MOTHERS WHO KILL THEIR CHILDREN
A literature review

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Abstract

Maternal filicide, the murder of a child by its mother, is a complex phenomenon with various causes and characteristics. Research, by means of the development of several classification systems and in identifying particular risk factors, has been conducted with the aim of better prevention of this emotionally evocative crime. Various disciplines have offered a wide range of perspectives on why women kill their biological children. These are intended to yield a better understanding of the aetiology of this crime. This literature review delineates three dominant perspectives: psychiatric, psychological, and sociological. The main findings of each perspective are discussed. However, these three perspectives frequently operate in conjunction with each other in that both intrapsychic and interpersonal dynamics play a role in acts of maternal filicide. The most vulnerable women appear to be those who have had a severely deficient developmental history (trauma and/or grossly inadequate parenting), those who experience current difficult psychosocial circumstances, and those who have been diagnosed with a psychiatric illness. However, not all women who experience such problems kill their children. In this regard, individual differences have an important role to play and more carefully delineated future research is suggested. One of the most significant findings of this literature review is that there appears to be a paucity of systematic research on the South African phenomenon of parental child homicide.

Keywords and phrases: neonaticide, infanticide, filicide, maternal child homicide, psychiatric, psychological, sociological, psychodynamic

Opsomming

Moedermoord, die moord van ’n kind deur sy of haar moeder, is ’n komplekse verskynsel met verskeie oorsake en karaktereienskappe. Navorsing deur die ontwikkeling van verskeie klassifikasiestelsels en die identifisering van spesifieke risikofaktore is uitgevoer met die doel om hierdie misdaad, wat soveel emosies ontlok, beter te voorkom. Verskeie dissiplines bied ’n wye verskeidenheid perspektiewe oor die redes waarom vroue hul biologiese kinders vermoor. Die doel van hierdie perspektiewe is om ’n beter etiologiese begrip van hierdie vorm van misdaad te verkry. Die literatuurstudie dui drie dominante perspektiewe aan: psigiatries, psigologies en sosiologies. Die hoofbevindinge van elke perspektief word bespreek. Hierdie drie perspektiewe werk dikwels saam aangesien sowel intrapsigiese en interpersoonlike dinamiek ’n rol in moedermoorddade speel. Die kwesbaarste vroue blyk dié te wees met ’n ernstig gebrekkige ontwikkelingsgeskiedenis (trauma en/of ernstig onvoldoende ouerskap), diegene wat hulle in moeilike psigososiale omstandighede bevind, en dié wat met ’n psigiatriese siekte gediagnoseer is. Nie alle vroue wat hierdie probleme ervaar, vermoor egter hulle kinders nie. In hierdie opsig speel individuele verskille ’n belangrike rol en word versigtig afgebakende toekomstige navorsing voorgestel. Een van die belangrikste bevindinge van hierdie literatuuroorsig is dat daar ’n gebrek aan sistematiese navorsing oor die Suid-Afrikaanse verskynsel van kindermoord deur ouers blyk te wees.

Sleutelwoorde en -frases: neonatale moord, kindermoord, moedermoord, kindermoord deur moeder, psigiatries, psigologies, sosiologies, psigodinamies

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1. Introduction

The act of killing another human being, arguably, is considered to be the most violent of all crime. Murder committed by women is frequently considered to be the pinnacle of criminality, and the murder of a child by its mother is perceived as almost unthinkable (Meyer et al., 2001; Worrall, 1990). Reasons for this include a general denial of female aggression and the discourse of idealised motherhood (Morrissey, 2003; Motz, 2001; Worrall, 1990). When women fail to live up to idealised expectations, especially those of motherhood and stereotypical femininity, they are denigrated as either 'mad' or 'bad' (Frigon, 1995; Meyer et al., 2001). Violent women are constructed within particular discourses of domesticity, sexuality and pathology, and these cultural stereotypes about women's violence have serious implications regarding the experiences of women when in the criminal justice system and with regard to social policy (Gilbert, 2002).

One step towards understanding women who kill is to consider who their victims are. Women commit intragender homicide just as men do. In other words, women kill other women who are either known or not known to them (Mann, 1996). However, the most prevalent type of female homicide is towards key attachment figures, specifically, partners, spouses and/or children with the murder/s taking place within the family home (Lyman et al., 2003; Mann, 1996; Motz, 2001; Oberman, 2003a; Scott & Davies, 2002). Thus, it appears that women's homicide occurs mostly in a relational context. In addition, there appears to be an inverse relationship between the level of relational intimacy (as defined by the relationship between the victim and offender) and degree of violence used to fatally injure an infant victim. That is, mothers were more likely to kill their infants via passive forms such as asphyxiation or abandonment, in contrast to fathers, stepfathers, or boyfriends who would use more violent methods. This seems to support the notion that maternal child homicide is a distinct

phenomenon in comparison to more general female crime (Schwartz & Isser, 2000; Smithey, 1998).

A woman's violent act needs to be understood within the holistic context of her life. White and Kowalski (1994) indicate that when taking this holistic view, "the problem of female aggression is located within interpersonal and institutionalized patterns of a patriarchal society" (p.502) as opposed to purely intrapersonal attributions. Sometimes women do carefully plan to kill, but mostly,

> …women did not plan the act, it happened – it was a combination of circumstances, of situation, it involved a life crisis, depression, alcohol and drugs misuse, physical or sexual abuse – in almost all cases it was a very *complex situation* and chain of events. (Shaw, 1995, p.122)

According to Kruger (2006), ideologies on motherhood appear to include the following characteristics:

- the claim of the universality of the motherhood experience
- that differences of race, class, ethnicity, religion, sexuality are obscured
- the hidden dimension of power such as the medical establishment, the mother, the child, the developmental psychologists, the state, the middle class.

For many women, motherhood is an experience that is deeply fulfilling and enriching. For others, however, it appears to be a difficult path of ambivalence of reward and meaning on the one hand, and on the other, a painful struggle. For another group of women, it seems to be overwhelming, disappointing, and intolerable. This is the dark side of motherhood – the side that does not have a voice in mainstream society. Motz (2001) refers to this as the "perverted"

(p.25), lesser-known aspect of motherhood with its acts of denial of pregnancy, neonaticide, infanticide, and filicide.

Parental child killing is not a new phenomenon. In some societies (ancient and contemporary), the killing of an infant shortly after birth was/is either explicitly or implicitly sanctioned depending on circumstances. The anthropologist, Susan Scrimshaw's (1984) study of infanticide in human populations observed that parental child homicide is enacted in a variety of ways across different human societies and includes "behavior ranging from deliberate to unconscious which is likely to lead to the death of a dependent, young member of the species" (p. 442). Just as parental child homicide has been carried out in different ways, so have societal attitudes towards it varied, as is indicated by the variety of legal statutes and penalties in contemporary cultures (Oberman, 1996). Historical and legal perspectives of these differences are beyond the scope of this paper but provide an interesting account of how parental child homicide is located in time and culture.

More recently, some cultural practices and attitudes towards unmarried mothers and 'illegitimate' children have begun to change. In addition, economic development and innovations in technology and medicine have facilitated communities that can provide more nurturing environments for families as well as choice with regard to family planning (Swartz & Isser, 2000). Despite these technological and economic advances, religious convictions, social disapproval of teenage pregnancy, and the powerful institution of marriage continue to play a role in the phenomenon of parental child killing (Macleod, 2006; Swartz & Isser, 2000).

Although the murder of a child by its mother is relatively infrequent in developed societies, it is a profoundly disturbing event with serious ramifications such as the incarceration of the

mother, leaving behind devastated families and possibly other children. Statistics obtained by Hatters Friedman, McCue Horwitz and Resnick (2005) from the 1994 reports of the Centres for Disease Control and Prevention, indicated that 30% of children under the age of 5 years in the United States have been killed by their mothers during the last quarter of the 20th century. In addition, homicide of children less than one year old seemed to be on the increase. The United States, in comparison to other developed countries, has the highest rate of child homicide: 8.0/100,000 for infants, 2.5/100,000 for children aged 1-4 years, and 1.5/10,000 for children aged 5-14 years. Canada, on the other hand, reported infant homicide rates that were less than half of that for the United States: 2.9/100,000. Official figures obtained during 1990-1996 in Britain estimated infant homicide to be between 30-45 cases per year with neonaticide accounting for 20 – 25% of discovered deaths (Marks, 1996). It seems that the efforts by mothers to keep their homicides concealed make it a difficult phenomenon to subject to scientific study (Putkonen, Weizmann-Henelius, Collander, Santtile, & Eroene, 2007), thus it is difficult to establish true prevalence.

Considering South Africa's violent context and the negative impact of homicide on families and society, research about women who kill seems important. Despite this, very little empirical research on homicidal women in general within the South African context has been undertaken, and almost nothing seems to exist specifically on maternal child homicide. Statistics for the period 1 January 2003 to 31 March 2007 show that 675 women were sentenced for murder in South Africa. Although it was reported that some of those women had been convicted for killing their children, statistics were not available with regard to the scale of this crime in South Africa (C. Gerber of the South African Police Service, personal communication, April 19, 2007, and July 8, 2008).

As mentioned, despite an incarcerated and clinical population of South African women who have killed their children, almost no contemporary research on this phenomenon was found in the various databases. Key informants of relevant institutions were contacted to ascertain whether they had knowledge of research that may have been conducted on this issue. They confirmed that almost no such research had been undertaken on parental child homicide in South Africa (A. Dawes of the Human Sciences Research Council, Cape Town, personal communication, July 7, 2008; A. Berg of Cape Town Infant Mental Health, Red Cross Children's Hospital, personal communication, July 9, 2008; J. van Niekerk of Childline, personal communication, July 7, 2008; M. Briede of Child Welfare SA, personal communication, August 12, 2008; S van As of Red Cross Children's Hospital, personal communication, July 8, 2008). During the searches of the databases, only one study specifically on child homicide that focused on infanticide within the colonial context during the 1800s (Scully, 1996), and one case study of attempted maternal child homicide in South Africa were found (Berg, 2003). The latter study raised important issues with regard to the role of the African worldview in understanding this specific case. The researcher (and treating psychiatrist) believed that the mother was failed by the application of Western assumptions of mother-infant attachment, and that insufficient attention was paid to her personal context within her community (Berg, 2003).

Due to the dearth of research on South African women who have killed their children, a search of South African newspapers for the period 2000 – 2008 was undertaken and 22 reports of child homicide were found (see Table 1) in which the biological mother was the perpetrator of the crime[1]. The types of child homicide included neonaticide, infanticide, filicide, and in

[1] The search was conducted using the SA Media database that comprises a limited number of publications. Thus, more reports in other newspapers may have been available that were not captured by this particular database.

several cases, the mother attempted to commit suicide after the homicide. Reasons cited included recent dissolution of the marriage/relationship, altruism (i.e. for the benefit of the child), 'accidental' filicide within the context of child abuse, and partner-assisted filicide within in the context of domestic violence. In many instances, it appeared that the mother was lacking appropriate support structures, and was struggling with single parenthood in particularly difficult circumstances. However, the newspaper reports mostly did not comment on other important factors such as the prevalence of psychiatric/psychological disorders (perhaps due to the confidential nature of such records).

Table 1
Summary of South African Newspaper Articles from 2000 – 2008 on Maternal Child Homicide

Publication	Date published	Author	Headline	Type of homicide	Reason cited
Beeld	13.01.2000	Du Preez, L.	Jong ma se vonnis uitgestel	Attempted filicide-suicide	Break up of marriage and single parenthood
Sowetan	04.04.2000	Sefara, M.	Woman accused of murdering tots	Filicide[2] followed by attempted suicide	Husband's infidelity
Sowetan	02.05.2000	Chuenyane, G	Shepherd finds baby corpse	Infanticide[3]	Absent father
Die Volksblad	04.10.2000	de Klerk, N.	Pasgebore baba met snuif gesmeer en weggegooi	Attempted Neonaticide[4]	No reason given
Cape Argus	08.06.2000	Ellis, E.	Mum accused of strangling her 5-year old son	Accidental Child Abuse	Diminished responsibility

[2] The term 'filicide' refers to a murder in which the victim was more than one year old
[3] The term 'infanticide' refers to a murder in which the victim was more than one day old, but less than one year
[4] The term 'neonaticide' refers to a murder in which the victim was a newborn infant not yet 24 hours old

Publication	Date published	Author	Headline	Type of homicide	Reason cited
The Star	29.11.2000	Otto, H.	Mother guilty of killing her baby with rat poison	Infanticide	Altruistic
Pretoria News	02.02.2001	Otto, H.	Mother accused of trying twice to kill her baby	Infanticide	Context of fatal child abuse
Natal Witness	16.06.2001	No author	'Disturbed' mum sentenced	Infanticide	Postnatal depression
Beeld	30.07.2001	No author	Vrou kap glo baba se kop af	Neonaticide	No reason given
Burger	06.07.2002	Philander, R.	Ma ook aangekeer ná baba se dood	Infanticide	Partner assisted; Domestic violence context
Volksblad	10.07.2002	van Wyk, M.	Jong ma in hof ná baba se dood	Infanticide	Fatal child abuse
Citizen	11.03.2003	Momberg, E.	'Aborted' baby: two appear	Attempted neonaticide	No reason given
Daily News	12.03.2003	Oellermann, I.	Baby killer is set free	Neonaticide	Difficult psycho-social circumstances
Beeld	13.11.2003	du Preez	Vrou wat baba glo by venster uitgooi in hof	Neonaticide	No reason given
Star	26.03.2004	Maphumulo, S.	Baby's decomposed corpse found in drain	Infanticide	No reason given

Publication	Date published	Author	Headline	Type of homicide	Reason cited
Beeld	05.07.2005	Snyders, K.	Vroeggebore baba dood in asblik by Emmarentia-huis gekry	Neonaticide	No reason given
Beeld	10.03.2005	Templelhoff, E.	Seun kry baie slae ‘omdat by ‘n man is’, hoor hof	Filicide	Fatal child abuse
Pretoria News	29.03.2006	No author	Alleged child killer my lose her baby	Filicide	Partner assisted; Domestic violence context
Rapport	02.09.2007	van Heerden, D.	2 lykies op ‘n bed	Filicide followed by attempted suicide	Break-up of marriage and single parenthood
Daily News	06.10.2007	Kuppan, I.	Court hears of boy’s brutal death	Filicide	No reason given
Sowetan	08.01.2008	Makhafola, G.	Mom who buried kid alive might have done it before	Infanticide	No reason given
Witness	22.01.2008	Oellermann, I.	Killer mom gets five years	Filicide	Difficult psychosocial circumstances; Recent diagnosis of HIV positive

Publication	Date published	Author	Headline	Type of homicide	Reason cited
Beeld	12.04.2008	Otto, A.	Ma, kêrel vas ná baba glo onder hoop klere versmoor	Infanticide	Partner assisted (lover, not husband)
Pretoria News	26.04.2008	Venter, Z.	Mom gets 7 years in jail for killing sons	Filicide	Difficult psychosocial circumstances; Unstable marriage
Witness	26.06.2008	Magubane, T.	Mom charged with baby's death	Neonaticide	Difficult psychosocial circumstances in substance abuse context
Pretoria News	07.08.2008	Otto, H.	Dead babies: plea bargain	Neonaticide	No reason given
Daily Dispatch	08.08.2008	Booi, M & Ngcukana, L.	Humiliated mom poisons her four kids	Filicide-suicide	Believed she was HIV positive
Sowetan	22.08.2008	Dlamini, P.	As memory candle burned for her dead son, Zandile stabbed baby girl to death	Infanticide	Difficult psychosocial circumstances; Absent father
Sowetan	04.09.2008	Seleka, N.	Mother in court for kids' murder	Infanticide	Difficult psychosocial circumstances
Beeld	17.09.2008	van Buul, S.	Ma kry 8 j. oor babmoord	Infanticide	Fatal child abuse
The Argus	17.10.2008	van der Fort, F.	Support for mom accused of killing son	Filicide	No reason given.

A recent newspaper article (Sopoko, 2008) reported an initiative in Cape Town in which a safe drop-off point for unwanted babies has been created. This initiative was started after several dead babies had been found in a nearby drain, but very little is known about the circumstances of these deaths. Although the scope of maternal homicide in South Africa is unknown due to the different classification systems and the lack of reporting, the results of the SA Media database suggest that there has been a marked increase in 2008 when compared to previous years.

International research suggests that the rate of child homicide is underestimated in epidemiological studies of child death (Hatters Friedman et al., 2005; Overpeck et al., 1999; Putkonen et al., 2007; Wilczynski, 1997; World Health Organization, 2006). Currently, statistics in South Africa are gathered according to category of crime only, for example, murder, or according to particular demographic information. There is no breakdown of offender-to-victim relationship. Thus, given the absence of statistics on women who kill their children (C. Gerber of the South African Police Service, personal communication, April 19, 2007, and July 8, 2008; M. van Eeden of Department of Correctional Services, personal communication, August 6, 2008), and the dearth of local literature on the subject, the scale of the South African phenomenon remains an area to be researched. The lack of knowledge on maternal child homicide is especially problematic with regard to offender rehabilitation programmes, as these are not tailored to specific perpetrator groups (M. van Eeden of Department of Correctional Services, personal communication, August 6, 2008). For example, an incarcerated woman with no previous criminal record who murders her biological child may require a different kind of rehabilitation intervention to a woman with a considerable history of general crime, or one who killed her partner within the context of long-standing abuse. The lack of information in South Africa on local epidemiology and the contextual

factors surrounding women who kill their children means that this phenomenon cannot be effectively and appropriately addressed.

International literature shows that children from all social classes are at risk to be murdered by their parents. Mothers are most often perpetrators in the deaths of younger children and fathers are more likely to kill older children (Palermo, 2002). It is the homicidal act of a mother against her biological child/children that is the focus of this paper.

1.1 Purpose of the study

The purpose of this literature review is to explore some of the dominant explanations as to why mothers kill their children. It is only by submitting this phenomenon to rigorous scrutiny that appropriate preventative measures and rehabilitative options can be considered. Although different disciplines conceptualise and understand mothers who kill in different ways, this literature review specifically focuses on three particular perspectives. These include those explanations that concentrate predominantly on intrapsychic factors (psychiatric and psychological), and those that explain maternal child/infant killing from a primarily social perspective in which external stressors are emphasised (sociological).

1.2 Aim of the study

The aim of this literature review is to obtain a clearer understanding of the nature and the meaning of maternal infant/child homicide by way of a review of existing studies in this field, with particular reference to sociological, psychiatric and psychological perspectives. This is undertaken, firstly, by a review of existing classification systems of child homicide and the associated risk factors contributing to child homicide and is

followed by the three selected perspectives that help explain maternal child homicide. This review of the international literature may provide appropriate directions for future research in the South African context that, in turn, could inform prevention and intervention strategies.

1.3 Methodology

An exhaustive literature review was beyond the scope of this particular project; that is, not all possible perspectives explaining maternal child killing are included. As this project forms part of an applied degree in Clinical psychology and Community counselling, the focus is primarily on psychiatric, psychological and sociological explanations. According to Mouton (2001), a good literature review could be organised in a number of ways. This review is organised according to particular schools of thought, theory and/or definition, namely, psychiatric and psychological explanations that constitute predominantly intrapsychic explanations; and the significant role of external stressors and contextual factors constitute the sociological explanations.

Literature was obtained from both international and national databases. International databases consulted included Academic Search Premier, PsychINFO, Proquest Social Science Journals, ScienceDirect and Medline. PsychINFO is a global database comprising citations and summaries of books, journal articles, technical reports and international dissertations. Academic Search Premier, ScienceDirect and Medline offer abstracts and full-text articles from scientific, technical, medical and social sciences journals. Proquest yielded full-text periodicals covering the social sciences. South African databases consulted via Sabinet Online were SA ePublications, SA Media, SACat, and ISAP. SACat, ISAP, and SA ePublications offer access to electronic

journals and books, and SA Media yielded newspaper reports on the South African incidence of parental child homicide. Nexus, the South African database for current and completed research was also consulted. A total of 131 sources were reviewed in depth, although a somewhat higher number of journal articles and other sources were initially consulted. The search was limited to material published from 1970 onwards, although seminal work published before that time, where relevant, was included.

Only peer-reviewed books and journal articles from the disciplines of criminology, psychiatry, psychology, and sociology were included. Keywords and phrases used during the searches included ‘women who kill’, ‘theories on violent women’, ‘homicidal women’, ‘murder and women’, ‘mothers who kill their children’, ‘maternal child homicide’, ‘infanticide’, ‘neonaticide’ and ‘filicide’, and ‘fatal child abuse’.

Empirical studies and theoretical sources formed the basis of the information gathered for this review. Studies reviewed were based on a variety of samples such as psychiatric and correctional services populations. In addition, case studies were included as well as studies that used tertiary data such as general population studies of coroners’ files, media reports on child homicide incidents, national database statistics, and newspaper accounts of maternal child homicide. Because of the different methodologies of these studies, some results appear contradictory. For instance, a forensic sample from a psychiatric unit is likely to show a high incidence of mental illness, whereas a study of filicide within a prison sample is more inclined to show a high incidence of fatal child abuse (Bourget, Grace, & Whitehurst, 2007). This is an example of the difficulty encountered in trying to simplify as complex a phenomenon as maternal child homicide.

1.4 Parameters and limitations

As mentioned, this literature review is limited to a discussion of psychiatric, psychological and sociological perspectives on maternal child homicide. More specifically, this study was restricted to biological mothers who have killed their children after having given birth to them. Also, the literature reviewed is of modern societies as opposed to ancient anthropological and/or ethnographic accounts in which infant and child killing might have been socially sanctioned. A general review of theories of aggression has not been undertaken for this review. Such theories are only discussed when they were specifically applied to maternal child homicide. From a critical perspective, the variables of race and gender in relation to maternal child homicide were also regarded as important. However, due to space limitations, that correlation has not explicitly been explored in this paper. The literature reviewed was also limited to material published in English only, except for South African newspaper articles that included a search for Afrikaans reports. In addition, literature obtained was mostly restricted to what was readily available in South Africa. It was necessary to purchase a limited number of papers from abroad, but due to financial constraints, it was not possible to obtain all that was available. Literature from various non-governmental agencies was not included as only peer reviewed journal articles and books were included. However, where relevant, information was obtained via personal communication with key individuals from such non-governmental agencies, specifically Childline and Child Welfare SA.

1.5 Definitions

Violence is defined in many ways. It can be seen as “a loss of control of aggressive impulse leading to action” (Shengold, p.xii, 1999, cited in Motz, 2001, p.2). Implicit in

this definition of violence is the act of causing physical harm. The international literature reviewed for this project refers interchangeably to the terms *homicide* and *murder*, although each has specific legal parameters.

The terms *neonaticide, infanticide,* and *filicide* are all definitions of particular kinds of child homicide. However, they have been used interchangeably in some of the literature (Bourget et al., 2007). In some studies, *filicide* is a generic term referring to the murder of a child by its biological or stepparent, no matter what its age. Some definitions have particular medico-legal implications, such as that of *infanticide,* which applies primarily to the killing of a child within its first year of life by its mother. Some countries have specific laws regarding child killing within the first year of life such as the Infanticide Act of 1922 in the United Kingdom. However, in New Zealand, infanticide is regarded as the killing of a child up to the age of 10 years. Thus, different societies understand child killing in different ways (Oberman, 1996). It is generally accepted that different factors come into play according to the age of the victim (Bourget et al., 2007; Hatters Friedman et al., 2005; Pitt & Bale, 1995; Resnick, 1969, 1970; Silverman & Kennedy, 1998). For the sake of clarity and consistency, the following definitions according to the age of the child victim are used in this literature review unless otherwise stated:

"Neonaticide" is the killing of a newborn baby within the first 24 hours of life (Resnick, 1969, 1970).

"Infanticide" is the murder of a child by its mother during its first year of life because she is suffering from the effects of pregnancy or lactation (Cameron, 1987).

"Filicide" is the killing of a child who is older than 24 hours by either of or both of its parents or foster-parents (Cameron, 1987; Motz, 2001; Resnick, 1969). Thus there is

some overlap between infanticide and filicide in that filicide can also occur during the first year of the infant's life, however, in these instances postpartum disorders are *not* a feature.

For the purpose of this paper, these definitions will refer specifically to maternal child killing only, unless otherwise stated. The general reference of 'maternal child homicide' will be used when the general phenomenon of mothers who kill their biological children is discussed; that is, when the emphasis is on the *mothers* as opposed to the age of the victim at the time of death.

These categories of child killing are specifically relevant to this research investigation as they are all instances of homicide in a relational context. In order to come to some kind of understanding as to the causes, kinds of perpetrators, and to contribute to appropriate preventative strategies in this particularly tragic phenomenon, various researchers have attempted to classify the different kinds of child homicide and have outlined what they maintain to be the associated risk factors (Pitt & Bale, 1995).

2. Classification Systems

The earliest studies on maternal child homicide were case reviews of incarcerated women, and women in psychiatric institutions (Resnick, 1969; 1970). These studies were problematic as they contained poorly defined samples and outdated classification systems. It was towards the latter part of the last century that a more scientific approach to this field of research was undertaken. No single classification system is likely to do justice to the complex phenomenon of child homicide, and each system has its strengths as well as its shortcomings.

In their efforts to expose reasons for parental child homicide, several authors have proposed classification systems that sort cases into various categories based primarily on the motive for the murder. Resnick (1969) was one of the first investigators of the modern era (20th century) into the phenomenon of parental child homicide. Based on a review of 131 cases of child homicide from a variety of sources such as psychiatric hospitals, psychiatrists in practice, prison psychiatrists, and a coroner's office, Resnick (1969) devised a new classification system centred on motive. Resnick's definition of 'Filicide' in this classification system was more general, that is, it included children (as well as neonates and infants) of all ages, and his 1969 study covered paternal as well as maternal child homicide. Resnick's categories included motives based on altruism, unwanted children, acute psychosis, accidental, and spousal revenge. The hallmark of 'altruistic' filicide is the desire of the parent to relieve the real or imagined suffering of the child, and this category often includes homicide followed by suicide. The category of unwanted child is associated with children who were never wanted or are no longer desired by their parents. Acutely psychotic filicide occurs when the parent kills within the context of a psychiatric disturbance. Accidental filicide usually occurs within the context of child abuse, and spousal revenge takes place when the parent kills the child in order to retaliate against the spouse.

Criticism of Resnick's system included concerns that classification by motive was too subjective. Most often, police or forensic psychiatrists obtained motive during the initial reporting stage, and the offender was likely to be defensive and focused on presenting a favourable account in view of a future legal process. In addition, Resnick's sample was not considered to be representative of the general population and was thus limited in its explanations (Meyer et al., 2001; Scott, 1973; Stanton & Simpson, 2002).

Subsequent classification systems proposed by Scott (1973) and d'Orban (1979) categorised parents who killed their children according to the source of the impulse (parent, child, or situation). d'Orban's (1979) model, a modification of Scott's (1973) system, included the categories of battering mothers, unwanted children, altruistic homicide, and mentally ill mothers. The latter category includes all child homicides committed in the context of psychosis or depression. Unwanted children are killed either by active aggression, or through passive neglect. Finally, altruistic homicide or mercy killing is that in which there was genuine suffering in the child without any secondary gain by the parent.

An interesting factor that emerged from d'Orban's study (1979) was that only 2 of the 89 women in his sample had a history of prior violence; both were convicted child abusers. Most cases (40%) were in the 'Battering mothers' category, and 27% were in the 'Mentally Ill mothers' category. In contrast, Resnick's (1969) study found that only 6% of women had killed as an outcome of battering, and 21% were acutely psychotic. The latter statistic could be regarded as misleading as he also included psychotic women in his 'altruistic' category. Thus, psychosis is likely to have featured in even more of his cases. Resnick's (1969) highest category of child homicide was that of 'altruistic associated with suicide' (42%), of which depression was a major factor, lending further credence to the role of psychiatric disorder in this phenomenon.

Cheung (1986) tested d'Orban's system with a sample of 35 women charged with the homicide or attempted homicide of their children in Hong Kong over a 14-year period. Both Cheung and d'Orban's results (as cited by Stanton & Simpson, 2002, p.5.) are presented below.

Table 2

Frequency of Categories of Maternal Filicide (after d'Orban, 1979, and Cheung, 1986)

Categories	d'Orban		Cheung	
	N	%	N	%
Battering mothers	36	40.4	11	31.4
Mentally ill	24	27	14	40
Neonaticide	11	12.4	6	17.1
Retaliatory	9	10.1	3	8.6
Unwanted	8	9	1	2.9
Mercy killing	1	1.1	0	0

Both of these studies are regarded as scientific as they had probable population samples across two very different cultural groups yielding similar results. Three broad groups of maternal child homicide stand out: neonaticide, battering mothers, and mothers with diagnosed psychiatric disorders. In both studies, the neonaticidal group was distinguished by several particular factors: the women were young, most were unmarried, and there was a low prevalence of psychiatric illness, but significant psychosocial stressors. These findings were similar to Resnick's (1970) study of neonatcidal women. Both Cheung (1986) and d'Orban's (1979) studies revealed that battering mothers suffered the highest rates of psychosocial stress.

The mentally ill mothers were the oldest age group, they were usually married with the least marital stress, tended to attack older children, and frequently had multiple victims. The retaliatory groups tended to have 'unstable' personalities illustrated by high marital stress, and frequent suicide attempts. With regard to the 'Unwanted children' category, Cheung (1986) recorded only one case, while d'Orban (1979) recorded 8 cases. d'Orban divided these cases into two groups of four: a younger group of women who killed by neglect, and an older group

who killed by an active act of aggression. Pure mercy killing was almost non-existent and those who were most at risk were children less than six months old.

Bourget and Bradford's empirical study on homicidal parents concluded that despite existing classifications of child homicide, key inconsistencies remained. Therefore, they formulated a system that took into account various motives as well as the clinical situation in order to allow for greater focus with regard to the aetiology of any given child homicide. Their definition of 'filicide' includes children of all ages, with the exception of neonaticide, which is of newborn babies up to 24 hours old. Bourget and Bradford (1990) included five major categories: pathological filicide (including extended homicide-suicide), accidental filicide, retaliating filicide, neonaticide, and paternal filicide. In this model, pathological filicide designates major psychiatric illness as a primary factor in the perpetrator. Accidental filicide includes battered children and other kinds of 'accidents' such as those arising from Factitious Disorder by Proxy (or Munchausen's Syndrome by Proxy)[5]. Retaliating filicide (similar to prior models) occurs when an angry spouse kills the child/children for revenge, while neonaticide is usually as a result of an unwanted pregnancy. Bourget and Bradford (1990) were the first to include paternal filicide as a separate category worthy of investigation.

Guileyardo, Prahlow and Barnard (1999) motivated for a more detailed system in order to assist with more difficult child homicide cases that could not be explained according to existing systems. They proposed that filicide be categorised according to 16 subtypes based on selection of the primary motive or cause. In addition, they criticised previous classification

[5] Factitious Disorder by Proxy is classified as a Factitious Disorder Not Otherwise Specified in the DSM-IV TR. Factitious Disorder by Proxy is the intentional production or feigning of physical or psychological signs or symptoms in another person e.g. a child, who is under the mother's care for the purpose of her indirectly assuming the sick role (APA, 1994).

systems on account of too narrow a perspective, specifically, a psychiatric perspective. They maintained that their experience as medical examiners warranted a more detailed classification system based on the wider variety of case types than those seen traditionally by psychiatrists, although some overlap is present. Although a more detailed classification could be considered as helpful specifically for medical examiners, Guileyardo et al. (1999) did not specify how many of each subtype they encountered. Thus, there is a query over limited case evidence to support some of these subtypes. However, these researchers highlighted the difficulty in classifying parental child homicide because of the many factors and dimensions inherent in this crime.

Bourget and Gagné (2002) published a more recently modified classification system based on a sample of 34 women convicted of killing their children in Québec, Canada. This retrospective clinical study used information obtained from coroners' files from 1991 – 1998. New research on the role of the serotonergic system in impulsivity, suicidality, and aggression was incorporated in this study. The results prompted a revision of the Bourget and Bradford (1990) classification system. Bourget and Gagné (2002) argued that their revised system highlighted the role of neurotransmitter activity in both suicidality and homicidality of all types, and they stressed the importance that a clear identification of any psychiatric diagnosis should be made. Considering that their sample demonstrated a high incidence of psychiatric disorder (85%), it is not surprising that they regarded psychiatric illness as important in classifying the type of child homicide.

Bourget and Gagné (2002) suggested that filicide (children of any age) should be classified according to type of filicide, and also to state whether or not the intention to kill was present. As per their study in 1990, they included five groups of filicide: mentally ill, fatal abuse,

retaliating, mercy, and other/unknown filicide. In the mentally ill category, the homicidal act is associated with a major Axis I disorder which is active at the time of the killing, and it can be specified as either with intention to kill or not. Infanticide can only be used with regard to mothers who have committed homicide due to postpartum phenomena such as hormonal changes due to recent childbirth and the category should only be applied when the act of homicide is not better accounted for by any other category as illustrated below.

Table 3

Bourget and Gagné (2002) classification system for filicide

Classification (type of filicide)	Description	Intent	Mental Illness
Mentally ill	Axis I diagnosis present; psychotic or nonpsychotic; infanticide	Present or not present	Yes
Fatal abuse	Recurrent or isolated event of neglect or shaken baby or battered child syndrome	Not present	No
Retaliating	Associated with revenge and anger	Present	No
Mercy	Child ill with severe or debilitating illness; not better accounted for by any other category	Present	No
Other or unknown specifiers:	Insufficient information; may include cases with multiple factors	Present or not present	Yes/No
Group A	Associated with suicide or not associated with suicide		
Group B	Associated with substances or not associated with substances		
Group C	Predictable or not predictable		

Fatal child abuse is committed without specific intention to kill, and can be the outcome of recurrent abuse or of an isolated occurrence. To apply the classification of fatal child abuse, the perpetrator cannot meet the criteria for a mentally ill filicide. In contrast, retaliating filicide *is* associated with intent to kill in the context of revenge or anger. Parents with serious

personality disorders and chaotic intimate relationships most often commit this kind of filicide as outlined below.

Table 4

Intent and Mental Illness in Filicide

	No Intent	Intent
Mentally ill	Mentally ill filicide: psychotic/nonpsychotic infanticide	Mentally ill filicide: psychotic/nonpsychotic infanticide
Not mentally ill	Fatal abuse filicide: recurrent/ isolated	Retaliating filicide; mercy filicide

Mercy filicide is also associated with intention to kill, but the emphasis is different. In this instance, the intent to kill is due to the child suffering a debilitating illness. The parent has no perceptual and/or thought disturbances. Bourget and Gagné's (2002) contribution with regard to the role of neurotransmitters in parental child homicide is important, but other than that, they do not contribute anything different from prior classification systems.

Meyer and colleagues (2001) and later extended by Oberman (2003a), developed a typology of mothers who kill their children based on an empirical study that they conducted using tertiary data on 76 cases. This typology classifies maternal child homicide into five broad categories: neonaticide, fatal child neglect (unintentional killings when the mother is inattentive to the child's needs), abuse-related filicide (women who kill their children 'accidentally' during an episode of violent abuse), assisted or coerced maternal abuse (mothers who kill their children in conjunction with their male partners within the broader context of domestic violence and child abuse), and finally, purposeful maternal filicide. The latter category is distinct from others in that these women deliberately set out to kill their children and is characterised by a considerable prevalence of mental illness in combination with social isolation. There is much overlap between these categories and the other classification systems

already discussed. The exception is the ‘assisted or coerced maternal abuse’ category, which is an addition to other classification systems.

In summary, various researchers have attempted to classify child homicide. Broadly, the three most common categories of maternal child homicide perpetrators are mentally ill mothers, battering mothers, and neonaticidal mothers (Bourget et al., 2007; Hatters Friedman et al., 2005; Pitt & Bale, 1995; Simpson & Stanton, 2002). Using the above classification systems as a basis and with prevention in mind, several studies have been conducted to assess which mothers are most at risk for killing their children.

3. Associated Risk Factors

Research indicates that the one of the highest categories of maternal child homicide is that of neonaticide, namely, the killing of an infant within the first 24 hours of its birth (Craig, 2004; d’Orban, 1979; Marks, 1996; Resnick, 1969). Thus, the child’s age is considered to be a significant risk factor. Single, young mothers (under the age of 20) who experience challenging psychosocial circumstances, including dysfunctional families and economic deprivation perpetrate most neonaticide (Cheung, 1986; Crittenden & Craig, 1990; d’Orban, 1979; Haapasalo & Petäjä, 1999; Overpeck, Brenner, Trumble, Trifilietti & Berendes, 1998; Simpson & Stanton, 2002).

The most common reason for neonaticide is that the child is unwanted. In some instances, these mothers already have a child and a second or subsequent child puts significant strain on already stretched resources. These deaths mostly occur on account of inaction rather than violence in comparison to the deaths of older children (Marks, 1996). In many cases, pregnancy is denied although it is unclear whether the denial is deliberate (except when it is

part of a diagnosed mental illness such as schizophrenia) or operating on a more unconscious level by way of dissociation (Brockington, 1996; Green & Manohar, 1990; Spinelli, 2004). Denial of pregnancy is a serious risk factor as it deprives the young mother-to-be of appropriate antenatal care. In most cases, those around the woman – family, friends and even her employers (and in one instance, her physician) also denied it (consciously or unconsciously) (Oberman, 2003a; Schwartz & Isser, 2000).

According to some researchers, mothers who commit neonaticide are seldom mentally ill (Cheung, 1986; d'Orban, 1979; Resnick, 1970; Schwartz & Isser, 2000). They tend to give birth alone and unassisted, significantly increasing the risk of infant death (Crittenden & Craig, 1990). Although the relative youth of the mother and her deprived circumstances are factors that correlate to neonaticide, the connection is by no means conclusive (Craig, 2004). However, some studies claim to have found evidence of mental illness among neonaticidal mothers. Spinelli's (2001) systematic investigation of a sample of neonaticidal women describes symptoms of depersonalisation while giving birth, dissociative states including brief psychosis, and intermittent amnesia upon delivery. The pregnancy of most of the women in her sample proceeded without the usual obvious signs of pregnancy. The women had their babies in secret and were unassisted. Because this secrecy is a common factor, it is unclear whether neonaticidal women have prior or existing diagnoses of mental disorders, especially as they are unlikely to seek medical attention (Marks, 2006). It also depends on what is included in the definition of mental illness. It could be argued that a state of temporary dissociation, brought about due to the shock of an unprepared for birth, does not necessarily constitute a mental illness. Haapasalo and Petäjä's (1999) analysis of mental state examination reports of neonaticidal mothers in Finland found evidence of mental illness in one third of those women. Finally, a recent study by Krischer, Stone, Sevecke and Steinmeyer (2007) on

neonaticidal mothers revealed maternal psychiatric diagnoses on the schizophrenic spectrum, along with impaired intellectual functioning. Thus, while mental illness does not seem to be a primary factor in most studies of neonaticide, it cannot be entirely discounted and is thus still an important consideration in prevention and treatment.

The literature state that as a child gets older, the risk of parental homicide decreases. However, in contrast to neonaticide, a significant risk factor in infanticide (maternal homicide within the first year of life) is that of psychiatric illness (Hatters Friedman et al., 2005a; Marks, 1996; Simpson & Stanton, 2000; Spinelli, 2004), especially postpartum psychiatric disorders. In addition, studies revealed that infanticidal mothers were often older, married and suffered from significant family-related stresses (Haapasalo & Petäjä, 1999; Craig, 2004). For this group of women *not* suffering from psychiatric disorders, accidental death of infants (not neonates) and toddlers on account of battering appeared to be a key factor (Crittenden & Craig, 1990; d'Orban, 1979).

Although the research suggests that different risk factors are associated with neonaticide, infanticide and filicide, the commonalities should not be obscured by these differences. For example, in a study by Crimmins, Langley, Brownstein and Spunt (1997), most women convicted for killing their children had a history of physical and/or sexual abuse from a family member. Despite this correlation, Kaufman and Zigler (1987) concluded that the 'intergenerational transmission of abuse' occurred in only about one third of families. In contrast, Widom's (1989) critical review on intergenerational abuse found many correlations between the abuser and onward abuse. More recently, Brockington's (1996) review of later studies on the cycle of violence suggests that intergenerational violence is one factor among many that might perpetuate ongoing abuse in families. Thus, although it is not specifically the

cause, a history of abuse is an important consideration in understanding maternal child homicide.

The lowest at-risk group is that of older, school-aged children. It seems that other than maternal child neglect or deliberate abuse, the most common risk factor for this age group was that of accidental death by shooting. This finding was specific to the United States in which gun laws are considerably lenient (Crittenden & Craig, 1990). Older children were also killed in the context of filicide-suicide (Hatters Friedman et al., 2005b). However, in this group of perpetrators there was a high degree of psychiatric illness, which will be elaborated on later in this paper.

A final risk factor relevant to all child homicide is that of substance abuse, directly or indirectly. The use of substances during pregnancy often impacts negatively on infants in that they frequently are described as having poor feeding and sleeping patterns, and are more irritable. In addition, the use of certain substances such as alcohol is linked to increased aggression that impairs the judgement of individuals to evaluate and control their own behaviour (Rasko, 1976; Smithey, 1997). However, some studies did *not* find a significant correlation between substance abuse and child homicide as its prevalence was found in only 10% to 25% of cases (d'Orban, 1979, McKee & Shea, 1998). Rather, impaired judgement was more a consequence of high levels of situational stress, anger, frustration, and/or depression, rather than intoxication. So, it seems that substance abuse in isolation is not a significant risk factor, but that the context in which it occurs is more explanatory than whether or not it is used (McKee & Shea, 1998; Oberman, 1996).

What appears to be lacking in research on risk factors for maternal child homicide is the systematic study of a large number of risk factors. Social deprivation and depression are ubiquitous, but not all mothers with those problems kill their children. What does seem more evident is that the motive/s to kill and underlying associated dynamics are different for the different women (Krischer et al., 2007). The literature attempt to explain these differences and those will now be explored.

4. Perspectives on Maternal Child Homicide

The boundaries between the psychiatric, psychological and sociological explanations for child homicide are somewhat artificial. Each discipline offers a specific perspective to understand and explain the act of child homicide and these will be explored in greater depth in this section.

4.1 The medical model as represented by the psychiatric perspective

Although the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV TR), is a manual that provides a classification system of mental disorders, it does not purport to hold a definitive understanding of mental illness. Rather, it admits that no single definition or conceptualisation adequately encompasses all situations. The American Psychiatric Association (1994) conceptualises mental disorder as:

> …a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern

> must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. (p.xxi)

There is substantial evidence for the role of mental illness in maternal child homicide with specific reference to postpartum disorders, depression, manic states, suicidality, substance use disorders, personality disorders, and diminished intellectual functioning (Bourget & Bradford, 1987; Brockington, 1996; Chandra, Venkatasubramanian, & Thomas, 2002; Lewis & Bunce, 2003; McKee, Shea, Mogy, & Holden, 2001; Oberman, 1996; Spinelli, 2001, 2004; Stanton, Simpson, & Wouldes, 2000). These studies revealed that women diagnosed with a mental disorder were older (above 20 years of age) compared to mothers who killed their newborns. These women were usually married, and had less psychosocial stress than those who killed in the context of fatal child abuse (Cheung, 1986; d'Orban, 1979).

Pregnancy and childbirth is a regarded as a time of significant biological, social and psychological adjustment and brings with it an increased risk of psychiatric disorder (Brockington, 1996; Miller & Rukstalis, 1999; Spinelli, 2004). Postpartum psychiatric disorders are especially pertinent to infanticide, although a full description and analysis of these in relation to infanticide is beyond the scope of this paper. Brockington's (1996) seminal work entitled, *Motherhood and Mental Health,* is a testament to the vicissitudes of motherhood. He includes a portfolio of postpartum disorders, namely: psychoses (including various confusional states), the 'maternity blues', stress reactions (including post-traumatic stress disorder and psychogenic psychosis), anxiety (including phobias, panic and generalised anxiety), obsessional disorders (including obsessions of infanticide and obsessions of child sexual abuse), and depression. In

addition, Brockington highlights problematic mother-infant interactions in psychiatrically disordered mothers that include diminished maternal emotional response towards the infant, rejection of the infant and pathological hostility and aggression towards the infant.

The psychiatric disorder that seems most prolific in infanticide cases tried in court, (particularly in countries with an Infanticide Act) is that of postpartum psychosis (Oberman, 1996; Wilczynski, 1997). Spinelli (2004), a psychiatrist specialising in postpartum disorders and filicide writes,

> A delirium-like, disorganized, labile clinical picture of postpartum psychosis has been observed and repeatedly reported by contemporary researchers [6]. The descriptions of fluctuating affect lend support to the contemporary theory of an underlying bipolar disorder diathesis [7] . In addition, Wisner's group described a 'cognitive disorganization psychosis' in women with child-bearing related psychoses. In their study, the post-partum group demonstrated thought disorganization, bizarre behavior, confusion, lack of insight, delusions of persecution, impaired sensorium/orientation, and self-neglect, a clinical picture consistent with delirium…These psychotic postpartum women also have more unusual psychotic symptoms, such as tactile, olfactory, and visual hallucinations consistent with an organic psychotic presentation…This biologically driven state presents as a toxic organic psychosis [8], complicated by affective mood changes consistent with a bipolar disorder clinical picture. (p.1551)

Despite these well researched symptoms specifically related to the postpartum phase of birth, there is still no separate diagnostic category for postpartum psychiatric illness in the DSM-IV TR. Postpartum disorders are relegated as specifiers only in relation to

[6] Spinelli refers to Brockington, et al. (1981), and Wisner, et al. (1994).
[7] Spinelli refers to research by Oosthuizen, et al., (1995).
[8] Spinelli refers to research by Sichel (2003).

some DSM-IV TR diagnoses. According to Spinelli (2004) these could have various implications. Firstly, mental health practitioners who are not aware of the literature describing postpartum psychiatric disorders may be less concerned about the potential risk towards the infant. Secondly, because the waxing and waning of symptoms matches the clinical picture of infanticidal mothers, this mood lability is frequently used as evidence against the infanticidal mother. Finally, post-psychotic amnesia could appear suspicious as the woman could vacillate from lucid to confused states suggesting that she is dishonest, despite the organic basis for this mental state. Spinelli regards this as problematic given that the judiciary relies on the DSM-IV TR to give credibility to the mental states of an individual when in violation of the law, especially when research has shown that psychotic women are particularly at risk of killing their children (d'Orban, 1979; Husain & Daniel, 1984; Lewis & Bunce, 2003; Stanton, et al., 2000).

Spinelli (2004, 2005) maintains that both the US judiciary and the psychiatric profession failed Andrea Yates when she was sentenced to life imprisonment for the murder of her five children, despite overwhelming evidence by both the defence and the prosecution that Yates was psychotic at the time of the murder. In addition, Yates had a family history of psychiatric illness (bipolar disorder and major depression), and a diagnosis of puerperal psychosis shortly after the birth of her last child. A diagnosis of psychosis is not regarded as sufficient grounds in the US for "insanity" as a legal defence. Spinelli (2004) states that the fact that,

> …the insanity defense is nonexistent in some states and extremely limited in others speaks to our society's disregard for mental illness and the right of

> those with mental disorders. Until mental illness is addressed with the same dignity afforded to other illnesses, the course will remain unchanged. (p. 1555)

Oberman (1996) supports Spinelli's stance as demonstrated with her example of the Sheryl Massip case in 1987 in the US. Massip was in the postpartum phase of birth and psychotic when she threw her six-week old son into oncoming traffic, picked him up before taking him to her garage where she hit him over the head with an object, and finally ran over him with her car. During this time, she demonstrated severely disordered thinking although by the time of her trial, Massip was no longer psychotic (a typical feature of the waxing and waning of postpartum psychosis). She was found guilty of second degree murder although she was later acquitted on the grounds of insanity. It seems that Massip had informed both her family and her physician of her struggle to cope with motherhood, but no serious evaluation occurred in response to Massip's efforts to alert others of her difficulties. According to Oberman (1996), Massip's son's death was due to not only her mental illness, but also a significant failure of her social network to provide her with necessary support and intervention.

Spinelli (2005) admits that her stance on the clarification of postpartum psychiatric disorders in the DSM-IV TR for the purpose of improved legislation for women is not without contention. Although she acknowledges the criticism from feminist groups who oppose the idea that women should not be held hostage to their biological changes, she states that the benefit to women derived from recognition of scientific data and approved diagnostic criteria is greater than the loss.

Psychosis is not only dangerous shortly after birth, but also as part of other more chronic clinical syndromes. The most common recorded mental disorders of filicidal mothers with mental illness included Schizophrenia, Major Depressive Disorder with Psychotic Features, and Personality Disorder (Lewis & Bunce, 2003). The literature, however, does not elucidate which personality disorders were the most common in child homicide. In addition, psychotic women were more likely to kill more than one child in comparison to non-psychotic women (Lewis & Bunce, 2003). However, various studies are careful to point out that the women with mental illness also had other stressors such as housing problems, financial concerns, limited social support, domestic violence, conflict with family members other than their sexual partners, and they were mostly the primary caregiver for at least one child (Hatters Friedman et al., 2005a; Lewis & Bunce, 2003). From these studies, it appears that very few filicidal mothers had prior criminal records, and their motives were mostly “altruistic”. That is, most women were described as loving mothers who killed their children in response to psychotic hallucinations that instructed them to do so for the benefit of their children (Resnick, 1969).

In instances of filicide-suicide, the mothers frequently displayed a high rate of ongoing mood disorders, schizophrenia and schizoaffective disorder (Hatters Friedman et al., 2005b; Willemsen, Declercq, Markey & Verhaeghe, 2007). The motive for murder in these cases was mostly also altruistic as the mothers were concerned about the level of care the children would receive were they to remain alive.

The psychiatric literature thus suggests that mothers who suffer from predominantly Axis I[9] disorders (Clinical conditions and Other conditions that may be a focus of clinical attention) combined with other factors such as a history of drug abuse, domestic violence, restricted social support, financial problems, and having no partner to share the burden of motherhood, are most at risk of committing child homicide. Axis II[10] diagnoses (Personality Disorders and Mental Retardation) are more frequently implicated in fatal child abuse which is a significant contributor to maternal child homicide.

In countries that have legislation, the legal system tends to protect women with Axis I diagnoses. Such women will usually serve suspended sentences with compulsory psychiatric/psychological treatment. In contrast, women with Axis II diagnoses are usually incarcerated and often stimulate the 'mad' versus 'bad' debate (Laporte, Poulin, Marleau, Roy, & Webanck, 2003). This was illustrated in the case of Susan Smith who killed her two children in 1994 in the US. The media portrayed her as a ruthless, vindictive woman who had callously strapped her children in her car and who then deliberately drove into a pond whereupon the children drowned. During the trial, the context of Smith's life revealed an abusive stepfather, social isolation, her failure to ask for help when she clearly needed it, her limited options, as well as a history of depression and substance abuse. As a reflection of both her 'madness' *and* 'badness', Smith was incarcerated only as opposed to receiving the death sentence. Oberman (1996) describes this dilemma as follows:

> …the dialectic of madness and badness …is [a] manifestation of jury ambivalence about allocating blame in infanticide cases. Thus, the shifting

[9] DSM-IV TR (APA, 1994).
[10] DSM-IV TR (APA, 1994).

> characterizations of an infanticide defendant from bad to mad, and sometimes back again reflect a systemic struggle to devise an appropriate punishment for her. (p.47)

Matters are even more complicated when women present with both Axis I and II disorders. For example, women with psychiatric illness as well as intellectual deficits who commit child homicide will, at the best of times, struggle with the daily demands of life. These are women who are particularly at risk of becoming overwhelmed when having to care for their child/children without assistance who then resort to drastic action in the form of child homicide (Oberman, 1996).

Despite the revised classification system of Bourget and Gagné (2002) that incorporated the role of neurotransmitters, it does not appear to date that any systematic studies have been done that isolate this variable as a factor in maternal child homicide, unless perhaps in the context of postpartum disorders. Even though biology cannot be ignored, it seems unjustified to assume that a homicide is merely a series of events in the brain in isolation of what is taking place in the environment (Cameron, 1987).

Psychosocial stressors play a significant role in fatal child abuse, including the particular stress of coping with a psychiatric illness. However, the difference is that mothers with Axis I disorders do not usually have a personal history of child abuse, in contrast to mothers with Axis II personality disorders who frequently do (Korbin, 1986; Stanton & Simpson, 2001). In a small percentage of cases, parents kill for financial gain such as claiming life insurance when the children die from what appears

to be arson, neglect, drowning or "Sudden Infant Death Syndrome" (SIDS)[11] (Schwartz & Isser, 2000). According to Overpeck et al., (1999), at least 5% of infant deaths classified as SIDS may be caused by child abuse and neglect which is why they suspect the epidemiology of child homicide to be underestimated. Stanton and Simpson (2001) explored a case of SIDS in which it was revealed (after three children had died) that the mother had been diagnosed with an Axis II Personality Disorder. However, research in general is sparse with regard to the correlation between Axis II disorders and maternal child homicide.

Mothers also kill for personal gain when suffering from Factitious Disorder by Proxy (FDBP). However, the kind of gain sought is not external, but internal. When suffering from this condition, a mother would harm her child/children in an attempt to obtain attention for herself from physicians and/or others (Motz, 2001; Schwartz & Isser, 2000). FDBP behaviour seems to indicate underlying mental illness in acts of child abuse. This is suggested in the difference between the two major classification systems of the DSM-IV TR, and the ICD-10[12] in which FDBP is classified as a clinical syndrome on Axis I according to the DSM-IV TR, but in the ICD-10, it is classified under child abuse, not factitious disorders (Sadock & Sadock, 2003). However, FDBP does not seem to be a common occurrence in the studies reviewed. If mothers indeed wanted secondary gain by means of abusing their children, it would not make sense for them to kill them as then there would be no further opportunity for such gain.

[11] "Sudden Infant Death Syndrome" is when no clearly identifiable cause of death can be established.
[12] International Classification of Diseases, 10th edition is a diagnostic manual developed by the World Health Organization.

Although the psychiatric perspective on maternal child homicide is one of the most important – notwithstanding its authority in a medico-legal context, it provides more of a descriptive account of the factors and risks associated with maternal child homicide. The psychiatric discourse is not without its critics. Much has been written about the 'medicalisation' of women and childbirth in which women as subjects, all but disappear in the 'service' of the foetus and the treating physician (Kruger, 2006; Meyer et al., 2001). Hidden dimensions of power are sometimes at play in the pathologising of women's childbirth experiences. However, a full review of that criticism is beyond the scope of this paper. Psychological explanations, in contrast to the psychiatric perspective, attempt to provide a deeper understanding of the psychic mechanisms involved in such violent acts.

4.2 Psychological perspective

As already mentioned, the boundaries between the particular perspectives offered in this paper are somewhat artificial: a mother can be viewed as an individual, or placed within her context of community and family. Psychological explanations discussed in this review place greater weight on intrapsychic factors that may contribute to child homicide. There is a vast body of psychological theory and schools, each with its own understanding of violent aggression. However, this paper is limited to those theories that are specific to maternal child homicide. For example, Behavioural theory may have a perspective on aggression in general, but because no empirical studies were found in the literature search that specifically applied this model to maternal child homicide, it has not been included in this review. The only strictly psychological explanations specific to maternal child homicide seem to be from psychoanalytic and

psychodynamic perspectives[1]. For the purpose of this paper, the two approaches are treated as one. Some of psychodynamic literature pertains only to one particular form of child homicide, for example, neonaticide. Other studies have a more general focus that includes other forms such as infanticide and filicide.

It is asserted that child homicide is a complex, multifaceted phenomenon that is brought about by more than only psychosis or psychosocial stressors. Moreover, not all mothers who suffer from psychiatric disorders kill their children. Thus, an additional risk factor appears to be the individual's underlying psychodynamic conflicts (Papapietro & Barbo, 2005).

4.2.1 Psychodynamic

Bonnet (1993) focused on the psychodynamics of why women choose to give up their infants for adoption. Her study was conducted in France where liberal laws on adoption protect against neonaticide and infant abandonment in a public place. She found that the motives behind the women giving up their infants included a denial of pregnancy - for many of the women, the birth process came as an unwelcome shock. Those women who were aware of their pregnancies harboured murderous fantasies towards their unborn babies. Shortly after labour, the new mothers did not wish to see, touch or hear their babies. Bonnet (1993) drew a link between a history of neglect or abuse in the childhood of the women in her sample, and their own fearful feelings toward their unborn babies. She writes,

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> The boundaries between the fetus and the psychic experience became fluid and rather than confront the traumatic, unthinkable past they preferred to eliminate the fetus. Thus, for these women, it was less a question of killing a human being than of making unbearable thoughts, unthinkable nightmares from the past disappear. (p.506)

Those who did not deny their pregnancies reported violent fantasies during pregnancy and became progressively afraid that they would not be able to control their violence once their babies had been born. Idealised notions of motherhood seemed to prevent these women from getting help during this period. According to Bonnet (1993), it seemed that the pregnant women harboured thoughts of aggression towards their unborn children that evolved into feelings of guilt and anxiety that they did *not* want to be mothers.

According to Brozovsky and Falit (1971), a key factor in maternal child homicide is the new mother's fear of being abandoned by her own mother. They conducted two case studies in which both subjects murdered their newborn infants. Both women lived with their parents and had been threatened with actual abandonment were they to become pregnant. This threat of abandonment by families of homicidal women along with denial of pregnancy by themselves and family members, are key characteristics of the neonaticidal group of women (Resnick, 1970). In addition Brozovsky and Falit (1971) concluded that when a disturbed mother-daughter relationship existed, a fear of separation was an important factor in the psychopathology of these women. At the time of giving birth, these women were overcome with the fear that they would be abandoned and thus unconsciously identified with their aggressors (their own mothers). According to Brozovsky and Falit, this leads the young mother to over-

identify herself with the infant. That is, she sees herself represented by the infant and does to the baby what she fears her mother would do to her. Both women in their study responded to auditory command hallucinations that instructed them to throw their newborn infants out of the window. Although Brozovsky and Falit's (1971) findings were based on only two case-studies, other studies report similar results and explanations.

Willemsen et al. (2007) offered a similar explanation with regard to extended child homicides, that is, filicide followed by suicide. They conducted a case-study with a young mother who had a psychiatric diagnosis of Borderline Personality Disorder. The mother, because of her lack of differentiation from her own mother and insufficient ego functioning, viewed the child as an extension of herself. By means of projective identification, unmanageable emotions were projected into the other, and the advantage of this for the mother was that she could control her own affect by controlling her child. Thus, the manipulation or over-concern of those with certain personality disorders (Borderline and Histrionic) is an attempt to control others in order to control the self. According to Willemsen and colleagues' (2007), filicide-suicide was committed on altruistic grounds, that is, the mother wanted to take her child away from its father, as she believed it was beneficial for the child to do so. She was, however, not only killing the child, but also herself, as she could not differentiate between her child and herself (Willemsen et al., 2007). Therefore, it appears that maternal child homicide followed by the mother's suicide is more closely associated with self-destructive tendencies as opposed to homicidal tendencies (Meyer et al., 2001).

Maternal over-identification with the infant/child is also a suggested psychodynamic explanation for Factitious Syndrome by Proxy (FSBP). It appears that mother and child become fused, and that the mother is unable to psychically differentiate between herself and her child (Motz, 2001). Background characteristics in women diagnosed with FSBP include a history of criminal delinquency in adolescence, eating disorders, parental abuse and/or neglect, past and current self-harm (Schwartz & Isser, 2000). As Motz (2001) describes,

> For women who have undergone experiences of abuse, their conception of the value and use of their own bodies may be heavily distorted and they may use their bodies to express their pain and despair, as well as their anger at the parents whom they feel have let them down and betrayed them. Their sense of identity may reside in their bodies, as their early experiences have not allowed them the opportunity to develop a clear sense of themselves as separate from their bodies, which have been treated as objects to be punished or sexually exploited by adults. The domain of control and of the sense of self are located firmly in the body which therefore assumes a central importance and expressive function for these women. (p.65)

If, as Motz describes, the child is a narcissistic extension of the mother, the child then becomes the site of the mother's internalised aggression towards herself but projected onto her child.

According to psychodynamic theory (Crimmins et al., 1997; Harder, 1967; Kunst, 2002; Willemsen et al., 2007), primitive defence mechanisms of denial, splitting, and projective identification operate to protect against acts of violence. Clearly, it is when stressors become so acute that these defences fail. In addition, Harder (1967) describes the defence mechanism of reaction formation as a key factor in so-called altruistic homicides. Despite the mothers of victims of altruistic murders being described as

loving and caring (given a different slant when the dynamics of a personality disorder is taken into account as elucidated earlier in this paper), Harder discredits genuine altruism as a motive for child murder. Instead, he attributes such an act to an unconscious hatred of the child and thus *not* a manifestation of love. Harder (1967) writes,

> The killer's assertion that it was for the child's best to be killed must be seen as a manifestation of the killing being in accordance with the killer's own desires, and, consequently, ego-syntonic. (p.244)

In this way, an understanding of unconscious defence mechanisms brings a deeper understanding to that which is superficially described as an act of altruism.

Tuteur and Glotzer (1959) were of the first researchers to explore maternal filicide-suicide, and based on their data, they interpreted such an act as an attempt to remove the whole of the self so that nothing remains; that is, both the actual and the extended self (viz. the child). The source of the aggression is thus again understood as an extension of aggression towards the self. It is important to bear in mind that most filicide-suicides are carried out in the context of psychiatric illness (Hatters Friedman et al., 2005b; Stanton et al., 2000; Willemsen et al., 2007), although it appears that psychodynamic explanations offer an augmented understanding as to the underlying conflicts embedded in such acts.

Crimmins and colleagues' (1997) empirical study explored maternal child homicide from a self-psychology perspective. Their sample was an incarcerated group of women who had killed their children. Although not made explicit in their study, it appears that

psychiatric illness was not a significant factor in this sample. In essence, they suggested that,

> …the woman's sense of self is too damaged for her to care about another human being. Self becomes damaged not simply because trauma occurs but also because an absence of social supports and an inability to rely upon others in times of need lays the foundation for the message that self is unimportant. (Crimmins, 1995 cited in Crimmins et al., 1997, p. 51)

From a psychodynamic perspective as elucidated from empirical work, the killing of a child is not necessarily understood only in a literal sense. It may be that the child represents some other object that needs to be destroyed, and this could be an internal object. In particular, in Crimmins et al.'s (1997) sample, self-damage indicators were prevalent in the personality development of the women. These included characteristics of women who themselves were inadequately mothered, a history of drug and/or alcohol abuse in the family of origin, self-drug history, significant childhood and adult harm such as physical, emotional and/or sexual abuse, and self-harm. Not only did this sample of women have significantly low internal resources to cope with motherhood, but also their inability to engage external support was also evident.

Like many other studies, Crimmins et al. (1997) found that there was not one single factor that precipitated such acts of lethal violence. Rather, the women in their sample had several significant blows to the self commencing early in their lives, such as, the loss of their mothers in early childhood, inadequate parenting and limited social support. These losses ultimately evolved into traumas that corroded their sense of self, and "when self no longer exists, the roots of violence are born." (Crimmins, et al., 1997, p.65)

Similar to Bonnet's (1993) findings, Crimmins et al. (1997) found that the women were unable to move through their past and present self-damaging experiences which included suicidality, substance abuse, and physical and sexual victimisation. Added to this, were chronic low self-esteem (due to consistently unmet emotional needs), widespread social isolation, and poor communication of their distress (similar to Bonnet's 1993 study). According to Crimmins et al. (1997), if empathy is understood as an extension of the self, then children who have a poor sense of self are unable to feel genuine empathy for others. The failure of significant objects (such as parents) to extend empathy to the needy child could contribute significantly to the child's uncertain sense of self as a consequence of feeling low self-worth, rejection and isolation. The frequent outcome of this is feelings of chronic rage and despair that have the potential to explode into violent behaviour.

The psychodynamic literature regards rage and its variants (anger, hostility, resentment, revenge) as an important factor in violent behaviour (Crimmins et al., 1997; Harder, 1967; Lerner, 1980; Palermo, 2002; Papapietro & Barbo, 2005; Scott, 1973; Silverman & Kennedy, 1988). Aggression is associated with the need to protect the self from a perceived threat (Crimmins et al., 1997). In the case of a mother who has a particularly fragile sense of self, the normal developmental process of a small child attempting to establish its autonomy may be construed as a threat by the mother, in the form of a rejection. This perceived rejection may evoke painful feelings of rage, despair and anxiety of the mother's own rejection by her parents. This threat is then introjected as self-annihilation or death - a loss of self, and a loss of power and identity due to the mother's own incomplete separation from her own parents. On an

unconscious level, the mother may punish the child whenever it demonstrates behaviours that attempt to separate from her due to her aggressive identification with her own parents. The child's behaviour (misconstrued as wilful) is sufficient for the mother to perceive it as a deliberate betrayal of her influence and power. For a woman with a fragile, damaged sense of self, this so-called disregard of maternal authority could be construed as a very real threat to a fragile identity that could be restored through physical violence. Thus, there appear to be links between self-damaging experiences and homicide (Crimmins et al., 1997).

In Papapietro and Barbo's (2005) study, repressed rage was found to be an intrinsic part of an underlying personality disorder that finds a violent release through psychosis leading on to the homicidal act. According to that study, it is the accumulation of childhood or infancy losses and/or traumas, frustrations, and emotional deprivation that gives rise to a chronic experience of anger that cannot be resolved by the ego. Papapietro and Barbo (2005) state that,

> ...[f]rustration that cannot be mitigated (by the primary parent) becomes anger, and anger that cannot be resolved becomes rage, and rage toward the abandoning or frustrating object (the primary parent) is kept repressed and out of conscious awareness. From this repressed rage come fantasies and fears of destroying the object that must themselves be repressed. From a psychodynamic perspective, it is this repressed rage that is subsequently unrepressed until disinhibited by depression or psychosis and acted out through the murder or attempted murder of the child. (p.506)

This explanation seems to correlate with the category of child homicide mothers who retaliated against their spouses by displacing their aggression onto their children (d'Orban, 1979; Resnick, 1969; Scott, 1973). However, it is important not to overlook

the role of culture in the expression of anger or rage. Lerner (1980) explored the reasons for the general dampening down of anger and/or rage in women and concluded that the cultural definition of an acceptable woman is one who is devoid of such aggression. That is, a stereotypically feminine woman equates to an agreeable, compliant woman.

Kunst (2002) explains the psychodynamics of maternal child homicide from an object relations perspective. Her study was based on her clinical work at an inpatient forensic hospital in the US. She differentiates between two types of personality structure: the disorganised type in which the psychodynamic scenario involves the woman's attempts at defending against massive internal breakdown, and the organised type which involves efforts to manage the danger of persecution and annihilation. The disorganised type is manifested mostly in women whose poor reality testing is chronic and is primarily organically based, while the organised type usually has some kind of rudimentary ego formation that becomes severely splintered in the short term. Many of these (the organised type) women have had a better pre-morbid development relative to the disorganised type in that they were more likely to have been married, educated and employed. For the organised type, physical violence is used because of failures in mentalization whereupon they enact their catastrophic internal anxieties. Bateman and Fonagy (2006) define mentalization as:

> …a focus on mental states in oneself or in others, particularly in explanations of behaviour. And that mental states influence behaviour is beyond question. Beliefs, wishes, feelings and thoughts, whether inside or outside our awareness, determine what we do…To adopt a mentalizing stance, to conceive of oneself and others as having a mind, requires a representational system for mental states. (p.1)

Affect regulation is an important aspect of anger and anxiety management, and mentalizing thus helps to regulate emotions. The manner in which an infant might understand whether or not it is safe is frequently conveyed via the emotional tone of the adult to the infant. In general, the expectation of the child is to receive all kinds of knowledge through the mind of a trusted other such as the parent (Bateman & Fonagy, 2006).

Failure of mentalization is thus linked to poor attachments with significant caregivers in the context of personal histories of neglect and/or abuse. However, the organised type had a mother throughout childhood or at least until late childhood (albeit in a dysfunctional context), whereas the disorganised homicidal mothers had lost their mothers in early childhood (Kunst, 2002). For the disorganised type, the infant murdered was either newborn or under 12 months of age. As elucidated in the psychiatric discourse, infanticide and neonaticide are associated with postpartum hormonal changes, as well as the psychological and economic challenges of childbirth. In addition, the presence of a destructive early home environment coupled with organic underpinnings of psychosis significantly predisposed these women to such an act of violence. The method of homicide was almost exclusively “frenzied stabbing” (Kunst, 2002, p.24) and after the crime, the mother was frequently confused and disoriented. From an object relations perspective, Kunst noted that the disorganised type frequently felt very little emotion for their infants. Their babies were not conceptualised as human, but rather as inanimate part-objects into which was projected split-off and unwanted parts of the self. As Kunst (2002) describes, “[t]here is an unfeeling attitude, with no sense of bonding and no concern for the welfare of her child that might suggest a trace of the depressive position, even in its most embryonic form” (p.24). The

primitive defences of projective identification and splitting are used to defend against a turbulent, toxic and highly dangerous internal object world.

According to Kunst (2002), these severe psychological and biological factors in conjunction with a deficit of psychic resources to defend against them, is what leads to such a crime as maternal homicide. She argues that neither neurobiological nor psychosocial explanations are sufficient in explaining such acts of homicide, as few schizophrenic women and few abused or deprived mothers murder their children.

In contrast to the disorganised type, the organised type suffered from a variety of psychiatric conditions such as depressive disorders, personality disorder/s, and/or substance dependence, with psychosis emerging later on account of severe stress. That these women had the presence of a mother until at least late childhood permitted these women a level of basic attachment. However, although the mother-child relationship was problematic as demonstrated by inconsistent, intermittent care for the child, the actual physical loss of the mother was the ultimate blow to internal security.

Kunst (2002), similar to Crimmins et al. (1997), attributes great importance to the damage caused by the loss of the woman's own mother in early childhood. Through this loss, the young child has little chance to develop the capacity to think (or mentalize) about herself and her experiences. Because of this, she may struggle to develop a sense of personal integrity and psychic safety that in turn, would facilitate the ability to cope with the challenges of daily life. The woman's sense of self becomes endangered and it is this sense of self-endangerment that creates the pathway for the

future use of physical violence as the only self-protective option available (Fonagy & Target, cited in Kunst, 2002; Fonagy, Moran, & Target, 1993).

Thus, despite that the organised type is very oriented toward her objects, she is not fully able to comprehend an object outside of herself – that is, she cannot mentalize. There is a sense of desperation in her search for a primal sense of security, admiration, and coloured by fantasies of idealisation and merger. This psychological state of mind is a consequence of these women's early environmental deprivation in combination with their temperament.

Many of the organised type women revealed unrealistic fantasies and expectations of motherhood as a process of transformation of the past. That is, the child is expected to recapture the period in early life when the mother (omnipotently) believed she had everything she needed, including feeling totally loved, safe and cared for, and without psychic pain. The effort to establish a pure, unsullied, loving relationship by the mother towards her infant may be understood as an attempt to recreate the longed-for good relationship with her own mother, and the mother increasingly turns towards her infant to satisfy her own unmet needs for fulfilment. Although these longings are also demonstrated by non-pathological mothers, they are able to bear the inevitable disillusionment brought about by the child's real needs and are capable of making the necessary sacrifices for the sake of the child's psychological well-being. Non-pathological mothers are thus able to tolerate the inevitable ambivalence that occurs with caring for a completely dependent, helpless new individual (Kunst, 2002).

From an object relations perspective, for the organised type, Kunst (2002) states that a recent object loss (husband, boyfriend) is a major factor in the execution of the crime. This does not preclude the other factors of financial stress and poor social support. These women frequently try to find help, but are often not successful in obtaining adequate responses to their calls for help and experience a growing sense of alienation from those around them, and a subsequent increase of internal disintegration. As anxiety increases, so do the merger fantasies. The danger stems from a strong sense of persecution and fear of annihilation by bad objects. As the mother has not separated from the child, the fantasy of violence "can serve to preserve and protect both the self and the child, transporting them through death to a state of ultimate safety in heaven" (Kunst, 2002, p.37). It is usually from within this context that the woman kills her child as an unconscious act of aggression turned towards herself on account of her own internalised aggressive parental imagos. She destroys her child literally as her parents destroyed her symbolically.

In both the disorganised and organised personality types, physical violence is considered to be an outcome of the failure to mentalize. Because the woman is unable to tolerate and regulate chaotic affect, she kills her child in a kind of "narrative enactment of her enduring internal object world" (Kunst, 2002, p.37). From an object relations perspective, it is the failure to develop sufficient interpersonal capacities in infancy and childhood that may then impair the appropriate ego formation to cope with anxiety and stress and it is from this, that structural deficits of personality arise. In addition, it is these deficits when carried to adulthood as personality disorders that may increase a woman's vulnerability to major psychiatric disorder as well as problematic mother-child bonding (Papapietro & Barbo, 2005).

The contribution of psychodynamic approaches to the phenomenon of child homicide provides mental health providers with treatment options that have specifically explored the underlying conflicts and developmental deficits that are likely to contribute to the breakdown of ego functioning in such an act of violence. From a dynamic perspective, maternal child homicide can be viewed as an expression of suicidal feelings onto one part of the self, the baby/child, who becomes the "poisonous container" (deMause, 1998, cited in Motz, 2001, p.132) that ultimately, must be destroyed.

Some research, however, has questioned the evidence supporting the 'mentally ill' hypothesis. This research queries whether a diagnosis of mental illness may be a less contentious option for professionals in the various medical and legal systems than having to face such atypical gender behaviour (Silverman & Kennedy, 1988), that is, the very real capacity for female violence. A typical heuristic stereotype frequently applied to mothers who kill their children is, "if they killed their kids they must be crazy" (Silverman & Kennedy, 1988, p.123). There is a body of research that considers it erroneous to consider the contribution of intrapsychic factors in maternal child homicide in isolation of the individual's environmental context.

4.3 Sociological perspective

As mentioned previously in this paper, in contrast to other types of child homicide, a high proportion of social variables seem to operate in contemporary neonaticide. These include unmarried status, absent fathers, social isolation and inadequate support systems, financial insecurity, late or no antenatal care, and non-hospital births (Meyer et al., 2001; Oberman, 2003b; Pitt & Bale, 1995; Resnick, 1970). Research suggests

that neonaticide is an unpremeditated act accompanied by intense emotions such as shock, shame, guilt, and fear. Neonaticide is closely associated with the fact that it is primarily women who bear the burden of responsibility for contraception as well as who have to manage the difficulties of single parenthood. The problems of neonaticidal women "appear to lie in the realm of relationships, access to resources, and sense of self" (Meyer, 2001, p. 43).

Research has shown that one of the most significant types of child homicide is that which occurs in the context of fatal child abuse (Bourget & Bradford, 1990; Bourget & Gagné, 2002; d'Orban, 1979; Guileyardo et al., 1999; Resnick, 1969; Scott, 1973). There is a paucity of research on the relationship of child abuse to child murder. One study explored the differences between filicidal[14] and abusive mothers (Husain & Daniel, 1984). A comparison was made between abusive mothers (those with no previous or current psychiatric disorder) who battered their children, and filicidal mothers with mental illness who murdered their children. The filicidal mothers' characteristics included a history of mental illnesses, low incidence of childhood abuse by their own parents, and they had rarely abused their children in the past. In contrast, the abusive mothers had no past or current major psychiatric illness, but most of them had been abused by their own parents. Thus, child homicide in the context of child abuse appears to be mostly accidental, that is, no specific intention to kill was present (Haapasalo & Petäjä, 1999; Husain & Daniel, 1984; Korbin, 1989). If, as the research suggests, most battering mothers do not have Axis I psychiatric diagnoses at the time of the perpetration, what factors could be involved in this type of maternal child

[14] Husain and Daniel (1984) use the term 'filicide' in the generic sense i.e. all maternal child homicide regardless of the victim's age.

homicide? It appears that sociological perspectives have something to offer in this regard.

According to some researchers, (Korbin, 1987; Smithey, 1997), psychiatric/psychological explanations of child homicide are incomplete. The group context of the mother, the typical social interactions conducive to child homicide, and the impact of social structures on the family should be incorporated as major factors (not merely background indicators) in maternal child murder.

Smithey (1997) provides one of the few comprehensive sociological perspectives on maternal child homicide. She applied three theoretical domains – social learning, economic deprivation, and self-attitude – to her empirical study of women who had fatally injured their children. The social learning predisposing factors from childhood included:

- exposure to violence in the home with its associated rewards
- abusive parents in the home
- substance abuse by the subject's father leading to the formation of a poor role model and a poor attachment figure, and
- an abusive or unsupportive partner in adulthood mimicking that of her primary socialisation agents from the mother's own childhood.

Other predisposing factors included economic deprivation and adverse living conditions. With regard to economic deprivation, almost all the subjects in Smithey's study did not have an available partner for either financial or child-care assistance. In

addition, all her subjects reported adverse living conditions such as homelessness, or reliance on friends and family for shelter resulting in several families living in crowded conditions. These factors in combination created the precipitating factors of significant emotional distress and substance abuse (an attempt to mitigate the level of distress) by the mother, resulting in reduced inhibition and increased impulsivity, and poor judgment. Also, the misuse of substances defended against negative feelings of self with regard to poor parenting. Moreover, substance abuse during pregnancy is likely to have affected the newborn's temperament (irritability, poor feeding patterns, and sleep disturbances) leading to a heightened sensitivity to aggravation of the mother in response to her irritable baby. All of this culminated in the mother's murder of the infant.

Smithey's (1997) sample of women differed from many of the maternal child homicide studies in that none of these women had a formal history of past and current psychiatric diagnosis, and all of the infant deaths were unintentional. That is, these infants died on account of 'accidental' fatal abuse. According to Smithey (1997), their deaths were due to a culmination of highly toxic predisposing factors from early childhood in combination with equally problematic precipitating factors of economic deprivation, poor social and emotional support (most notably the absence of the biological father), and substance misuse. This view is supported by other studies (Cheung, 1986; d'Orban, 1979).

In a later paper, Smithey (2001) challenged the psychiatric and psychological explanations even further. She cited studies in which mental illness was *not* a significant factor in child homicide. Although those studies did find hormonal

aetiology among the more clinically depressed women, it was concluded that this was secondary to stressful life events (Bartholomew & Milte, cited in Smithey, 2001; Resnick, 1969). Smithey (2001) further developed her theory on maternal child homicide by drawing on existing criminological theories of homicide of which one is homicide as a 'Situated Transaction' that unfolds in sequential stages (Luckenbill, 1977). Smithey (2001, p.73) has applied this model to maternal child homicide as illustrated below.

Table 5

Situated Transaction Model

Stage	Transaction per stage	Outcome per stage
Stage 1:	Initial action by victim	Incessant crying; prolonged illness; difficult to train
Stage II:	Interpretation by offender as non-compliance	Challenges to mother's self-perception as parent, authority, or overall character
Stage III:	Offender becomes more forceful in an attempt to restore order	Typically shaking, hitting, yelling, or temporarily withdrawing
Stage IV:	Continued non-compliance by victim	Escalation of activity and heightened emotion; working agreement of violence inapplicable
Stage V:	Fatal injury	Typically head trauma

With regard to Stage IV, Smithey (2001) explains that Luckenbill's working agreement of violence is not applicable to infants or toddlers as they are assumed a lack of intent to provoke the offender, as well as their inability to anticipate the consequences of their actions (e.g. prolonged crying). Smithey (2001) thus attempts to provide a

theoretical framework that explains how the mother's inadequate efforts to console the inconsolable infant escalate into violence by the mother on account her distorted perception that the child is challenging her mothering.

Another attempt to explain parental child homicide from a sociological perspective taking into account the structural variable of poverty is that of Gauthier, Chaudoir and Forsyth (2003). These researchers conducted a review of how the Economic Stress hypothesis features in explaining cross national variation in child homicide rates in the US. According to that review, there seems to be support for the role of economic stress in both child abuse and child homicide, and they proceeded to test this with a sample of their own. Gauthier at al. (2003) study also found that economic hardship featured in maternal child homicide. However, they urge caution in this finding as their data, based on tertiary data, did not allow them to conclude clearly that it was poor women who were perpetrating infanticide. Instead, they simply found that states in the US with high numbers of poor women were also states with reported high rates of maternal homicide. In itself, this would perhaps be an inadequate explanation for maternal child homicide, but their study implies that economic hardship is one factor to consider.

Based on her study of incarcerated women convicted of fatal child abuse, Korbin (1989) has proposed a framework comprising six stages in understanding how the fatal incident within the context of ongoing abuse came about. These stages were:

a) Negative parent-child interactions

   The mothers had personal histories of emotional and physical abuse, and they also believed their children to have a range of health and behavioural problems

that made them difficult children to care for. Some of these beliefs were distortions, but others had some basis in reality.

b) Signal/plea for help

As the abuse towards the child/children increased, these women attempted to signal or plea for help. For example, child protection agencies and/or other health professionals such as physicians or paediatricians were aware of many of the women.

c) Denial and a continuing cycle of abuse

While the women indirectly informed others of their abuse, they also minimised and denied the extent of their actions.

d) Continuing cycle

By this stage, the women had considerable experience in minimising and rationalising their behaviour, thus the cycle continued. Even in instances where the child was removed from the home, the cycle resumed once the child was placed back in the home.

e) The fatality

The final fatal incident was the last in a long line of recurrent abusive behaviour by the mother. However, due to its serious nature, it could not be rationalised away.

f) The aftermath

After the fatality, the women experienced guilt and suffered the stigma of failed mothers. Korbin (1989) writes, “Motherhood was critical to their self-concepts and ideal social roles” (p.487).

According to Korbin (1989), society (health professionals, social agencies, relatives and friends who are likely to have seen the signs of abuse) failed the children who died as a result of fatal maltreatment, as the circumstances leading up to the fatal incident were neglected by all concerned.

Another category of child homicide is that of mothers who kill by means of neglect (d'Orban, 1979; Guilyardo et al., 1999; Meyer et al., 2001; Resnick, 1969; Scott, 1973). Meyer and her colleagues (2001) collected data from 76 cases that involved maternal neglect. They defined "neglect" as mothers who did not intend to purposefully kill their children, but did so anyway as a result of one of two possible scenarios: acts of omission or commission. In the former, mothers fail to attend to the basic needs of their children such as adequate nutrition, safety, and proper supervision. An illustration of neglect-omission is one of their cases that involved two mothers who left their children unsupervised in a locked apartment while they were out for 24 hours on a shopping/entertainment expedition. The five small children (one of whom had cerebral palsy) were left without food, water, or access to a bathroom. The children managed to get out of the locked bedroom, and attempted to bathe their 23 month old cousin/sibling who subsequently drowned. The children tried to turn off the taps of the bath, but were unable to do so and flooded the apartment, which in turn, alerted a neighbour to take action.

The second type of neglect is that of commission-based neglect in which mothers were irresponsible in their response to a child's behaviour which lead to the death of the child. Again these women did not purposefully intend to kill their children, but death resulted nonetheless. All of these cases in Meyers et al.'s study (2001) were as a

consequence of the mother attempting to stop the child from crying. An illustration of commission-based neglect is the case of a 20 year old mother who tried for several hours to quiet the cries of her nine month old baby girl. The mother informed investigators in the case that she had stuffed toilet tissue in the baby's mouth, even though the baby struggled to spit it out. The mother went to bed afterwards and in the morning, she alerted the police. She admitted to prior attempts to silence her daughter in the same way, although stated that her daughter had always been able to spit out the tissue in the past.

Little research has been conducted specifically on the category of neglectful maternal child perpetrators. According to Meyer and colleagues (2001), these mothers are generally young, single, have inadequate social supports, have large families, and are of lower socioeconomic status with low levels of education. Although not formally investigated, there appeared to be the suggestion of psychiatric illness in some of the cases, notably depression, as well as instances of substance abuse. When each of these variables was examined, Meyer and colleagues (2001) presented a picture of women who were overwhelmed with single parenthood and who had little access to power and privilege in order to change their situations.

Another category of maternal child homicide is that of 'assisted or coerced maternal filicide' (Meyer et al., 2001; Oberman, 2003a). Existing research on maternal child homicide suggests that most women who kill their children act alone. The most unique characteristic of this group of women is that they were involved with abusive male partners at the time at which either they committed the killing themselves, or in which they failed to protect their children from the violent abuse of their partners. Oberman

(2003a) highlights structural issues that impede these women from simply leaving such abusive environments. She states,

> Of course, much of what is known about battered women would suggest that these women are themselves caught in the cycle of an abusive relationship, and are unable to act to protect themselves or their children. Instead of reflecting mental illness or apathy, these cases generally arise out of a battered woman's fear of being required to manage alone, as a mother with children, with limited economic and social supports. Ironically, in the cases, we once again find mothers who may be paralyzed by the same structural fears that plague the girls who commit neonaticide. (p.498)

Although the aspect of gender in relation to maternal child homicide is not explicitly explored in this literature review, it is an underlying thread that runs through existing understandings of it. Research suggests that neonaticide, in particular, is committed by a group of predominantly young women subject to very particular structural conditions in their lives. Some research suggests that the meaning that the act of child homicide has for mothers is a reflection of their position in society (Meyer et al., 2001; Oberman, 1996, Wilczynski, 1997). According to Wilczynski (1997), for women, child homicide is a reflection of their simultaneous position of power and powerlessness in which expressive concerns are more likely to be evident. For men, on the other hand, child homicide is an expression of instrumental concerns such as their desire to influence their families by means of power and control. Therefore, the act of killing one's biological child is a reflection of the playing out of traditional roles, albeit in an extreme form.

Sociological explanations of maternal child homicide give an additional perspective to these desperate acts by way of highlighting the social and structural variables in these

mother's lives. In isolation, though, they are not satisfactory. The fact is, most women who struggle not only with the difficulties of motherhood, but also with concomitant factors of social isolation, poverty and so forth, do not kill their children. Thus psychiatric and psychological explanations offer valuable dimensions to the underlying dynamics of individual human interactions. Moreover, it seems difficult to ignore the likely role of personality disorder in some types of child homicide, for example, maternal neglect and/or abuse. For example, to construe an infant's crying as a challenge to the mothers' authority, and to then proceed to kill the infant (Smithey, 2001) suggests possible pathological narcissism.

Much research supports the notion that the majority of mothers who kill their children suffer from deep personal inadequacies, serious personality disorders, and/or Axis I psychiatric illnesses. However, other research suggests that the seemingly intrapsychic variables of personality disorders are in fact more sociocultural in nature. Modern societies, in particular, are at risk of such sociocultural factors that include a lack of social structure, limited availability of appropriate social roles, and normlessness (Laajasalo & Häkkänen, 2004; Paris, 1998). Thus, even the distorted Axis II personality variables that have been associated with maternal child homicide (Palermo, 2002; Stanton & Simpson, 2001) are located in a specific context and geographical space. Specifically, these include early environmental deprivation and abuse in the home, parental substance abuse, and problems at school.

In summary, the sociological perspective on maternal child homicide demonstrates that vulnerable populations particularly affected by patriarchal institutions include women who are abused by their partners, those who are psychologically disordered, and/or

women whose options are severely limited due to their disempowered, marginalised socio-economic status (Craig, 2004; Oberman, 1996; Overpeck et al., 1998; Smithey, 1997).

5. Conclusion

5.1 Overview

This literature review examined some of the existing explanations on mothers who kill their biological children. Literature reviewed was mostly drawn from Europe, the United States, the United Kingdom, Australia, and Canada. Most research illustrates that there are a myriad of factors involved in this phenomenon and the abundance of classification systems is testament to this, despite that it is a relatively infrequent crime. Empirical studies have tried to elucidate the most important risk factors in maternal child homicide. These include the age of the child (the younger, the higher the risk), psychiatric illness, substance abuse, maternal history of abuse, and challenging psychosocial circumstances.

Specific perspectives drawn from the disciplines of psychiatry, psychology and sociology were applied as explanations for maternal child homicide, and yet, a sharp separation of these (intrapsychic versus contextual factors) is an over-simplification of the problem as it negates their interaction. In addition, the role of personality disorder has been mentioned in the literature, but deconstructing its specific contribution would be even more challenging and complex than examining the association between mental illness and stress (Stanton & Simpson, 2002).

Society takes one of three basic approaches to women who kill their children: denial, punishment, or prevention. And yet, similar conditions prevail in contemporary times to those that precipitated maternal child homicide in previous centuries, such as financial difficulties and social ostracism (Oberman, 1996). It is expedient for a society to blame and punish the mother alone for such an act as in doing so, it removes itself from its responsibility towards the crime. Most notably, the patriarchal underpinning of the traditional family structure is that it is still mostly women who assume responsibility for the domestic sphere. And, as has been demonstrated by the literature, in so many cases of child homicide, the fathers of the children were notably absent.

Although each category of maternal child homicide reflects distinct patterns of behaviour, motives and methods of killing, there are also similarities. Neonaticidal women are those who typically deny their pregnancies for fear of being cut off from their social supports were they to disclose their pregnancy, which in turn (if this fear is realised), would compel them to have to manage parenting alone without financial support and limited job options (bearing in mind most neonaticidal women are still in adolescence).

Women who are assisted or coerced by their partners to kill their children have similar fears in that they tend to prioritise their relationship with their partners over that of their children, as the challenge of single parenthood was deemed too high. These women are often trapped in abusive relationships and are unable to protect either themselves or their children.

Neglect-related cases of maternal homicide involve mostly women who are also poor and alone. Psychiatric illness, chronic intellectual impairment, and abuse related child

homicides yield similar results of a system that relies predominantly on a single individual, the mother, to parent according to the script of idealised motherhood (Meyer et al., 2001). As most mothers know, the demands of caring for a family, especially one with small children, are extraordinarily high. To do so without any support 24 hours of each day is extremely challenging. The point of this is not to excuse child homicide, but rather, to illustrate that it is "far from unthinkable" (Meyer et al., 2001, p.175). The fact that the vast majority of child homicides are carried out by women with no previous criminal record suggests that this phenomenon is not about some deranged, evil woman killing her children in cold blood (Meyer et al., 2001; Oberman, 1996, 2003b). Rather, there is a context behind such a desperate act and it is important to understand that context so that effective interventions can be implemented.

5.2 Future Directions

Hatters Friedman et al. (2005) in their extensive review of the current state of knowledge on maternal child homicide declare that such homicide is on the increase in the US. They identified particular gaps in the literature for future study, namely:

- Cross-sectional studies investigating the circumstances of all child deaths in a particular cachement area that should include examination of factors associated with different kinds of child homicide.
- Case-control studies in which aspects of child homicide victims whose mothers were known to child protection agencies for abuse could be compared to those of abused children who are not murdered.

- Comparison groups such as psychiatrically disordered mothers or battering mothers from the general population who do not kill their children compared with those mothers (incarcerated or hospitalised) who do.
- Future studies could examine specific perpetrator subpopulations including mothers with or without specific risk factors. These subpopulations could include abusive mothers, mentally ill mothers, and mothers who receive/do not receive prenatal care. These studies might allow for more focused risk profiles for mothers who are vulnerable to killing their children.
- The investigation of a large number of possible risk factors seems important. For example, depression and social problems are widespread across the general population. Mothers who commit child homicide are likely to demonstrate several risk factors, rather than a single one. Specific constellations of risk factors could include demographic factors, sociocultural milieu, psychiatric factors, history of previous family conflict, history with social service agencies, and specific situational factors.
- Maternal filicide-suicide is another important area of study, as these mothers are not included in either incarcerated or clinical samples, thus access to death records of the victims should be amplified with information about the perpetrator. As a group, maternal filicide-suicide represents approximately 16%-29% of mothers who kill their children (Marzuk, Tardiff, & Hirsch, 1992).

According to Stanton and Simpson (2002) a comprehensive formulation of maternal child homicide is still lacking. Of the different types of child homicide, neonaticide seems to be the understood the best. However, an integrated formulation for the other

groups is lacking, except perhaps for fatal child abusers and clearly mentally ill women. These include: retaliating mothers who kill their children by displacing their aggression for someone else (usually their spouses/partners) on to the child; mothers who do not want their babies and then proceed to kill them either by neglect or more active means (as was the case in the study by Berg (2003) of the South African Xhosa woman); and the group of women who kill in the context of wishing merciful relief for their suffering children marked by the fact that there is no apparent secondary gain for the mother (d'Orban, 1979). Perhaps such a comprehensive formulation could be an integration of the different perspectives presented in this paper into a multidimensional consolidated theory of maternal child homicide. Notwithstanding this, other perspectives that have not been covered by this particular review may also add value, for example, evolutionary, anthropological, legal and feminist.

5.3 Research directions for South Africa

Although much can be learned from the international literature, that which is relevant to western societies may not be appropriate for more multicultural societies such as South Africa. Aspects of race, ethnicity, class, religion and sexuality may offer a particularly enriched perspective. For the South Africans who wish to understand and take preventative measures against parental child homicide, perhaps the most significant gap in the literature is the paucity of our own systematic research of this phenomenon. "Filicide does not happen in a vacuum" (Mugavin, 2005, p.75). That is, it happens within the domestic space of the family, and a family operates in an even wider context of a society.

The international literature states that neonaticidal mothers are mostly young women (<20 years) who live in highly deprived circumstances, and have limited resources available to them (Hatters Friedman et al., 2005; Mugavin, 2005; Pitt & Bale, 1995; Resnick, 1969; Stanton & Simpson, 2002). Given the high level of teenage pregnancy and the prevailing difficult socio-economic context in South Africa, it is questioned whether South African young mothers, from a variety of sociocultural contexts, could possibly be classified in the same way. The role of the extended family in more traditional families may be a mitigating factor against maternal child homicide. Child Welfare managed a monthly average of 2,973 cases of abandoned children in South Africa during 2007 (M. Briede of Child Welfare, personal communication August 12, 2008). The international literature regards maternal acts of abandonment as a passive kind of murder (Meyer et al., 2001; Oberman, 2003b; Pitt & Bale, 1995). A recent newspaper article (Joseph, 2008) reported that single mothers residing in deprived Western Cape communities are most often responsible for deliberately neglecting or abandoning their children. It is surmised that a range of psychosocial circumstances might be involved in such acts of neglect and abandonment. It would perhaps be interesting to explore how many instances of acts of neglect would have resulted in child fatality had there not been timely intervention.

In addition to the overall future directions suggested, a number of issues that may be especially relevant to understanding the South African phenomenon of mothers who kill their children are suggested as follows:

- Recent statistics reveal that the rate of child murder in South Africa has increased by 22% for the financial year of 2007/2008 since one year ago bringing the total number of children murdered to 1,410 (SA

Government Information, 2008). How many of these murders are committed by the biological mothers and/or fathers of these children and how are these murders different or similar to parental child homicide committed in other parts of the world?

- Considering that so many South Africans live in dire poverty (Hoogeveen & Özler, 2005) and in deprived, overcrowded environments (Townsend & Dawes, 2004; van der Merwe & Dawes, 2007), could there be a link between intergenerational abuse and parental child homicide in South Africa as is suggested in the international literature?
- What is the current prevalence of familicide (a parent's perpetration of murder of his/her spouse and children simultaneously) and what are the contributing factors? Local research suggests that psychopathology, structural violence, and cultural factors play a role (du Toit, 1990). If so, to what degree might these factors have a role to play in the South African women who commit child homicide?
- Considering that South Africa has the highest prevalence of HIV/AIDS in the world (Unicef, 2008), what might the influence of this disease have on the mental health of the mother, and on her capacity to care for her children? (as suggested from some 2008 South African newspaper reports – see table 1).

These are just some of the issues that rigorous, systematic research into the South African phenomenon of parental child homicide could explore.

5.4 Recommendations

Even though the majority of women do not kill their children, those who are at risk of doing so need to be identified so that appropriate preventative action can be taken. The outcome of this review and of future research could be of considerable value for various mental health professionals working at primary, secondary and tertiary healthcare levels. As prevention implies the recognition of causes and underlying factors, a better understanding of these aspects of potentially fatal maternal/familial dynamics leading to child homicide could facilitate who is most at risk and enable effective intervention strategies. Community clinics would be better informed with regard to which women might be at greater risk of committing child homicide. This could lead to acting proactively in terms of disseminating information of this phenomenon in such a way that women do not feel patronised or stigmatised when they express uncertainty or ambivalence about impending motherhood. As the international literature illustrates, the assumption that all women are pleased at the prospect of motherhood is erroneous, and those who express displeasure will not benefit from becoming ostracised.

Non-governmental agencies with a focus on the family might also be able to benefit from this information. Such agencies are frequently in direct contact with vulnerable population groups such as abused women or teenage girls who may be at risk of child homicide.

Given the findings from the international literature and the high number of children abandoned in South Africa each year, it seems that explanations that such mothers are “mad” or “bad” may be somewhat simplistic. The legal profession might also benefit

from exposure to this literature in order to promote understanding and insight into the underlying dynamics and multi-factorial nature of this phenomenon. Finally, at tertiary level, correctional services centres may be able to tailor rehabilitation programs more effectively when they have thoroughly researched and validated explanations available that help make sense of why some women resort to killing their children.

The literature on maternal child homicide demonstrates the complex interrelation of factors relevant to the origins of the impulse to kill in the individual (with or without mental illness), in conjunction with her developmental history and current social circumstances. Classifications systems are helpful in providing broad categories but they do not fully address the wide range of factors found in an individual case. Clinicians and other relevant stakeholders need to also take into account the women's quality and stability of key interpersonal relationships, illness variables and social context (Simpson & Stanton, 2000). This approach is likely to lead to more meaningful risk management strategy in relation to perpetrators or those who may be at risk of maternal child homicide. As Oberman (1996) states,

> We must acknowledge the role that all of us play in driving these women to the edge of despair, where, with our blessing and our curse, they take the lives of children who should, by right, have inherited our future. (p.90)

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