality disorders to be reported in neonaticide offenders. Dobson and Sales (2000) indicated that even postpartum blues, which can cause mental disturbance in new mothers, does not play a role in neonaticide, given that it generally begins approximately three days after delivery. Their lack of mental health history is also observed in the relatively low frequency of offender suicidal behavior. Researchers theorize that neonaticidal offenders experience an enormous sense of relief shortly after the offense and have the desire to continue living rather than take their own life (Shelton et al., 2014).

Many neonaticide offenders are cognitively aware that they were pregnant, but often demonstrate magical thinking associated with the pregnancy by having an unrealistic expectation that the pregnancy will "just go away" or they will "think about it tomorrow" (Shelton et al., 2011, 2014). Neonaticide offenders have been described as passive individuals, and their passivity explains

their inability to initiate a plan or seek alternative options for the pregnancy and impending birth (Dobson & Sales, 2000; Meyer et al., 2001; Resnick, 1970). Although offenders typically engage in denial and concealment of their pregnancy, in some cases, others are aware, but it is described as a "pseudo-awareness," whereby others become drawn into the offender's denial surrounding the pregnancy and its outcome. Others close to the offender may have noticed some changes in her physical appearance and suspected that she was pregnant, but when they explored this possibility with the offender, she denied the pregnancy.

Motivation among the neonaticide offenders most often pertains to the fear and shame of having engaged in premarital sex. A recent break up with the victim's biological father, a hindrance to college or career goals, and unknown paternity due to multiple sexual partners is also reported by offenders to be motivating factors. Many offenders are also concerned that their parents, specifically their mother, will be upset with them due to the stigma of illegitimacy. However, fear and anxiety is not exclusive to young, unmarried offenders. Older, married offenders also express concern over the discovery of the pregnancy by others. This concern is less related to illegitimacy and premarital sex, but more often due to the "irresponsibility" the pregnancy represents. For example, in cases where the offender is older and married at the time of the neonaticide, family members and friends may have made statements indicating that the offender already had several children for whom she could not provide proper care (Shelton et al., 2011).

Offenders often describe an altered perception at the time of the birth characterized as lapses in memory, blacking-out, anxiety, fear, pain, feelings of being out of control, detachment, and depersonalization (Shelton et al., 2011; Spinelli, 2001). They commonly give birth alone and in a nonmedical setting, typically in their residence (Shelton et al., 2014). Victims in neonaticide cases are killed in a variety of ways; however, it is more likely that the deaths are a result of inaction by the mother rather than violent outbursts that are more often seen in the killing of older children (Shelton et al., 2011). Asphyxial-related causes are the most common (suffocation, drowning, and strangulation) and are often accomplished by placing the infant in a plastic bag, wrapping the infant in a cloth, delivery into a toilet, or by placing a foreign body into the airway of the infant (Corey & Collins, 2002; Crittenden & Craig, 1990; DiMaio & DiMaio, 2001; Resnick, 1969; Shelton et al., 2011). After birth, mothers typically attend to themselves and do not assess their baby's condition for some time.

During labor and delivery, many offenders are concerned about detection as there are often other individuals within close proximity at the time of the birth and homicide. Many have the opportunity to seek help from others at the time of the offense yet refrain despite the physical pain and fear they were experiencing. Neonaticide offenders can murder the newborn, dispose of the body, clean up the crime scene, and remain undetected by others close by. Many exhibit a physical and emotional resiliency prior to, during, and after delivery as they participate in routine activities around the time of delivery and after the homicide. During delivery, this resiliency is exhibited as they frequently give birth silently and without assistance (Mendlowicz, Rapaport, Mecler, Golshan, & Moraes, 1998; Schwartz & Isser, 2000). Post-offense, some offenders return immediately to their routine activities including attending school, shopping, dancing, or returning to work. A period of recovery typically does not occur and absences from work or school shortly before and after the birth are rarely seen. This resiliency is likely influenced by: (1) the enormous relief they feel after the birth, (2) their desire to live in an unburdened and uninterrupted manner and/or (3) concern that unexplained absences would be viewed suspiciously and increase the possibility that their secret will be revealed (Beyer et al., 2008; Shelton et al., 2011).

Infanticide

The first months of a child's life appear to be a very vulnerable time with studies reporting that many victims die before reaching 4 months of

age (Overpeck et al., 1998; Shelton et al., 2014). The homicide most often involves personal weapons (e.g., hands or feet) rather than the use of a traditional weapon (e.g., gun and knife) (Jason, Gilliland, & Tyler, 1983; Overpeck et al., 1998). Asphyxiation is frequently reported as the most common cause of death. Victims of infanticide also die from abusive head and abdominal injuries and typically have suffered prior abuse and/or neglect by their mother (Brewster et al., 1998; Friedman & Friedman, 2010; Klevens & Leeb, 2010). This finding is important to note given that in previous studies males have been consistently identified as the perpetrators of abusive head trauma. However, more recent analysis has found that biological mothers are also well represented in fatal abusive head trauma cases (Esernio-Jenssen, Tai & Kodsi, 2011; Shelton et al., 2014).

Common offender characteristics reported among mothers who kill their child within the first year of life include young, undereducated mothers, with more than one child, who are of low socioeconomic status, and who do not obtain timely prenatal care (Beekman, Saunders, Rycus, & Quigly, 2010; Shelton et al., 2014). Young maternal age combined with being unmarried and of low socioeconomic status can leave many mothers unprepared for the emotional and financial demands of raising and caring for an infant and other children. Additionally, many mothers have not yet established good support systems (e.g., marriage and secure intimate partner relationships) (Shelton et al., 2014). Some live with their boyfriend/biological father of the victim; however, these relationships are often characterized as being unstable, dysfunctional, and sometimes violent. As a result, these mothers commonly abuse substances to cope and their substance abuse often precedes a violent interaction with their child (Smithey, 1998, 2001). It has been suggested that the use of substances contributes to infant homicides in two ways: (1) newborns and infants who have been exposed to drugs are typically described as difficult to care for, hard to please, fussy, and lacking good feeding and sleeping patterns; (2) substance use by the mother can lead to impulsivity and aggression, hampering her ability to control her own behavior as well as an inability to provide routine and structure for child (Cherek & Steinberg, 1987). Their lack of reliable and healthy emotional support combined with other stressors (e.g., poverty, lack of education, joblessness, and additional children) can increase the likelihood of maltreatment because emotional resources should be stable and satisfying if the parent-child relationship is to function within developmentally appropriate constraints (Pianta, Egeland, & Erickson, 1989). In addition, research examining the father's role in child development found, "that the mother's ability to enjoy her infant, and regard [the infant] with affection may be in part a function of the quality of her relationship with her husband" (Price, 1977, p. 7).

Psychological perspectives are often discussed in the infanticide literature, specifically postpartum psychosis. However, other researchers have proposed that although physical hormonal causes are common among offenders in many infanticide cases, traumatic life events and psychosocial stressors are more significant contributing factors (Bartholomew & Milte, 1978; Resnick, 1969; West, 1966). For example, one recent study of law enforcement infanticide cases found that nearly 80% of the offenders did not have a formal mental health diagnosis at the time of offense. In addition, only four offenders were specifically diagnosed with postpartum depression (Shelton et al., 2014). The constant attention and complete dependency that infants require can quickly overwhelm many mothers (Finkelhor & Ormrod, 2001), even when psychopathology is absent. Their frustration and their inadequate coping skills and knowledge of how to handle the demands of infant behavior, reflect that some mothers simply do not adjust well to their postpartum duties and very quickly become overwhelmed with the needs of a young baby. However, frustration is commonly described by many (if not all) new mothers and previous studies have noted that some mothers in the general population experience homicidal ideation or aggressive thoughts toward their children (Jennings, Ross, Popper, & Elmore, 1999; Levitzky & Cooper, 2000). A general study of

mothers found that 70% of mothers of colicky infants had explicit aggressive thoughts toward their infants, and 26% of these mothers had infanticidal thoughts during the infant's episodes of colic (Levitzky & Cooper, 2000). An additional study, which compared 100 depressed mothers with a child under 3 years of age to 46 non-depressed mothers, highlighted that 41% of the depressed mothers had experienced thoughts of harming their children (Jennings et al., 1999).

With impaired judgment, low impulse control, sleep deprivation, and desperation to get their baby quiet, some mothers have thoughts of silencing their baby even through violent measures (Friedman & Friedman, 2010). In interviews of maternal infanticide offenders, common pre-offense scenarios are described that often involved a mother who cannot console her crying child, a child with frequent or prolonged illness, or difficulty in training (feeding/sleeping schedule) (Smithey, 2001). Instead of viewing these events as common experiences of a child's first year, she finds them personally offensive and they challenge her self-perception and capabilities as a mother. Because she is unable to alleviate her child's discomfort, her feelings of inadequacy as a parent are further embedded, resulting in either the mother withdrawing or becoming more forceful. However, these tactics do not reduce the infant's undesirable behavior, but rather increase it (Smithey, 2001). Desperate to quiet them, mothers inflict injuries on their child intentionally in order to stop the child's fussiness or because they were angry with the child for not behaving in the manner they expected.

Other studies have explored the relationship between infanticide and the unrealistic demands of modern motherhood (Smithey, 2001). Some have proposed that societal expectations of motherhood have increased over the past several decades leaving some mothers with an inability to escape feelings of failure, remaining in an intense, stressful, and often escalating situation (Hays, 1998; Smithey, 2001). Others believe that the mother's lack of understanding of her child's development needs is more to blame than any societal expectation that is placed on mothers (Center of Disease Control, 2011). As an infanticide mother stated, "I now realize there was a lot more to it (raising a child) than I thought. I wanted to do a good job but I couldn't get him (the infant) to do the right things. [What do you mean by right things?] You know sleep all night eat at certain times of the day, that kind of thing" (Smithey, 2001, p. 76).

Filicide

Mothers who commit filicide (victims 1 year of age or older) are more of a diverse population; thus, generalization is limited. The most common reason for this is the various types of samples (e.g., psychiatric versus correctional mothers) (West, 2007) and the variety of ages among victims (e.g., developmental stages heavily influence case dynamics). For instance, a mother's motivation and the cause of death are often quite different for an 18-month-old child versus a 10-year-old victim. Toddlers and preschoolers are completely dependent on their caregivers (usually their parents) to meet all their physical and emotional needs; therefore, homicides early in childhood are more often the result of maladaptive attempts by parents to manage child behavior (Crittenden & Craig, 1990). Filicides of school-age children often present differently, due to meeting significant milestones like talking, toilet training, and their shift toward reliance on their expanding world (e.g., teachers, neighbors, and friends).

Despite these differences, some general conclusions have been consistently reported among filicide cases. Offenders are often in their late 20s, unemployed, have financial problems, are in abusive intimate partner relationships, have conflict with family members, and experience social isolation (d'Orban, 1979; Harder, 1967; Jason et al., 1983; Resnick, 1969). In addition, mothers who commit filicide often report high levels of stress and a lack of social support and resources at the time of the offense (d'Orban, 1979; Goetting, 1988; Resnick, 1969; Wilczynski, 1997). Neglectful and abusive mothers often had problems with substance abuse.

Filicide offenders who kill their school-aged children are more often in their 30s, primarily from middle or upper middle socioeconomic classes, and typically lack a criminal history. Although unemployment is frequent at the time of offense, many offenders are educated beyond high school. For example, in a recent study nearly three quarters of the mothers in the sample with a college degree killed a child over the age of six years (Shelton et al., 2014). Many are married or have been married, although some are separated from their husbands. The combination of divorced and separated mothers indicates that many are living apart from the support system that a marriage provides. Common stressors (often in combination) for mothers who kill older children are financial concerns, marital/relationship problems, and a recent change in family dynamics (e.g., recent move, separation, divorce, and custody changes) (Shelton et al., 2014). In some cases, these recent changes in the household are due in part to her long-standing mental health issues and the self-isolation that typically accompanies severe mental illness. Facing a major life change requiring them to evolve and adapt, many mothers feel even more out of control and uncertain of the future. Altruistic motivations are most common and many involve the killing of multiple biological children during the same event (Shelton et al., 2014).

Compared to offenders with younger victims, many do not have an abuse history with the victim prior to the filicide and their parenting style can be described by others as overly attached or enmeshed with the victim. Collateral interviews after the filicide can reveal that the offenders appeared to be very devoted and involved mothers who sacrificed career and time to meet their child's needs (Shelton et al., 2014). However, close friends may depict a mother who was concerned that she was not doing enough or had still failed her child(ren) in some way. In some case, offenders had confided in another person (e.g., friend, relative, or professional) that they had/were having thoughts of harming their children prior to the filicide(s), indicating the possibility of prior intervention/prevention (Shelton et al., 2014).

Numerous studies also report high rates of previous mental health treatment, depression, suicidality, and psychosis (Bourget & Bradford, 1990; Friedman, Hrouda, Holden, Noffsinger, & Resnick, 2005). Bourget and Bradford (1990) noted that 31% of parents who committed filicide had a diagnosis of major depression compared to offenders of non-parental child homicide. Mental health issues, particularly mood disorders, can negatively affect parental functioning and capacity with reactions to one's child ranging from withdrawal to intense concern. Depression likely contributes to their disruptive and sometimes hostile relationships with their child(ren) as well as compromising the victim's basic care, emotional stability, and safety. Early emotional deprivation from their own mothers, as well as other forms of abuse may also increase their likelihood of developing depression. Additionally, with decreased energy levels, some mothers simply do not have the motivation to conduct basic parental tasks and various forms of neglect are observed (e.g., physical, educational, medical). In cases where the child is not wanted or is no longer wanted, some mothers transfer their depressive symptoms onto the child and blame the victim for their own difficulties. Unable to control their emotions, physical abuse in the name of discipline can occur. In some cases, the depression is so severe that offenders experience psychotic symptoms characterized by auditory or visual hallucinations and delusions. Common themes are that voices say she is a bad mother and/or the child(ren) should be killed in order to spare them of a perceived suffering (e.g., sinful world, bad mothering, sexual abuse, abnormality) (Shelton et al., 2014).

Bourget and Bradford (1990) noted a high frequency of Borderline Personality Disorder among the filicide accidental-battered child group. Additionally, research has also shown the importance of the offender's own childhood as a factor due to the number of women who had mothers who were unavailable to them due to abandonment, alcoholism, absence, abuse, or mental health problems (Crimmins, Langley, Brownstein, & Spunt, 1997; Friedman, Horwitz & Resnick, 2005). High levels of stress and lack of social support/resources are also common findings in other maternal filicide samples

(d'Orban, 1979; Goetting, 1988; Resnick, 1969; Wilczynski, 1997). In many cases, stressful life events seemed to be present in nearly every aspect of their lives and are not isolated to a specific situation or time frame. In fact, even before having children offenders often are anxious, unpredictable, and sometimes aggressive. Their homes can be described as extremely disorganized, with crises and chaos being nearly a weekly event. With little structure or predictability to their daily lives, the offender's parenting experience can be extremely negative. However, many lack the insight or discipline to put into place consistent schedules (sleeping, feeding, playing) in order to curb their child's behavioral issues (Shelton et al., 2014).

Victims in filicide cases are often young, with an average age of 3 years reported in various studies (d'Orban, 1979; Friedman, Horwitz & Resnick, 2005; McKee & Shea, 1998; Resnick, 1970; Rodenburg, 1971; Rouge-Malillart, Jousset, Gaudin, Bouju, & Penneau, 2005). The most common methods of murder are head trauma, drowning, suffocation, and strangulation (West, 2007). The cause of death (COD) in cases involving younger children is often related to abuse or neglect, even though the victims have lived past the vulnerable first year. Nevertheless, this does not mean that they had not escaped abuse during their first year as many have been previously physically abused by their mother prior to death (Shelton et al., 2014). This irony may be due, in part, to several factors. First, mothers who have unresolved interpersonal issues of trust, dependency, and autonomy are often considerably stressed with the demands of an inherently dependent child. Even so, for some women, the development needs of children during the first year, while demanding and intense, may help to gratify some internal need for attention and acceptance especially in those mothers who lack a cohesive sense of self. It is not uncommon for these mothers to be both overly protective and abusive especially during certain child behaviors, like crying, which can intensify feelings of frustration and anger (Shelton et al., 2014). This can result in insecure attachment between mother and child because the infant's needs are so interconnected with the mother's and her tendency toward narcissism and self-preservation prevents her from seeing her child's perspective. As a result, as the child ages and becomes more of an individual with changing demands, the mother's parenting experience becomes more negative, resulting in outbursts of frustration, aggression, and even violence. For some mothers this will occur within a few days or weeks of birth, while others experience this after their child's first year and/or during the toddler phase. The frequent histories of maltreatment, child protective services, and/or loss of custody also indicate that insufficient bonding between mother and child is common. Some reject their children to varying degrees or separate quickly and easily from their responsibilities as a caretaker (Shelton et al., 2014). Additionally, financial, emotional, and childcare support from family members is usually concentrated during the transition of the first year of a child's life and may serve as a protective barrier against fatal abuse during this time. However, as the child grows older, the amount of support provided usually wanes and mothers are expected to have established parenting routines without major support from others (Shelton et al., 2014).

When older children are killed they are more often victims of purposeful filicide and more lethal weapons are used (Shelton et al., 2014; West, 2007). For instance, filicide cases involving gunshot wounds and stabbing occur more frequently as the victim's age increases (Smithey, 1998). Kunz and Bahr (1996) analyzed over 3000 filicide cases and found that 60% of victims over 10 years of age died from gunshot wounds or stabbing. In addition, Shelton et al. (2014) noted that over half of the mothers who killed children six years of age or older used fire, firearms, or a sharp force instrument.

Purposeful filicide is typically related to such motivations as personal gain, revenge, or altruism (Shelton et al., 2014). However, one study found that these motivations are not exclusively limited to more lethal weapons (e.g., firearm and knife) (Shelton et al., 2014). Asphyxiation via suffocation and smothering can also be found among filicides that are planned, which suggests that less aggressive methods are not always indicative of reactive

violence (e.g., frustration, crying, and lack of sleep) or limited to victims in the first year of life.

Suicide or suicide attempt by the mother following filicide has been noted in some cases. A 1999 study reported that between 16% and 29% of mothers commit suicide after killing a child and many more make unsuccessful attempts (Nock & Marzuk, 1999). These cases often involve a mother who takes control of a situation in the only way she perceives to be available (Alder & Baker, 1997). The act represents a way to protect the child(ren) and remove them from a real or perceived harm. It is also not uncommon to see child custody disputes occurring at the time of a filicide/suicide (Friedman & Resnick, 2007). Sometimes mothers are so convinced that the child will be harmed in some way by the other parent that they believe the child is better off “in heaven.” In other cases, revenge is the primary motivation and the child is killed in order to get back at the father or other relatives. Ironically, in many cases, friends and relatives reported that the offender had a positive relationship with her children and was a good mother. However, many of these mothers believed that filicide was the only option to ensure the happiness of their children (Alder & Baker, 1997). Parents often believe they could not abandon their children when they killed themselves, so the children had to die with them (Alder & Baker, 1997).

Suicide/filicide is more common in cases involving older children and can often involve multiple children being killed (Bourget, Grace, & Whitehurst, 2007). Age of the child may also impact the mother’s motivation for the suicide/filicide. Resnick (1969) reported that in suicide/filicide cases involving younger children the mother often feels inseparable from the child and views him/her as a personal possession, whereas older children killed in a maternal filicide/suicide scenario are more likely to be viewed as defective.

Family Patterns

The interaction between mother and child is an important and dynamic process. The mother is the infant’s primary focus and she almost solely meets the child’s primal needs. Bowlby (1969, 1982) examined these unique dynamics between mother and child. His attachment theory focused on the importance of proper bonding and how it not only provides for the survival of the child, but is critical for individuation throughout the child’s life span. Despite conventional wisdom, attachment and bonding between mother and child is not automatic and does not occur immediately. Rather, it becomes engrained as the result of learned experiences that begin during the first year of life and are repeated daily throughout one’s childhood and adolescence (Bowlby, 1969, 1982; Crowell & Theboux, 1995). Another influential factor is the dynamic between the behavior and personality of the child and the caretaker’s reaction to the child. This relationship is vitally important to understanding how the child’s behavior interacts with the caretaker’s deficits. Attachment continues to impact individuals throughout their lifespan and the attachment needs of adults are similar to the needs of infants and children (Bartholomew & Horowitz, 1991). For instance, when adults experience stress they often seek out someone with whom they are attached and comfortable.

From Bowlby’s (1969, 1982) initial examination of attachment between a child and caretaker, two main categories of attachment styles were identified to explain the dynamics of this bond—Secure and Insecure attachment. Children with secure attachment are able to cope or self-soothe when their caregiver is unavailable. Upon their mothers return, the child is able to reconnect with her without feelings of anger or anxiety. Securely bonded mothers are emotionally balanced, empathetic, and nurturing, as well as have a better understanding of infants between the first and second years of life. They can anticipate how a situation might affect their child(ren) and adjust appropriately to ensure the child feels safe and comforted (McKee, 2008). Securely attached adults have fewer problems in interpersonal relationships and are described as warm, nurturing and expressive. They are comfortable with and value intimacy and closeness, as well autonomy (Bartholomew & Horowitz, 1991; Solomon & George, 1999).

On the contrary, individuals with an insecure attachment style have a negative perception of either self and/or others, resulting in greater conflicts in their interpersonal relationships. These individuals react to periods of separation with feelings of abandonment, jealousy, and/or verbal and physical aggression. Insecure attachment is associated with anxiety and depression along with other psychiatric symptoms, including alcohol abuse as well as criminal activity (Mickelson, Kessler, & Shaver, 1997; Roberts, Gotlib, & Kassel, 1996; van Ijzendoorn et al., 1997).

Kernberg's *Object Relations Theory* (1976) also may help explain aspects of filicide. Interactions with important people in a child's environment, referred to as "objects," can provoke anger, frustration, or strong feelings of dependence. These feelings can overwhelm children as they begin to recognize that their mothers are more than a source of food. Children over the age of 36 months begin moving from viewing others and themselves as all good or all bad to integrating favorable and unfavorable aspects of individuals (Kernberg, 1976). They begin realizing that the object (mother/other caretaker) who sometimes frustrates them can also meet their needs. When children realize their mothers can be both good and bad, their distress is alleviated, leaving room for love to develop. This is also the time that children begin to develop concern and empathy for others, putting themselves in the other person's position.

However, this mother and child dynamic can become problematic when children never complete this level of development. Traumatic experiences, such as abuse and/or separation from their mothers[4], can create maladaptive responses and destructive impulses. For example, when children are abused by a parent or caregiver they frequently internalize the experience, feel responsible, and blame themselves for causing the negative reaction by the attachment figure. Instead of integrating the good and bad aspects of the mother, the child splits off the bad aspects of the mother, so he/she can maintain a positive view of the mother or caretaker. When a child does not see another person as a separate being, he/she experiences the other person as a "part object" and not a whole or complete person with their own separate needs and feelings. This occurs when the child focuses on the function of the caregiver, or what the caregiver can give him or her. As a result, this limits one's ability to self-soothe and cope with stress, which can impact the individual's ability to regulate affect. As adults, these individuals find it difficult to develop mature relationships because they are often narcissistically focused and continue to split off bad or good aspects of themselves or others to decrease feelings of anxiety, guilt, and grief, and maintain a sense of control.

Filicide offenders interviewed in the Oberman and Meyer (2008) study were often very dependent on their mothers and appeared to not have successfully mediated the stages of development, such as separation individuation, resulting in unresolved attachment styles. Many of the mothers reported that during their childhood, they experienced a lack of warmth and nurturing from their own mother and the relationship was more often filled with ambivalence and conflict (Oberman & Meyer, 2008). Crimmins et al. (1997) suggested that maternal filicide results from mothers with a damaged sense of self who are often exposed to high rates of parental alcoholism, child abuse, and other violence. Maternal abandonment and abuse could increase anxiety and feelings of emptiness even into adulthood. As a result, some women attempt to fill the emptiness through intimate partner relationships or by having a child of their own, which often leaves them feeling disappointed or abandoned again.

A damaged sense of self can also be attributed to childhood experiences that lacked maternal affection, resulting in intergenerational behavior of *absent mothering*. Two previous maternal filicide studies found that many offenders were "motherless," meaning their own mothers had been unavailable to them due to substance abuse, mental health problems, abuse/neglect, or death

[4] Some researchers have suggested that physical abuse by maternal figures is more disruptive of healthy child development than physical abuse by paternal figures (Feshbach, 1989).

(Crimmins et al., 1997; Haapasalo & Petaja, 1999). Unsafe and unstable living environments prevent them from developing positive stress management, coping, and resilience during times of crisis (Oberman & Meyer, 2008) and many exhibit an attachment disorder. For women who have unresolved attachment issues, they struggle to fully engage in this caretaker role and may be unwilling to give up being the recipient of care.

Unresolved attachment issues can even be observed during the pregnancies of maternal filicide offenders. For example, a mother's delay or absence of prenatal care may be the first indicator of their inattentiveness to their pregnancies and their ambivalence about becoming mothers. Overpeck et al. (1998) found that mothers who never pursued medical care during their pregnancies were over ten times more likely to commit filicide as those who began seeing their doctor before the second month of pregnancy. Researchers have noted how little attention offenders pay to their pregnancies and how they neglect to plan for even the most fundamental events (Oberman & Meyer, 2008). Their unborn babies tend to be viewed abstractly, rather than as separate beings who would soon demand constant care and love. Once their children were born, the women, who had romanticized about being mothers are confronted by the realities of motherhood and long for a return to their lives before giving birth. Having a child was another attempt to fill the void in the hopes that the babies would love them and meet their needs. In some cases, the constant demand of an infant, who is in a developmentally appropriate narcissistic state, becomes competition. Instead of meeting the mother's emotional expectations, the infant "reawakens" her own childhood trauma and unmet needs (Motz, 2008, p. 24).

In other cases, mothers lack healthy boundaries and are overly clingy and needy of their children. Motz (2008) described these mothers as having no internal sense of herself (i.e., "I don't exist without you"). The child becomes the container for the mother's unwanted feelings. Filicidal women often refer to their children as if they were extensions of themselves or as if they are property (Oberman & Meyer, 2008). Some speak of their children with little affect and typically objectify the child as a part-object. As one offender said, "my kids were my personal doll babies … I wanted to make sure they were the prettiest girls around" (Oberman & Meyer, 2008, p. 80). It appears that for some women there are distinctions between the wish to become pregnant and what it means to bring a child into the world versus what it means to be a mother.

Although attachment styles cannot determine any specific clinical diagnosis, a mother with Insecure attachment style may exhibit poor parenting skills or even abuse (Zeanah, Berlin, & Boris, 2011). As emotional dysregulation[5] is common among individuals with personality disorders (American Psychiatric Association, 2013), the inability to cope with negative affect may result in a mother's inconsistent reactions to her child. Depending upon the mother's mood, the child can react negatively (e.g., crying and disobedience) and feel that the world is unsafe.

Assessment and Diagnosis

In order to articulate what is perceived as abnormal, it is often assumed by society that the overwhelming majority, if not all, mothers who kill their children are severely mentally ill and exhibiting psychotic symptoms (e.g., hallucinations or delusions) (Pearson, 1997; Stangle, 2008). Filicidal mothers with histories of mental illness and psychiatric treatment are common findings in many studies (McKee, 2006). In a thorough analysis of existing maternal filicide literature, it was reported that the strongest general factors identified among the studies were a history of suicidality, depression, or psychosis, as well as past use of psychiatric services (Friedman, Horwitz & Resnick, 2005). However, previous maternal filicide research has frequently consolidated diag-

[5]Emotional dysregulation is occurs when the individual is unable to process the pain induced situation, resulting in feelings of anxiety and/or anger (Garber & Dodge, 1991). When this dysregulation becomes chronic it may be indicative of psychopathology defined as an inability to cope with one's feelings or emotional instability.

nostic categories of mental disorders due to relatively small sample sizes. Thus, it is difficult to examine accurate prevalence rates for specific mental disorders among filicide offenders. The literature indicates the most commonly reported psychiatric disorders among filicide mothers are depression, schizophrenia, and bipolar disorder (Bourget & Bradford, 1990; Bourget & Labelle, 1992; d'Orban, 1979; Falkov, 1996; Resnick, 1969; Rodenburg, 1971; Scott, 1973; Shelton et al., 2014).

Contrary to the belief that childbirth causes mental illness, there is research to indicate that some maternal filicide offenders had experienced and/or exhibited signs of mental illness prior to becoming mothers (Bourget & Bradford, 1990; Bourget & Labelle, 1992; d'Orban, 1979; Falkov, 1996; McKee, 2006; Resnick, 1969; Rodenburg, 1971; Scott, 1973). It is likely that certain filicidal women do not become mentally ill because they became mothers, but rather childbirth and motherhood can exacerbate a preexisting psychological disorder among susceptible women. While one cannot dispute the frequency in which mothers are diagnosed with severe mental illness, challenges arise because society often confuses mental illness and responsibility for a crime (Schwartz & Isser, 2006). This type of female violence is so unexpected there appears to be a greater need to attribute other reasons for the violence or "blame shift." Similarly, focus tends to be placed on the mother's mental state rather and less attention is given to the act of murder. For instance, in their examination of the legal outcomes of 948 female homicide defendants in Canada over a 23-year period, Silverman and Kennedy (1988) found that 67% of filicide offenders were declared mentally ill, compared to just 6% of the women who killed their spouses and 9% who killed an acquaintance or other family members.

Post-partum Mental Disorders

A presumption of the presence of severe mental illness in maternal filicide cases likely has roots in the common belief that a woman who has given birth may have an altered and disturbed mental state for up to a year following the delivery of the child (Spinelli, 2003). In fact, some countries have established a reduction from general homicide to a lesser charge, based on the findings that childbirth is a time of unique biological change which may lead to mental disturbance (Dobson & Sales, 2000). Even so, the presence of postpartum disorders in any given filicide case does not necessarily indicate the woman is unable to control her behavior and/or did not appreciate the difference between right and wrong (Schwartz & Isser, 2006).

In reality, the year following a child's birth is a time when women are more likely to become severely mentally ill. However, there are studies to suggest that hormones do not have a significant impact on women's mental health status (Wisner & Stowe, 1997). Further, there is data that show some filicide offenders are predisposed to mental disorders, such as depression, and their risk of manifesting symptoms is not increased as a result of the birth (Kumar & Robson, 1984). These women would have likely developed the mental illness diagnosis with or without the additional factor of giving birth. The most extreme form of postpartum mental illness is postpartum psychosis (PPP). PPP is rare, occurring in 1–4 cases per 1000 births (Friedman, Resnick, & Rosenthal, 2009). Psychiatric comorbidity can elevate the risk of PPP in susceptible women (Friedman et al., 2009). Because of the high risk of filicide associated with PPP, professionals have recommended that children should be temporarily removed from caregivers with this disorder (Spinelli, 2004). However, PPP can be missed by healthcare professionals because PPP symptoms wax and wane and some women hide their delusional thinking from their families (Friedman et al., 2009).

Even in the absence of psychosis, women are at higher risk of experiencing psychiatric symptoms up to a year following childbirth. Sleep deprivation, fatigue, and adjustments of duties and priorities make welcoming a new baby challenging; thus, the risk of non-psychotic depression in the month after childbirth was threefold (Cox, Murray, & Chapman, 1993) and 10–15%

of women have an episode of major depression in the year after giving birth (Emery, 1985). Interestingly, research has shown that women who develop postpartum psychiatric illnesses commonly have homicidal ideation (Wisner, Peindl, & Hanusa, 1994). However, psychiatrists were surveyed and revealed that many did not specifically ask their patients who are mothers about thoughts of harming their children, but rather generally inquire about homicidal thoughts (Friedman, Sorrentino, Stankowski, et al., 2006) and suicidal ideations. Mothers who are at risk for suicide should be asked directly about the fate of their children if they were to take their own life. In addition, a lower threshold for hospitalization should be considered for mentally ill mothers of young children due to the possibility of a suicide/filicide scenario (Friedman & Resnick, 2007).

For women who do not experience PPP or postpartum depression, many will experience the "baby blues." Studies have found that 50–80% of women experience the "baby blues" most often 4–5 days post-delivery (Wisner, Gracious, Piontek, Peindl, & Perel, 2003). Symptoms include anxiety, unexplained crying, exhaustion, impatience, irritability, lack of self-confidence, and restlessness (Rosenberg, Greening, & Windell, 2003). Most women are able to resolve these emotional feelings successfully without medical treatment (Wisner et al., 2003).

Personality Disorders and Their Relationship to Violence

Although society commonly views major mental disorders as severe due to symptomatology, such as hearing voices, or delusional behavior, personality-disordered symptoms may not be as easily identified. Specifically, personality disorders are best understood as disorganization of the capacity for affect (emotion) regulation, mediated by early attachments (American Psychiatric Association, 2000; Sarkar & Adshead, 2006) and a number of factors contribute to its occurrence to include childhood exposure to abuse, abandonment, and/or loss (Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Johnson, Cohen, Chen, Kasen, & Brook, 2006).

Individuals who are diagnosed with a personality disorder often have significant conflict in their interpersonal relationships with family, friends, and intimate partners as they can be self-absorbed, demanding, clingy, inappropriate, and lack boundaries. Some are described as a "black hole" of needs that can never be satisfied, while others have tremendous fears and anxieties. Some individuals exhibit odd symptoms that make others around them uncomfortable; thus preventing or inhibiting the development of intimacy. Others display dramatic, emotional volatility, or rule-breaking behaviors. Their partners might feel they are being controlled as individuals with certain personality disorders can be quite rigid in their expectations and can be manipulative (American Psychiatric Association, 2000).

There is some support for the theory that individuals with a personality disorder may be at higher risk for aggressive or violent behavior. For instance, research has shown a relationship between women with antisocial, borderline, narcissistic, and histrionic personality disorders and impulsive and acting out behavior (Warren & Burnette, 2012). In some studies, personality disorders have been reported as being more prevalent and often the most frequent diagnosis among child abuse fatalities (Bourget & Bradford, 1990; d'Orban, 1979). Bourget and Bradford (1990) noted a high frequency of borderline personality disorder diagnosis amongst their accidental filicide-battered group. Other filicide studies have highlighted increased rates of chronic child abuse prior to the homicide, indicating problems with impulse control, managing frustration, and empathy deficits which could be consistent with characterological deficits (Crittenden & Craig, 1990; D'Silva & Oates, 1993; Levine, Freeman, & Compaan, 1994; Wilczynski, 1997). However, it is likely that the prevalence of personality disorders among maternal filicide samples is underreported given that many mothers are not formally diagnosed prior to the offense. This may be due to the fact that many individuals with personality disorders may not seek treatment, preferring to handle their symptoms by self-medicating, often

through substance abuse. In addition, many deny responsibility for their behavioral, affective, and cognitive symptoms and prefer to externalize blame.

Specifically among mothers with personality-disordered characteristics, Splitting[6] can often be exhibited, resulting in the idealization of some and hatred and blame of others, including their own children (Amin, 2008). They may exhibit more anxious or dependent traits and often have poor self-esteem. This could result in the parent not attending to their child's needs for stimulation or the promotion of a child's confidence or self-esteem (Amin, 2008). Their passive behavior may result in the parent's overreliance on the child to take care of the parent's needs. Those parents with more angry or paranoid characterological traits are often mistrustful of everyone and may project blame onto others, including the child, thereby preventing genuine closeness or intimacy.

Additionally, many maternal filicide offenders describe negative childhood and adolescent experiences, which may impact the development of personality disorders (McKee, 2006; Meyer et al., 2001). For example, women in various filicide studies have described caregivers who were unavailable to them during their childhood due to neglect or abandonment (Crimmins et al., 1997; Friedman, Hrouda, Holden, Noffsinger, & Resnick, 2005). Around the time of the offense, many mothers were also experiencing various stressors, such as relationship problems, frequent moving, unstable employment, birth of a child, or death of a loved one (Anderson, Ambrosino, Valentine, & Lauderdale, 1983; Herman-Giddens, Smith, Mittal, Carlson, & Butts, 2003; Lucas et al., 2002). These may be indicative of deficits in a number of different social and occupational areas to include interpersonal relationships, emotional stability, reactivity, impulsivity, and cognitive/judgment abilities.

[6]The term splitting refers to a defense mechanism in which people resolve contradictory or ambivalent feelings by "splitting" off negative aspects of the object in order to maintain the positive aspects (Vandenbos, 2007).

Course and Prognosis/Recidivism

Due to the complex aspects of maternal filicide cases, there are a variety of reactions to, and often ambivalent feelings about, these offenders. Since many believe that there is an automatic and sacred bond between mothers and their children, society has an even greater need to understand how and why these cases occur. During our search for answers we often focus on uncovering underlying reasons and/or diagnoses to explain its occurrence, potentially planting the seeds for bias and preconceptions. It is reasonable to presume that most individuals who commit murder have issues and/or problems that might meet DSM-5 criteria for a mental disorder. However, the more relevant questions are how do these symptoms manifest in that individual, and do they impact one's culpability in the crime they committed?

Biases are not restricted to society at large. Professionals in the mental health field can also be influenced by their unconscious expectations and biases (Motz, 2008). In many maternal filicide investigations, various disciplines will be involved, especially in cases where the mother has surviving children (e.g., CPS, family court, law enforcement, and other mental health professionals). In some cases, initially the perpetrator and/or the cause and manner of death are still unknown, but decisions must be made regarding other children in the home who might be in danger of harm. In these cases, information obtained from the law enforcement interview(s) conducted with the offender will benefit the CPS worker, who must determine if the surviving children in the offender's case should remain in the home or should be removed for their safety. Understanding the potential triggers and other underlying motivations on the part of the offender may assist the worker in evaluating if the offender has the capability to care for her children.

As the case progresses through the system, an offender's state of mind, psychological functioning, and/or competency might be brought into question. A mental health professional (e.g., clinical social worker, forensic psychologist, and psychiatrist) may be asked to evaluate an offender

for symptoms of a mental disorder. Conducting forensic assessments of these offenders for the court requires that the evaluator have an understanding not just of the standards of the mental health field from a forensic perspective, but that they have the capability to objectively consider all possibilities in assessing a female offender by obtaining any and all investigative reports and interviews related to the child's death. This allows the mental health professional to better assess the accuracy of the information the mother provides through self-report. Given the subjective nature of psychological evaluations, a combination of a structured forensic interview with valid/reliable psychological tests that measure the accuracy of responses would be most beneficial.

The psychological reports that have been generated in a number of filicide cases encompass a wide range of methods and differences in thoroughness and objectivity. Although it is standard to conduct an interview with the offender, it is reasonable to assume that she has an ulterior motive to minimize or distort certain facts to decrease her exposure or culpability. Many people engage in some impression management throughout their lives and mothers are no exception. Societal views surrounding motherhood can place significant pressure on mothers to *always* be self-sacrificing, loving, organized, and patient, expressing only positive feelings about their parenting experiences. However, even the best of mothers will have moments of frustration, impatience and negative feelings about their children. In addition, mental health professionals may need to compartmentalize their own parenting experiences and be cautious about filtering an offender's actions through their own understanding. For example, assuming the offender is attached to her child and that the child's death was a tragic result of the offender losing her temper. It is possible that the mother was not attached to her child, did not want the child and was relieved when the child was gone. Using objective psychological tests will assist in evaluating the degree to which the offender is presenting herself in a better light, i.e., "faking good."

On the other hand, some offenders may present themselves as lower functioning so they appear severely mentally ill and raise the likelihood of being found insane or incompetent to stand trial. Exaggerating or creating symptoms of mental illness is referred to as "faking bad or malingering." Hence, psychological tests, to include malingering scales, will help an evaluator assess the accuracy of the diagnosis, the offender's ability to understand right from wrong, and whether she can understand the proceedings, and can assist her attorney in her defense. A rather common misconception is that all individuals who are diagnosed with a psychotic disorder do not understand right from wrong. A thorough evaluation could offer additional information to better demonstrate the offender's ability to differentiate and understand the crime she committed. The aspects of an insanity plea are more complex and require the ability to integrate the psychological field with the forensic world as it relates to knowing right from wrong at the time of the offense.

Treatment

Maternal filicide cases can be extremely challenging to investigate and prosecute. No other type of homicide presents such complex psychological and social dynamics. Convictions and just sentences can often hinge on collaboration among investigators, CPS, and the prosecutor. Despite its rather common occurrence and improved system responses, society's opinions about mothers who kill their children vacillate between outrage and ambivalence. On one end of the continuum, society feels that justice must be served for the loss of an innocent child. On the other end, even in cases without evidence of extensive mental health issues, society believes that something must be terribly wrong with a mother who kills her own child(ren). This notion is likely affected by several societal beliefs, assumptions, and reactions including: (1) the denial of female aggression and violence, (2) our desire for special explanations in these cases, (3) society's instinct to label these offenders as

unmothering or non-mothers, and (4) the tendency to blame shift or transfer some or all the responsibility from the mother to some other source.

Denial of Female Violence

Women have committed crimes against their children since antiquity and they have done so for a variety of reasons, many of which reveal clear and rational intent. However, misconceptions about female violence and aggression still exist today. As one researcher noted, many believe that women are by nature passive individuals and that "half the population of the globe consists of saintly stoics who never succumb to fury, frustrations, or greed" (Neroni, 2005, p. 59). And although such statements are illogical and absurd when applied to an entire gender, these notions have undoubtedly influenced the legal outcomes of certain filicide cases. In addition, disciplines such as the mental health field can be equally influenced by this misnomer and may lack a comprehensive perspective to incorporate in their assessment and treatment of maternal filicide offenders.

Variations in the expression of anger between the genders might help explain how women's violent behavior often *appears* different from men. Without an acceptable outlet for expressing negative emotion, some women may experience a pattern of over-controlled hostility. This buildup of intense emotion could result in a significant act of violence, which is typically unexpected and inconsistent with prior patterns of behavior. Understanding how the expression or manifestations of anger may be presented differently for men or women can aid the mental health professional treating the maternal filicide offenders. Overcontrolled hostility (OH) may be more difficult to observe due to the less obvious or direct expressions of anger by individuals with OH. Additionally, the offender may fail to recognize the unique precursors of her anger and violence. In addition, the treating mental health professional may need to expand their treatment modalities to best address OH.

Special Explanations

Our culture often desires and demands special explanations as to why these acts occur; the most common and acceptable explanation appears to be related to psychological impairment of the mother (e.g., mental illness). Historically, negative behaviors exhibited by women, whether legal or illegal, are often explained away through hormonal imbalances and can be attributed to histrionic, depression, or anxiety-related disorders. Society makes greater attempts to search for reasons underlying the violent act in order to understand why a female offender would commit such an egregious offense. It is important for the mental health professional to be cognizant of what symptoms of mental illness will adequately meet the criteria for a mental health diagnosis. They should be accurate in their use of diagnosis and should not assume that all maternal filicide offenders are mentally ill.

An additional challenge is explaining a mother's motivation or reason, which can often be unsatisfying. Misconceptions exist that most maternal filicide offenders kill for extraordinary or bizarre reasons. However, many children are killed because they were never desired or were no longer wanted. In a society that believes that mothering is automatic, being unwanted is often a hard-to-accept motivation. In addition, presenting evidence of an unwanted victim often means highlighting a lack of behavior on the mother's part over an extended period of time (e.g., showing a jury what did not happen during this child's life, as well as what did). Illustrating the significance of the absence of something can be much more difficult than proving the importance of more overt statements or obvious behaviors.

Non-mothers

Reactions, both legally and culturally, illustrate society's instinct to label maternal filicide offenders as unmothering or non-mothers. However, in reality, most maternal filicide offenders are not that different from mothers who do not kill their children and investigations often reveal that

offenders had a history of both good and bad parenting moments. Nevertheless, society is intolerant of these two concepts coexisting comfortably due to myths and idealistic expectations of motherhood. Most people want a clear delineation between those who would harm their children and those who would not.

When society is presented with the co-occurring yet contradictory events of good mothering moments and filicide, the typical reaction throughout history is to assume mental pathology is to blame. It is the missing piece that connects two previously incompatible parts and helps us make sense of something that is perceived to be unexplainable. The assumption of mental illness not only assists in distancing ourselves from the offender, but also allows the child's death to be considered more of an isolated incident. The alternative would infer that other mothers may be capable of committing filicide and suggests a more pervasive problem.

In some cases, there is an assumption that the presence of good mothering moments was tangible evidence of attachment between mother and child and has the potential to complicate prosecution. However, some filicidal mothers are motivated to provide proper care to the child, even in the absence of attachment, because of their narcissistic tendencies and for impression management. This distinction between proper care of a child due to attachment or narcissism can be an important one to make. Behavioral indicators of the mother's motivation can include the offender's need for attention and/or desire for her good parenting to be observed by others or if she provides proper love/care even when alone with the child. In addition, financial and/or childcare support from others (e.g., offender's parents and other family members) may have recently stopped or significantly diminished and its absence or reduction affected the victim in a negative way. For example, victims may be generally well-cared for by their mother, but shortly before their deaths others observed changes in the child's physical or emotional well-being. Upon closer examination, investigators may find a recent change in family dynamics (often the offender's choice) either due to a recent move out of a family member's home or a dispute with parents/intimate partner. This change often places greater demands on her finances and lifestyle as well as requires the offender to spend more time with the child. Hence, mental health professionals who will be evaluating and/or treating maternal filicide offenders should have a thorough understanding of and assess for potential attachment disorders often seen in these cases. In addition, they should integrate attachment issues and potential mental health issues.

Blame Shifting

Blame shifting, the transfer of responsibility from the mother to some other source, can also affect our legal response in maternal filicide cases. It can be directed at a mother's financial difficulties, diminished mental capacity, as well as the moral climate, reproductive rights, and medical/mental health systems. It is most often effective in cases involving very young victims and youthful and dependent mothers (e.g., living with parents, student) because society feels more responsible for children and, to a lesser degree, teenagers and young adults. Blaming an offender's upbringing, her parents, or society-at-large can become a central focus of the case, resulting in the court focusing less on her responsibility and sharing or shifting the blame to some other entity. Successful prosecutions using behavioral and medical evidence have highlighted that the death of the child was due to the offender's choices over the preceding months rather than an uncharacteristically impulsive act. Furthermore, mental health professionals may continue to shift blame to others during treatment and may not address the offender's culpability in the death of her child.

Despite its rather common occurrence, society's opinions about mothers who kill their children vacillate between outrage and ambivalence. Faulty assumptions regarding the hormonal side effects of childbirth and misconceptions about female aggression or violence are likely the major contributors to the disparity in legal outcomes and society's inconsistent responses (Shelton et al.,

2010; Stangle, 2008). On the one end of the continuum, society feels justice must be served for the loss of an innocent child. On the other hand, even in cases without evidence of extensive mental health issues, society continues to believe that something must be terribly wrong with a mother who kills her own child(ren) (West, 2007).

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