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Review article

Infanticide: contrasting views

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Summary

Background: The subject of infanticide is met with complex reactions. Paradoxically, the very same society that practices gender selection may also prosecute a mother for killing an infant. The author reviews historical, cultural, and political views on infanticide.

Objective: Using the case of Andrea Yates, the author illustrates the outcome of an infanticide case in American Judicial System in which a floridly psychotic mother serves a life in prison. This work explores contemporary worldwide experiences of infanticide and investigates culture specific attitudes towards causes, facilitation, and punishment of this tragic cause of infant mortality. The work illustrates the intricate relationship between a society's construction of parenthood and mothering, and its experience of infanticide.

Results: Infanticide is deeply embedded in, and responsive to the societies in which it occurs. Causes vary from poverty to stigma, dowry and insanity. The worldwide experience of infant murder reaches from facilitation of gender determination in China and Asia to lethal execution of mothers as perpetrators in the United States.

Conclusion: Infanticide must be viewed against the political, cultural, social and legal backgrounds of societies that treat women with disregard. It is a reflection of social and cultural norms governing motherhood, a constant that links these seemingly disparate acts. The overall association of infanticide with crime, postpartum illness, population and sex selection speaks to unjust discrimination against women and children. We as a world society can do a far better job of protecting motherhood.

Keywords: Infanticide; gender selection; insanity defense; postpartum psychosis.

Introduction

In the year 1990, the worldwide prevalence of violent deaths of children (between birth and 4 years old) accounted for 1,926 of 17,472 per thousand violent deaths (Murray and Lopez, 1996). Infanticide or infant murder in the first year of life accounts for 1/3 of all US deaths due to injury. According to available data, one infant is killed every day in the US (Overpeck et al., 1998). Estimates double this number (McClain et al., 1993; Herman-Giddens et al., 1999). Yet, data and research on infanticide are scarce. Infant death statistics are likewise glaringly underestimated (Overpeck, 2002). In particular, there is a scarcity of data on infant fatalities from abuse or neglect particularly as related to the perpetrators. This underreporting is accounted for by poor documentation, infanticides reported as SIDS deaths, lack of death certificates and undocumented births due to pregnancy denial and unfound corpses (Herman-Giddens et al., 1999; Ewigman et al., 1986). Undoubtedly, the very nature of such tragedy makes it an unappealing subject of research.

Historically, the subject of infanticide has been treated with ambivalence. The very same tension between the demand for condemnation and the impulse towards mercy describes the evolution of infanticide laws (Oberman, 1996) from ancient times in both Western society and non-Western cultures (Mosely, 1986).

In Babylonian and Chaldeon civilizations abnormal infants, considered to be children of witches who consorted with animals or demons, were left on the roadside to die. In the Greek and Roman era, birth control and eugenic reasons were primary causes for infant murder by fathers who had absolute rule in the family. Infants were sacrificed to pagan gods, and unwanted newborns were exposed to the elements as a method of population control. The birth of a child with anomalies was considered good or bad omens of things to come and continued

to arouse superstition. Over time, inheritance, illegitimacy and stigma became grounds for infant murder (Lagaipa, 1990; Langer, 1974).

As the practice of infanticide became more common, the Catholic Church was the first to institute penalties. ''Overlaying'' was a practice in which mothers lay on the infant smothering it to death (Oberman, 1996). In the manuals for parish priests overlaying was identified as a venial sin comparable to failing to teach a child proper manners.

When the church elevated infant murder to a mortal sin, societies adopted laws in hopes for prevention (Brockington, 1996), and secular penalties became increasingly severe. By the 17th century, infanticide was so common that concealment of a murdered newborn became a capital offense (Lagaipa, 1990; Oberman, 1996). Such punishments as sacking were initiated in which a woman was placed in a sack with a dog, a cock, and a snake and thrown into the water.

In the eighteenth century laws in the US, Canada and Europe became increasingly strict particularly for unmarried women. In France, England and Russia, growing public awareness of the problem of dead and live abandoned newborns led to creation of the ''foundling home'' but they were unable to overcome the profound effects of infanticide and abandonment (Blaffer-Hardy, 1999).

In 1647, Russia became the first country to adopt a more humane attitude and by 1888, all European states except England established a legal distinction between infanticide and murder by assigning more lenient penalties to infanticide (Oberman, 1996; Spinelli, 2004). In 1922 and 1938, England passed the Infanticide Act in recognition of the time surrounding childbirth as biologically vulnerable and made infanticide a less severe crime proscribing sentences of probation and mandatory psychiatric treatment for women found guilty. Today, almost all-western societies have adjusted the penalty for infanticide (Brockington, 1996) by recognizing the unique biological changes that occur at childbirth.

Twentieth century response to infanticide

These early legal statutes have evolved into contemporary and contrasting legal views across the US, UK and other countries. Oberman (1996) estimated that 29 countries describe statutes explicitly governing the crime of infanticide. All nations that have statutes make infanticide a less severe crime than ordinary homicide with one exception. Luxembourg provides a *more* severe penalty for killing a child than for other homicide. New South Wales ascribes diminished responsibility to infant murder. Other countries make infanticide a less severe crime with sentences considerably less than manslaughter or murder. Infanticide is a less culpable form of homicide in Austria, Finland, Greece, India, Italy, Korea, New Zealand, the Philippines, New South Wales, Western Australia, Tasmania and Canada.

According to the Italian Penal Code, killing a parent is punishable by 24–30 years while ''infanticide'' is punishable by 3–10 years. Furthermore, Italy's law specifically provides for those who commit infanticide in order to ''save their honor (Oberman, 1996) Killing an illegitimate rather than a legitimate child is a less serious crime in the Philippines and Austria.

Some statutes also differ with regard to the infant's age. For example New Zealand's law includes infant murder from immediately after birth to age 10 with a maximum of 3 years in jail. Most statutes follow the British rule, which pertains to the first 12 months of life. Women are often given probation and mandatory psychiatric treatment in countries with such statutes (Linzer, 2001).

Generally speaking, infanticide has been treated as a far different crime than other homicides. Yet contemporary cries for greater punishment can be heard from abolitionists in countries where law reformers propose a change in legislation by overturning the existing infanticide law.

The United States has no particular laws governing infanticide. A woman who kills an infant is charged with the crime of homicide. If convicted in the American judicial system she may face a long prison sentence or even the death penalty. Due to the scarcity of psychiatric treatment in the overcrowded US prison system, these women exit the criminal justice system in their childbearing years with the same psychopathology that brought them into prison. Yet, there is no difference in the prevalence of infanticide in countries that mandate treatment compared to those who mandate punishment (Marks, 2002).

In 2001, when a psychotic Andrea Yates drowned her five children in the bathtub of her Houston, Texas home (Yardley, 2001), the nation was riveted and the western world responded. During her delusional state Satan told her that she would spare her children from hell if she killed them. Andrea Yates had a history of mood instability and family history of bipolar disorder. As a mother of 5 she home-schooled her children, swam 80 laps every morning, designed crafts and made childrens' costumes into the night. The fact that she was pregnant and/or breastfeeding from 1994 to 2001 describe her

sudden shift into postpartum depression, hypereligious preoccupation with Satan and psychosis. The fact that her psychiatrist discontinued haloperidol and maintained high doses of mirtazepine and venlafaxine without mood stabilizer augmentation likely contributed to the tragic ending (Denno, 2003).

Nevertheless, Yates was found guilty of capital murder after only $3\frac{1}{2}$ hours of jury deliberation. Spared the death penalty by the same jury, she was remanded to prison for life (Yardley, 2001). Her trial attracted international attention. Organizations dedicated to postpartum disorders such as Postpartum Support International and Marcé Society for the Treatment and Prevention of Postpartum disorder requested clarification of postpartum diagnostic criteria, improved medical education, guidelines for treatment and consideration of infanticide legislation. Advocates for the mentally ill blamed the inadequacy of the courts, the use of an archaic insanity (M'Naghton, 1843) defense and the troubling nature of expert psychiatric witnesses whose opinions differed so remarkably (Grinfield, 2002).

Cultural and contrasting views

Infanticide is deeply imbedded in and responsive to the societies in which it occurs. To that extent, it is a reflection of the norms governing motherhood (Oberman, 2002). Contemporary worldwide media accounts collected from Lexis Nexis for the past 2 years continue to reflect the ambivalent, contrary but intense responses to these tragedies. In addition, this complicated worldview from independent countries ranges from facilitation of sex-selective infanticide in India and China to death penalties for perpetrators in the US (Gardner, 2003).

China illustrates the paradoxical manner in which these cases are viewed from a social perspective. Despite a widespread practice of sex selection and policy of population control (Deutsche Presse Agentur, 2003), a 15-year-old Hong Kong girl who threw a newborn to death was charged with murder. After admitting to infanticide she was then placed on probation by the judge, who heard evidence that she was psychologically unbalanced at the time of the birth.

Culture specific problems associated with infanticide pose similar and long-standing difficulties. For example, India continues to struggle with the high incidence of female infanticide in a country where girls are undesirable. The headline that "Forty million women are 'missing' in India" (Gardner, 2003) describes the high rate of female feticide, infanticide and "neglect" which has caused a national "shortfall" of about 40 million women that is disproportionately high in some regions where inheritance practices discriminate against women and in poor families that cannot afford bridal dowries. In this case the government permits the gender imbalance. According to the 2001 census in India, there are 933 Indian women for every 1,000 men. By contrast, there are 1,029 women in the US for each 1,000 men, a normal proportion of women to men for a country with an average life expectancy of more than 60 years – unless a sex discrimination method is employed. Delhi, a city with a large Punjabi population, has an 821 to 1,000 ratio.

Although women's organizations demonstrate against the growing practice of sex determination, the social and political structure of the society encourages female infanticide, a practice that is also rife throughout China and southern Asia. As late as 1999, some districts in Africa counted 6 female deaths for every male infant death. This ratio has dropped to 1:2.4 because of female activists (Ilangovan, 2003).

Further socio-cultural imperatives precipitate the crime of infanticide in various cultures. In Jakarta, the capital of Indonesia (Jakarta Post, 2003) the number of infanticides remains high as more women are driven to the crime because of Indonesia's legal system and the social stigma attached to children born out of wedlock. Under Indonesia's 1974 law on marriage, children born out of wedlock lose their social and legal claim to their biological fathers and are declared illegitimate on their birth certificates. Meanwhile, the Jakarta Post reports that Indonesian courts often ignore cases of rape and forced sex, and side with the male partner. Under Indonesia's criminal code, the maximum sentence for infanticide is nine years imprisonment, more lenient than the social stigma and financial burden that mothers, as well as their children, have to bear for the rest of their lives.

In Viet Nam an unmarried woman may likely kill her infant because her village would oust her (Deutsche Presse Agentur, 2003). A woman from Xe Dang ethnic minority gave birth and kept the baby, but was forced to pay a fine in the form of two adult pigs, several chickens and rice wine.

Anthropologist Nancy Scheper-Hughes (1992) recounts her experience on the Alto de Cruzeiro (Hill of the Crucifix), the shantytown region of Northeastern Brazil, a culture where the high expectation of death ... produces patterns of nurturing that differentiate those infants thought of as "thrivers" from those thought of as

born ''already wanting to die.'' The survivors and keepers are nurtured, while the stigmatized or ''doomed'' infants are allowed to die ''of neglect.'' ... ''angels'' freely ''offered up'' to Jesus and His Mother in order to preserve the limited resources for stronger, older children and working adults.

And so, economic and cultural realities can contribute to the prevalence and even acceptance of infanticide. They illustrate the seemingly inconsistent and even incoherent manner in which societies respond to infanticide.

The US perspective

The subject of infanticide is met with contradictions (Spinelli, 2002). It is topic both compelling and repulsive. In the United States, the killing of an innocent is a crime. It demands retribution. That is the law. Yet the perpetrator of the act is a victim too, and that makes for a more paradoxical response.

Sara Ruddick (1989) has captured the contradictions well in noting that mothers, while so totally in control of the lives and well being of their infants and small babies, are themselves under the dominion and control of others. Simultaneously powerful and powerless, it is no wonder that artists, scholars, and psychoanalysts can never seem to agree whether ''mother'' was the primary agent or the primary victim of various domestic tragedies. And so myths of a savagely protective ''maternal instinct'' compete at various times and places with the myth of the equally powerful, devouring, ''infanticidal'' mother (Ruddick, 1980; Scheper-Hughes, 1992).

Although most countries have specific laws that rule out harsh sentences, there are no simple predictions to the United States experience of seemingly similar crimes, but radically different sentences. In this nation, states set their own policies for handling such cases.

The outcome of Yates v Texas is representative of conflicted legal views within the US about many insanity pleas in the US courts. A diagnosis of psychosis does not imply ''insanity'' under the US law. Despite overwhelming agreement by the defense and the prosecution that Andrea Yates was psychotic at the time of her actions, she was found ''not legally insane'' (Grinfield, 2002; Spinelli, 2004).

Formal DSM4 diagnostic standards do not exist for postpartum psychiatric illness, and a woman who commits infanticide may receive sentences that vary remarkably (McNaghton, 1843; MPC, 1962). Depending on the state, the defendant must pass the test of that jurisdiction in order to be found not guilty by reason of mental illness (NGMI). This inconsistent response is characterized by the fact that a woman who receives a prison sentence in one state may receive the death penalty in another despite the identical circumstances of the crime. Outcomes vary depending on the state, county or even the presiding judge.

While some states provide no defense of insanity, the insanity defense in most American jurisdictions is based on two main formulations for insanity: the M'Naghten Test (1843) and the Model Penal Code/American Law Institute Test (MPC). Under M'Naghton, the finding of ''insanity under the law'' depends on the cognitive ability of the individual or their ability to ''know'' right from wrong at the time of the crime. In order for the psychotic defendant to meet requirements for the insanity defense she must prove that she did not know (possess the cognitive capacity) right from wrong at the time she committed the crime.

The Model Penal Code is the second test of insanity which provides that a defendant is not responsible for a crime if she lacked capacity to ''appreciate'' the criminality (right or wrong) of her conduct or was unable to conform her conduct to the law. The expert psychiatric witness makes these respective determinations.

The M'Naghten Test, or the ''right and wrong test'' was derived from the landmark English case decided in 1843 and provides the 'cognitive' test for insanity in the state of Texas where Andrea Yates was prosecuted. There are inherent problems with this test. First, the likelihood that a 160-year-old legal case can be applied to 21st century neuroscience to accurately determine a state of insanity is improbable. Second, this test relies on the defendant's recall at the time of the crime. Since psychosis and particularly organic states are frequently associated with amnesia, the reliability of these retrospective reports is debatable. Finally, the psychiatric literature is replete with clinical case findings of postpartum psychosis and associated mood lability confounded by delirium, amnesia and impaired cognition (Spinelli, 2004).

The MPC approach has been adopted by about half of the states and the majority of the federal circuit courts of appeal (Robinson, 1984). The MPC's approach to insanity recognizes that mental disease may impair functioning in several ways. The satisfaction of either the cognitive or volitional prong is grounds for an insanity verdict in a MPC jurisdiction. It is likely that Andrea Yates would have been found NGMI in a state, which used the MPC test.

Ambiguity in the law is further complicated by psychiatry's failure to provide diagnostic guidelines for postpartum psychiatric illness. Consequently we have

little to offer the legal justice system (Macfarlane, 2002). This presents a virtual ''catch-22''. In a court of law, expert witness testimony must be founded on scientific standards that are recognized in the psychiatric community, yet few standards exist (Spinelli, 2004). Therefore, the defenses for these women are limited to early and outdated literature and laws. Our reluctance to place postpartum disorders within a diagnostic framework often leads to tragic outcomes for women, family and society. Moreover, it continues to result in disparate treatment for women in the legal system overall (Meyer and Spinelli, 2002).

Juana Leija (Crary, 2001) went on trial in Texas in 1986 after killing two children. Defended by Houston attorney Dick DeGuerin, who argued she had been driven insane by her husband, she received 10 years of probation. In May 2000, Christina Riggs was executed by injection in Arkansas for killing her children despite offering an insanity defense.

Viewed against a backdrop of women who are insane, these outcomes emphasize the haphazard manner with which we treat this crime.

Moreover, contradictions also persist within the American Court system between criminal and civil court proceedings which discriminate against women. For example, when the evidence for postpartum illness could assist women's interests in criminal cases, it is often barred from admission (Meyer and Spinelli, 2002; Meyer and Proano, 1999). On the other hand, postpartum syndromes are readily admitted into evidence during civil proceedings (Meyer and Spinelli, 2002) where they are almost always in opposition to a woman's interests such as child custody or adoption decisions.

For example, in a 1997 adoption appeal, a biological mother who had given her child up for adoption asserted that postpartum depression rendered her incompetent to consent to the adoption (Spinelli, 2004).

The Tennessee Appellate Court stated: ''We do not dispute that [the mother] was probably depressed or emotionally distraught following this rather traumatic experience, but it is not unusual for there to be depression and distress following the birth of a child, even under the best of circumstances. If emotional distress meant that a parent was always incompetent to consent to an adoption, we would rarely have adoptions in this state (Croslin v. Croslin, 1997; Meyer and Spinelli, 2002).

Britain's Infanticide Act

Contrary to US legislation, those of England and Wales provide that a woman who has killed her infant under a year can be indicted for infanticide. This law contained in the Infanticide Act (1938) provides a model of infanticide legislation often described in the literature.

> *"Where a woman by any wilful act or omission causes the death of her child – aged less than a year – but at the time the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation ... the offence which would have amounted to murder is deemed to be infanticide and is dealt with and punished as if it were manslaughter."*

The Infanticide Act assumes that should a woman kill an infant under one year old it is likely a consequence of mental instability. For example, a 19 year old British mother who killed her six-month-old baby was due to stand trial for murder, but the Crown Prosecution Service accepted a guilty plea to infanticide because she had suffered from post-natal depression (Watson, 2001). She was given a four-year sentence in a hospital to be treated for her psychiatric problems.

Marks (2002) describes the ongoing debate over the Infanticide Act in the UK. Proponents of abolition in the UK argue that 'medicalisation' of the offence encourages tolerance of infant murder. Marks argues that rather than abolish the Infanticide Act, what is needed is research into the reasons that lead the prosecution to bring charges of murder, manslaughter or infanticide. Further evidence to support this act comes from a comparison of England and Wales with Scotland.

Scottish legislation makes no special provision for maternal infanticide. A mother who kills her infant in Scotland will be charged with either murder or homicide. If more harsh legislation is a deterrent, then rates should be lower. However, rates of the offence, the characteristics of victims and perpetrators and the patterning of both convictions and sentences are similar in the two regions (Marks and Kumar, 1996). Abolition of the Act is unlikely to result in a reduction in the number of infants killed, nor to facilitate research into the precursors of these crimes.

The legislative debate and dilemma are not particular to the UK. These paradoxical responses to infanticide are aroused regardless of geography, legislation or social structure.

In Texas, Andrea Yates serves a life prison term for drowning her five children in a bathtub. Despite overwhelming agreement by defense and prosecution that she was psychotic, she was found ''not legally insane.'' In the US, the strong political and social basis for failure

of the insanity defense makes no provision for the scientific fact of mental illness.

In a report by the Calgary Herald (Woodard, 2001), psychologist Tana Dineen of Victoria opined in the case of Andrea Yates that psychiatric testimony should not be allowed in court. ''All you get is a lot of speculation''.

Gender and legislation

Journalist Janet Albrechtsen demands that punishment for infanticide should be based on justice, not gender, with mothers and fathers treated equally (Albrechtsen, 2001). Patricia Pearson exclaims ''if a hand rocks the cradle it must bear the blame... it comes with the territory of equality.''

Ironically, the proponents of abolition claim that medicalization is outdated. Yet contemporary neuroscience overwhelmingly supports the neurohormonal basis for postpartum illness (Sichel, 2002).

Kendall's study (1987) of postpartum women showed that psychiatric hospital admissions increase 7 times in the first three postpartum months compared to prepregnancy and represent the peak prevalence for psychiatric disorders in women.

The basis of infanticide legislation in most countries reflects concern for the biologically ''vulnerable'' state of women after childbirth. The Victorian Law Reform Commission challenges this accepted wisdom as it lobbies for abolition of the Infanticide Act.

Despite evidence for physiological underpinnings of postpartum disorder, our limited diagnostic guidelines and scarcity of research limit the role of the psychiatric community in the American court system (Spinelli, 2004).

In summary, some countries' culture facilitates infanticide, others prosecute it and others treat the illness. How do we understand this complicated view of the complex subject?

Contemporary perinatal psychiatrists have failed to demonstrate a unique phenomenology to postpartum disorders, precluding a distinct diagnostic category in the DSM4. Yet in the 19th century, Marce (1858) and Esquirol (1838) described unique presentations, which differentiated postpartum psychosis from other postpartum illness. The features included agitation, delirium, alternating mania and melancholy, bizarre and changing delusions, and loss or distortion of memory for acute episodes. These same clinical indicators have been described by contemporary experts (Brockington, 1981; Wisner, 1994; Wisner et al., 2002). Brockington reviewed extensive data on postpartum psychosis and described the same organic picture associated with a delirium-like, disorganized clinical picture of impaired sensorium, cognition and a waxing and waning picture of mood lability and amnesia (Spinelli, 2004).

Moreover, cognitive disturbance has been described and demonstrated by formal systematic study. Wisner's group described a ''cognitive disorganization psychosis'' in women with childbearing-related psychoses compared to women with non-childbearing-related psychoses (Wisner et al., 2002). The clinical picture in the postpartum group demonstrated thought disorganization, bizarre behavior, confusion, delusions of persecution and impaired sensorium/orientation, all consistent with a clinical picture of delirium. This hormonal – biologically driven state presents as any other toxic organic psychosis (Sichel, 2002).

The fact that there are no formal diagnostic criteria for postpartum disorders is particularly deleterious in the American court room where the judicial community relies on the DSM for testimony. In the legal arena, the systematic presentation of the perinatal literature is usually absent from the repertoire of psychiatric experts who testify in courtrooms. The consequence is that jurors responsible for the fate of these women are not informed about the illness associated with childbirth. Consequently, jurors are more likely to attribute secondary gain to pleas for insanity in order to avoid prosecution (Denno, 2003; Spinelli, 2004).

Moreover, improved documentation in the psychiatric literature could prompt major changes if communicated to the legal justice system and the juries who decide culpability.

Another political opinion arises from feminist groups who believe that women should not be identified as victims of their own biological changes. And yet, knowledge of the facts is, in and of itself, empowering. The search for scientific data and sanctioned diagnostic criteria should include a risk/benefit analysis. The benefit derived from recognition and equitable treatment under the law far outweighs the risk that women will be perceived as weak. The greatest risk is that women with these disorders will continue to suffer tragic consequences unless the potential benefits are met (Meyer et al., 1999; Meyer and Spinelli, 2002).

The fact that clinical research demonstrates the neurophysiological mechanisms as etiology of childbirth-related psychiatric disorders (Sichel, 2002) suggests reconsideration of contemporary American legislation and improved efforts to maintain infanticide laws in other countries. The challenge for psychiatry is to edu-

cate the legal community. The task for the expert witness is to communicate our scientific and biologically based knowledge to the jury-to use the courtroom as a classroom and encourage verdicts based on informed understanding of the facts.

After sentencing of Andrea Yates, the American Psychiatric Association made a public announcement on the Insanity Defense and Mental Illness (APA, 2002):

> *"The American Psychiatric Association hopes that the Yates case will lead to broad public discussion of how our society and its legal system deals with defendants who are severely mentally ill.... Advances in neuroscience have dramatically increased our understanding of how brain function is altered by mental illness, and how psychotic illness can distort reality.... Unfortunately, public understanding has not kept pace with these advances.*
>
> *A failure to appreciate the impact of mental illness on thought and behavior often lies behind decisions to convict and punish persons with mental disorders.... Defendants whose crimes derive from their mental illness should be sent to a hospital and treated – not cast into a prison, much less onto death row."*

The legal and medical consensus was that Andrea Yates was psychotic (Court TV, 2002). The prosecuting psychiatrist as expert witness testified that Yates ''knew'' the act was wrong at the time of the killings. He also falsely testified that Yates imitated a television episode of Law and Order in which a postpartum depressed mother killed her children and was found not guilty by reason of insanity. After the guilty verdict was in, the jurors were informed that the television episode had never aired. This matter accounts for the present Yates' appeal of the guilty verdict by the Texas Supreme Court.

The psychiatric expert for the defense testified that the patient ''knew'' that it was ''legally'' wrong to kill because her delusional belief was that she, as Satan would be executed for her crime (Denno, 2003). He also testified that Yates ''knew'' it was ''morally'' right to kill her children because Satan commanded that her children would suffer the fires of hell if she did not drown them.

In 2004, the Texas court found Deanna Laney not guilty by reason of mental illness. The conclusion reached by the medical experts and the court was based on her report that ''she did not know'' that her act was not wrong because ''God'' directed her actions. In contrast, they explained that Andrea Yates'' knew her act was wrong' because she was directed by ''Satan.'' This conclusion suggests that a legal state of insanity is based on the determination that psychotic hallucinations came from God or Satan (Casey, 2004).

Because M'Naghton does not specify that cognition should apply to legal or moral knowledge suggests further distortion of the facts. The empathic human being might ask whether cognitive factors should be considered when a mother's distorted reality demands that she save her children from an eternity of pain. We, in psychiatry make decisions that conform to legal standards that have no application to our scientific determination and therefore cannot possibly determine culpability. The fact that we attribute decision-making capacity to a psychotic mother speaks to the inaccuracies in our system. Impaired cognition or inability ''to know'' belongs to the pathophysiology that describes postpartum psychosis.

The single most important piece of judicial evidence for the existence of a clinical entity lies in the description of the phenomenology in peer-reviewed literature. The dearth of descriptive symptomatology on infanticide and postpartum psychosis leaves the expert witness with few scientific tools. The courts rely on scientific knowledge that is accepted in the medical community (Frye, 1923). Absent systematic clinical descriptions or research based case reports, each act is judged in isolation with little or no regard for similar cases (MacFarlane, 2002) And so the case of Texas vs. Yates was tried in the media and courts with little intervention from the psychiatric community.

Absent research-based information on the temporal relationship between childbirth and infanticide, and a clinical framework for understanding the diagnosis and phenomenology that underlie infanticide, we are in all likelihood missing the signs of potential tragedy as evidenced by the case of Texas v. Yates (Spinelli, 2002).

The tragedy of the Yates family: what can we learn?

In his 1902 paper presented at the Broadmore Asylum for the – Dr. John Baker described:

> *"The type of insanity most commonly observed amongst these lunatic criminals is delusional mania.... in such a condition those in attendance would naturally remove the child and guard against the contingency of danger.*
>
> *These tragedies are frequently preventable... it begins to dawn on the friends that the mind is gradu-*

ally giving way, yet owing to some perverse reasoning they defer placing her under asylum care and treatment, even if the woman herself begs to be safeguarded." (John Baker MD, 1902).

Before she killed her children, a paranoid and delusional Andrea Yates spent days in her bed pulling out her hair to demonstrate ''666'' (the mark of the beast) on her scalp. Was she begging to be safeguarded? to be recognized as Satan?

Mrs Yates' early history as exemplary pediatric oncology nurse, class valedictorian, champion athlete and exceptional mother was accompanied by early mood swings that worsened with childbirth. Were it not for the fact of criminality, the clinical assessment would be easily described as a postpartum affective psychosis.

Andrea Yates was persistently pregnant or lactating from 1994–2001. Bipolar disorder and/or depression prevailed in parents and siblings (Denno, 2003).

Each delivery was associated with postpartum depression (Court TV, 2002; Omalley, 2003). Jogging and swimming ceased after the first two pregnancies. With subsequent deliveries she became more depressed and isolated (O'Malley, 2003) Mood states of high energy and a hypereligious focus on Satan and religious doctrine switched to psychosis, suicide attempts and psychiatric hospitalizations.

After hospital discharge, a catatonic, psychotic Andrea Yates appeared to her friends and family like a ''caged animal'' staring for hours and scratching bald spots into her head (Court TV, 2002). Unfortunately, discussions about Satan's presence were not uncommon in the Yates' home where a rigid religious belief system dominated the family's life (Spinelli, 2004).

Hospital discharges were premature because of insurance limitations (Yardley, 2001). The psychotic mother of 5 children was discharged to home without family intervention (Denno, 2003).

Professional perinatal support and education are glaringly absent from the repertoire of psychiatric services in the United States. The dearth of educational material available to nurses, social workers, psychologists and psychiatrists leave them unprepared for the distinct presentation of postpartum psychosis. This was further evidenced when the treating psychiatrist discontinued Andrea Yates from her antipsychotic medication (Spinelli, 2002). These factors speak to poor medical management and overall failure of the system. The final word of the legal system to determine her culpability using archaic laws and values was the ultimate failure of humanity. The question to ask ourselves is our cultural norm is so different from another culture's pathology?

The lack of perinatal psychiatric services emphasize the dearth of preventive measure in place for new mothers. In contrast the UK, Canada, Australia and most European countries maintain a psychiatric presence in the antenatal clinics, provide postpartum home visits by midwives and offer mother-baby units to address the needs of mothers and families at this most vulnerable time in their lives. Any one of these services would likely have afforded the necessary protection for the Yates' children.

We, as a society share responsibility for the tragedy. Friends, neighbors and family failed to see or report as Mrs. Yates continued to decompensate. The medical community failed to provide appropriate protection, social work assistance and child services to a severely psychotic mother of five children. When the legal community and her state failed to appreciate the severity of her illness, they eliminated her last opportunity for appropriate treatment (Spinelli, 2004).

After 80 years of using probation and treatment in lieu of incarceration, the British legal system has demonstrated that this method is as effective at preventing or deterring infanticide as is incarceration, while being considerably more efficient and cost-effective (Marks, 2002; Oberman, 1996).

The question then to ask ourselves is what we seek to gain by this punishment and how can we prevent these needless tragedies in the future?

The fact that the insanity defense is non-existent in some states and extremely limited in others speaks to our disregard for mental illness and the rights of those who suffer. The task for the psychiatric community is certain. Until we treat mental illness with the same dignity afforded to other illnesses, the course will remain unchanged.

Conclusion

The potential benefit of a formal diagnosis for postpartum illness in the US is greater awareness, education and greater likelihood of early identification and treatment. In other countries, motherhood is further challenged by the seemingly inconsistent, even incoherent way in which societies respond to infanticide. The fact that infanticide laws are nonexistent in the US; that social and cultural imperatives facilitate infanticide in one society and punishes it in another speaks to the world-

wide discrimination of women. The question to ask is our cultural norm so different from another culture's pathology?

We, as a world society could do a far better job of protecting mothers and children.

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