

DISCARDED INFANTS AND NEONATICIDE: A REVIEW OF THE LITERATURE



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Introduction

A search of the San Francisco Chronicle for June 2004 turned up four cases of discarded newborns in the San Francisco Bay area. On June 4, 2004, the Chronicle reported “a full-term baby boy was found in a garbage can . . . after his 17-year-old mother, seeking treatment at a hospital, denied that she had been pregnant” (Lee, 2004, June 4). The young woman sought medical care for vaginal bleeding, and denied having been pregnant, despite the fact that she had a freshly cut umbilical cord. The baby was found dead in a garbage can in front of his mother’s San Leandro home.

On June 6, 2004, as reported in the June 8, 2004 edition, the corpse of a newborn boy was found in the parking lot of an apartment complex in Oakland (Lee, 2004, June 8). The 21-year-old mother was located shortly after the discovery, and an investigation of the situation has been initiated to determine whether or not the child was born alive, and if there was any criminal activity in the case.

The June 15, 2004 edition of the Chronicle reported that a woman called police to report the discovery of a newborn behind a tavern. After being tracked through the cell phone she used to make the call, the caller admitted she was the boy’s mother, and that she had given birth alone in her home. The baby was found alive, and his mother has two other children (Gathright, 2004).

On June 17, 2004, a 17-year-old farm worker from another Bay Area town delivered a child during her work shift, and she left the newborn abandoned in a portable toilet. A foreman heard cries and rescued the baby girl, who was alive, but reportedly in critical condition (DeFao, 2004).

Other cases of newborns found dead in public places have received national media attention. In November 1996, Amy Grossberg and Brian Peterson, both 18-year-old college students from affluent families, drove together to a hotel in Delaware so Amy could deliver their six-pound son. After the delivery, the couple killed the newborn, whose corpse was later found in a trash bag in a dumpster outside the motel (Ungar & Thompson, 1996).

In another case, Melissa Drexler went to her high school senior prom, delivered a son, cut the umbilical cord, and choked the child to death. She then placed the corpse in a plastic bag, knotted it, disposed of the bundle in the bathroom trashcan, and returned to the dance. Janitorial staff found the corpse (Hanley, 1997).

Cases like those described above have received considerable attention from the media and policy makers in recent years (Baran, 2003). Since 2001, 45 states have passed legislation in an attempt to address this social problem (Alan Guttmacher Institute, 2004). The effect and success of these laws is unclear (Bernstein, 2001) and, as described above, cases of discarded infants continue to occur.

To better understand the problem of women who kill and/or discard their newborn infants, we will review the existing scholarly literature to provide a description of the life circumstances of mothers who discard their infants, including demographics, emotional characteristics, and mental health. This paper will also review a number of possible interventions to address this social problem.

Definitions

The six cases described above are perhaps best described as instances of infant discarding and/or neonaticide, and we

will use these terms throughout this paper.¹ The U.S. Department of Health and Human Services (DHHS) (2001) defines discarded infants as children 12 months of age or younger found in a public place or another inappropriate location, and lacking care and supervision. The definition further specifies that discarded infants are born alive, are found either dead or alive and, if found dead, the cause of death is related to abandonment (e.g., from exposure or from dehydration).

Resnick (1970) defined “neonaticide” in his oft-cited article as the killing of a newborn within 24 hours of his or her birth. Bonnet (1993) refined this definition by describing two types of neonaticide: “active neonaticide” is the killing of a newborn as a direct result of violence, often following extreme panic, and “passive neonaticide” is the result of negligence directly following the birth. An example of passive neonaticide is delivering the newborn into a toilet and failing to take action to prevent his or her drowning. Another case would be leaving a newborn outside to die. Bonnet goes on to explain that, in some cases, would-be perpetrators of passive neonaticide leave their child in a public place, but the newborn is found alive.

An extensive review of the existing scholarly literature in this area found that research almost exclusively discusses neonaticide, and does not draw a distinction between discarding infants and neonaticide. Virtually no academic

¹ Although the newborns in these cases are often referred to as “abandoned babies” or “abandoned infants” by the media and public; the federal Abandoned Infants Assistance Act (P.L. 108-36) specifies that:

The terms “abandoned” and “abandonment,” used with respect to infants and young children, means that the infants and young children are medically cleared for discharge from acute-care hospital settings, but remain hospitalized because of a lack of appropriate out-of-hospital placement alternatives.

To avoid any confusion, we will not use these terms in this document.

literature exists on the discarding of older children, though much has been written about the killing of older children (Meyer & Oberman, 2001). For these reasons, we have chosen to focus primarily on neonaticide.

Although there is clearly considerable overlap between discarded infants and neonaticide, it is possible that there are instances where newborns are found dead, but are not considered cases of neonaticide. For example, a child may be born dead, and then discarded, as may have occurred with the situation described in the June 8, 2004 Chronicle story (Lee, 2004, June 8). In addition, there may be cases where a child is left unsupervised, but the parent intends for the child to be found alive. In the case described above, in which the mother called the police, it may be that this was the mother’s intentions. However, one could argue that the life circumstances of the mothers in such cases will likely be similar to those of the women who commit neonaticide.

As another caveat, because neonaticide by a father is extremely rare (Kaye, Borenstein, & Donnelly, 1990; Resnick, 1970), we will focus only on mothers in this discussion. Authors of future papers should examine the circumstances surrounding fathers, and discarded infants who are older than 24 hours at the time of death.

Prevalence

Neonaticide is by no means a new phenomenon. This form of child murder has been documented among the peoples of Mesopotamia, Greece, and Rome, and among the Vikings, Irish Celts, Gauls, and Phoenicians. Justifications included illegitimacy, societal preference for males, childhood disability, population control, eugenics, religious beliefs, and poverty (Meyer & Oberman, 2001). William Hunter proposed in 1783 to the British Medical Society that neonaticide is a form of killing different from other types of

killing, and it should be legally differentiated as such. A clinical distinction was made between the killings of neonates and older children in the early part of the 20th century (Brozovsky & Falit, 1971). In addition, Resnick (1970) conducted a literature review of documented neonaticides, dating from 1751 to 1968, from 13 different languages, illustrating that there are recorded cases of neonaticide dating to the 18th century.

Current estimates are difficult because many neonaticides go undetected (Meyer & Oberman, 2001), and there has been no continuing national data collection regarding this social problem (Dailard, 2000). However, the Abandoned Infants Assistance Act, which was reauthorized in June 2003 as P.L. 108-36, requires a study and report from the U.S. DHHS that provides:

- (A) an estimate of the annual number of infants and young children relinquished, abandoned, or found deceased in the United States and the number of such infants and young children who are infants and young children described in section 101(b);
- (B) an estimate of the annual number of infants and young children who are victims of homicide;
- (C) characteristics and demographics of parents who have abandoned an infant within 1 year of the infant's birth; and
- (D) an estimate of the annual costs incurred by the Federal Government and by State and local governments in providing housing and care for abandoned infants and young children.

The report is due to Congress no later than 3 years after the enactment of this law.

In a prior report, the U.S. DHHS (2001) estimated the number of discarded infants nationally in 1997 at 105, up from 65 in 1992 (an increase of 62%). The number of infants found dead increased from 8 in 1992 to 33 in 1997 (312.5% increase); the number of infants found alive increased from 57 to 72 between 1992 and 1997 (26% increase). However, these numbers should be considered with caution for a several reasons. First, the numbers were

calculated based solely on searches of electronic newspaper databases, rather than from any official records. Second, it is unclear whether these numbers reflect actual changes in the number of discarded infants, or just an increase in reporting. Third, these figures do not account for whether the babies were born alive or dead, or the reason of death, and the report does not include cases where it was known that the death was a result of active killing (e.g., known cases of neonaticide).

Characteristics of Mothers

There are remarkable similarities among women who commit neonaticide in the available literature, though the women's demographic characteristics run the gamut. For instance, they usually are emotionally immature, have common psychological conditions, and are most often socially isolated.

Demographics

Researchers have found that the women who commit neonaticide are: usually young, in their teens or early twenties; of all ethnicities; unmarried and not involved in a relationship with the father of the baby; and live with their parents or other relatives. Further, when considered independent from their families, most are poor (d'Orbán, 1979; Meyer & Oberman, 2001; Oberman, 1996; Resnick, 1970).

Age

As stated above, women who kill their neonates are usually young. In one study of 17 women who committed neonaticide, the mean age was 23 years, with a range from 15 to 40 years (Spinelli, 2003). In Meyer and Oberman's (2001) sample of 37 cases of neonaticide reported in newspapers between 1990 and 1999, the mean age was 19.3 years, with a range from 15 to 39. d'Orban (1979) found

that the women who committed neonaticide were 21.1 years of age on average, the youngest group in this study of women who kill their children. Mendlowicz, Rapaport, Mecler, Golshan, and Moraes (1998) compared a group of 72 Brazilian neonaticidal women to a group of 72 women who delivered babies who were not killed, and found that the neonaticidal women were an average of 22.5-years-old (ranging from 16 to 48 years), and the women in the comparison group were, on average, almost 25-years-old, a statistically significant difference.

The women who commit neonaticide are generally younger than women who kill their children (filicide) after the child is older than 24 hours (d'Orbán, 1979; Oberman, 1996; Resnick, 1970). For instance, Resnick (1970) found that 89% (n = 34) of women who committed neonaticide were under 25 years of age, and the majority (77%) of women who committed filicide were over age 25.

Ethnicity

Women who commit neonaticide are of all ethnicities. Case studies describe white (the cases of Melissa Drexler and Amy Grossberg), black (Brozovsky & Falit, 1971), Asian American (Meyer & Oberman, 2001), and Latina (Oberman, 1996; Silva et al., 1998) women who commit neonaticide. Of the 17 women in Spinelli's (2003) sample who committed neonaticide, 11 were white, 5 were black, and 1 was Asian.

Of her French sample, Bonnet (1993) explains that 13 were French, 6 were North or Central African, 2 were of European descent other than French, and 1 was Asian. In a Brazilian study of 53 cases of neonaticide, 12 were African-Brazilians, 11 were white, 18 were mixed African-Brazilian and white, and 1 was Indian (Mendlowicz et al., 1998).

Marital Status

Most women who commit neonaticide are unmarried and not involved in a relationship with the father of the baby. In addition, they usually live with their parents or other relatives. Resnick (1970) found that only 19%, of his sample of neonaticidal mothers, were married. More recent research has concluded that the women who commit neonaticide are even less-often married than Resnick's estimate.

Mendlowicz et al. (1998) found that of 51 cases of neonaticide where marital status of the mother was known, 43 were single, 2 were widows, and 6 were married. Of d'Orbán's (1979) sample of British and Welch women who killed their children, none of the 11 women in the neonaticide group were married. A Finnish study of 15 women, Haapasalo and Petäjä (1999) found that only one woman who committed neonaticide was married, only five were in a relationship, and nine (60%) were single. Meyer and Oberman's (2001) sample of 37 women who committed neonaticide contained only one married woman.

Psychological and Emotional Characteristics

Emotional Immaturity

Resnick (1970) noted that the most frequent motive for neonaticide was "unwanted child" (83% of cases studied), and that the women who commit neonaticide are "usually young and immature primiparas [a person bearing their first child]. They submit to sexual relations rather than initiate them. They have no previous criminal records and rarely attempt abortion" (p. 1416). Seeking an abortion would require acceptance of the situation and prompt decision-making, which are not characteristic of those who commit neonaticide; rather, they are often in denial about their pregnancy or avoid making any decisions about the pregnancy.

Spinelli's (2003) sample of women who committed neonaticide and one who attempted the act were described as cognitively immature, with limited intelligence, and lacking the ability to problem solve. They usually lacked insight into their current situation, had poor judgment, and did not possess sufficient coping skills.

Mental Illness

Although some women who commit neonaticide may be schizophrenic or otherwise psychotic, most women who commit neonaticide do not have long-term mental disorders (Meyer & Oberman, 2001; Spinelli, 2001). Haapasalo and Petäjä (1999) found that 27% of a neonaticide sample reported any psychological problems (compared with 85% of women who killed older children). Resnick (1970) found that only 17% of the women in his sample who committed neonaticide were psychotic (compared with two-thirds of the women in his sample who killed their older children).

Denial of Pregnancy

Denial of pregnancy is a common feature that precedes neonaticide. In Spinelli's (2003) sample of 16 women who committed neonaticide and one who attempted it, all denied pregnancy. Although pregnancy is usually concealed or denied, sometimes there is intermittent acknowledgement, but the pregnancy is quickly again denied (Haapasalo & Petäjä, 1999; Spinelli, 2001; 2003).

Although the majority of women who commit neonaticide do not have any long-term psychological pathologies, it is likely that often they experience abnormal mental functioning during their pregnancies. For example, denial of pregnancy can be considered both a social reaction and a psychological reaction to an unwanted pregnancy. There is a fine line between denial that is and is not considered of psychological origin but, as Meyer and Oberman (2001) point out, denial "does not automatically imply the presence

of profound psychosis or some other mental illness.

Instead, the denial is often a temporary state that may vary in depth among individuals" (p. 55).

Nonetheless, Miller (2003) explains that women with psychotic disorders prior to becoming pregnant may deny their pregnancy as an aspect of their mental illness. While the bodies of these women do physically change, the changes are dismissed with bizarre explanations, such as the sensation that something other than a baby is growing within them.

Miller (2003) also describes two additional types of denial: affective and pervasive. Affective and pervasive pregnancy denial are most common among young, unmarried, women bearing their first child; though sometimes the women have children from previous pregnancies (Bonnet, 1993; Spinelli, 2003). Miller (2003) reports that women who affectively deny their pregnancy cognitively realize they are pregnant, but do not experience the normal emotions associated with a pregnancy, and their behavior does not change to accommodate the pregnancy. They simply do not feel pregnant, and they do not prepare for the impending birth.

Pervasive denial is more extreme denial than is affective denial. Women who pervasively deny pregnancy, unlike the women experiencing affective denial, do not intellectually acknowledge that they are pregnant. Brozovsky & Falit (1971) also reported that some women who deny their pregnancies do not experience normal physical changes associated with pregnancy, such as weight gain and nausea, and they continue to have monthly bleeding. Labor is often misinterpreted as a need to defecate, and the birth is endured in a state of dissociation (Miller, 2003).

Social factors, such as isolation, and emotional factors may contribute to denial. The women who commit neonaticide, especially adolescents, may fear pregnancy (Atkins, Grimes,

Joseph, & Liebman, 1999; Meyer & Oberman, 2001). The idea of pregnancy may be unimaginable, resulting in denial when a pregnancy does occur (Bonnet, 1993). Among those who deny their pregnancy, “the common thread seems to be that something about the environment in which a woman becomes pregnant renders her pregnancy highly threatening to her well-being” (Miller, p. 92). Many women who deny their pregnancies and/or commit neonaticide have intense feelings of guilt over sexual relations that may be unacceptable in their cultures or communities, and denial is used as a defense mechanism (Finnegan, McKinstry, & Robinson, 1982; Meyer & Oberman, 2001). Fear of anger or rejection by the pregnant woman’s mother may be a particularly strong factor in choosing not to disclose the pregnancy (Resnick, 1970; Sadoff, 1995).

Labor and Delivery

Women who commit neonaticide generally experience labor and delivery preceding neonaticide alone, often at home on the toilet while others are home, making little or no noise, followed by either exhaustion or panic (Meyer & Oberman, 2001). Usually, the women experience intense cramping and stomach pains, and they interpret these as a need to defecate (Oberman, 1996). After delivery, they may be surprised, or they may be insufficiently mindful of the situation and lack the understanding that they have given birth. They may panic upon delivery and be in a state of mental confusion, rendering them unable to take appropriate action (Atkins et al., 1999; Meyer & Oberman, 2001; Oberman, 1996). If the new mothers understand the reality of the newborn, they may respond in a panic to silence the baby’s cry (Resnick, 1970).

Spinelli (2003) explored in more detail the psychiatric conditions present in women who commit neonaticide, using the Dissociative Experiences Scale to quantitatively measure dissociative symptoms that are employed during

denial of pregnancy. She concluded that all the women in her sample experienced similar psychotic reactions during pregnancy and delivery, including dissociative psychosis, dissociative hallucinations, and intermittent amnesia. The deliveries were experienced as if they were happening to someone else, and the women felt minimal pain. A key factor in these cases is that mental dysfunction was short-term, only present during pregnancy and delivery. Spinelli states that because the women maintain basic reality testing throughout pregnancy, when reality is again tolerable (i.e., when the infant is dead), the women experience “rapid reintegration” (p. 114). A woman finds herself in the presence of a dead newborn, confused over the circumstances leading to her present situation.

Social Relationships

Family of Origin

Spinelli (2003) described the families of the women in her sample as characterized by role confusion, emotional neglect, and boundary violations, with odd parental relationships. Fathers were often intrusive and jealous, and mothers were cold, hostile, or absent (because of physical or mental illness or substance abuse). They generally are lacking a positive support system, and may belong to a family who participates in the denial of the pregnancy, despite the fact that their bodies are physically showing signs of pregnancy (Brozovsky & Falit, 1971; Haapasalo & Petäjä, 1999; Meyer & Oberman, 2001; Spinelli, 2001; 2003). The fact that the neonaticidal women’s families did not notice their changing bodies, as is characteristic of pregnancy, is illustrative of the isolation they may have felt and of the relationships they had with family members and other significant others in their lives (Meyer & Oberman, 2001).

The women may come from families with strong religious or cultural mores against premarital sexual relations (Finnegan et al, 1982, Green & Manohar, 1990; Meyer & Oberman, 2001; Sadoff, 1995). Silva (1998) suggests that cultural clashes, such as those present between immigrant adolescents and their parents, may contribute to neonaticide in that parents may have strong cultural opposition to premarital sexual relations, while their daughters may embrace the more liberal ideals of American culture, such as increased sexual freedom for females. Further, Meyer and Oberman (2001) point out that many of the women who committed neonaticide were illegal immigrants who feared that pregnancy would threaten their fragile residency in the United States.

Young women who live in affluent families with apparent adaptive social interactions also experience isolation and conflicting emotions when they find themselves pregnant unexpectedly. Such women feel that an unwanted pregnancy will rouse feelings of disapproval, despite the fact that resources may be available to them (Atkins et al., 1999; Meyer & Oberman, 2001; Oberman, 1996). Fear of their parents' discovery of a pregnancy may lead some young women to commit neonaticide rather than seek an abortion if laws require parental notification before receiving an abortion (Meyer & Oberman, 2001). The cases discussed above, of Melissa Drexler and Amy Grossberg and Brian Peterson, likely fall into this category of isolation felt by more socially and financially advantaged individuals. They came from middle class backgrounds with family support, but they may have felt pregnancy would evoke disappointment from their parents and others in their communities.

Sexual Partners

As discussed above, very few women who commit neonaticide are married or involved in a committed

romantic relationship. If they are involved in a relationship with the father, it is usually a fragile relationship, illustrated by the fact that many of the women in the literature feared telling their boyfriends of the pregnancy because they believed their boyfriends would end the relationship (Meyer & Oberman, 2001). One researcher found that some women participated in sexual intercourse mere hours before delivery, and the males did not notice the pregnancy (Bonnet, 1993). These factors are further demonstrative of the social and emotional isolation inherent in neonaticidal women's lives.

Responses to the Problem

To this point, we have reviewed the literature on the phenomenon of neonaticide, and this paper has described circumstances surrounding pregnancy that precede neonaticide and infant discarding. Below is a discussion of the responses that scholars have recommended and that legislators have proposed and implemented.

Prevention of Neonaticide

Family Planning

Neonaticide appears difficult to prevent because of the concealment of pregnancy and lack of contact with health professionals prior to birth (d'Orbán, 1979; Wilkey, Pearn, Petrie, & Nixon, 1982). However, it has been suggested that "those who would prevent neonaticide must begin by identifying and remedying girls' vulnerability long before they become pregnant" (Oberman, 1996, p. 73).

An appropriate first step may be increased access to and education about family planning. Some family planning advocates believe that education about contraception is essential in preventing denial of pregnancy and neonaticide (Dailard, 2000). The life circumstances and characteristics of

women who commit neonaticide make the possibility of ignorance about birth control methods very high, indicating the importance of education. Education especially about long-acting contraceptives is warranted for women who do not always plan when they are going to have sex and for women who have emotional or mental difficulties using birth control every time they have sex or using methods such as birth control pills, which require daily attention (Miller, 2003). Family planning may prevent future neonaticides by reducing the chance of an unplanned pregnancy. However, this may be ineffective or irrelevant for women who do not acknowledge the fact that they are even having sex, such as those who passively submit to sexual relations or harbor feelings of guilt about sexual behavior.

Some researchers have also suggested that abortions be more readily accessible (Meyer & Oberman, 2001; Resnick, 1970). However, access to abortion services may be superfluous if the woman is in denial about her pregnancy (Haapasalo and Petäjä, 1999). Obtaining an abortion would require acknowledgement of the pregnancy, which is counter to the state of denial most often experienced. Some have also argued that an important goal is reducing the stigma attached to out-of-wedlock births. They argue that if women, especially young women, do not feel stigma associated with becoming pregnant, they may be more likely to seek adaptive approaches to an unwanted pregnancy, such as seeking safe medical abortions, or carrying the fetus to term and either raising the child or placing him or her up for adoption (Saunders, 1989).

Identification of Risk

Several authors recommend that anyone in contact with women or youth who appear to be pregnant, but are in denial of the fact, should take action. Usually perpetrators of neonaticide are isolated, and their families and

boyfriends, if present, often participate in denial. Detection of the pregnancy before labor begins, likely by someone outside of the woman's family, is important in reducing the chances of neonaticide. This outside party may be able to assist the woman with access to resources, such as counseling, prenatal care, abortion, or arrangements for care of the child after the birth (Bonnet, 1993).

Miller (2003) recommends, for instance, that teachers be alert to changes in their students' mood or dress that may indicate pregnancy. Bonnet (1993) suggests that health care workers should listen to the concerns of pregnant women and quickly intervene if a woman has hidden or denied her pregnancy and received no prenatal care. However, Bonnet's suggestion does not account for those women who are never in contact with medical professionals. Further, doctors often do not notice that a woman is pregnant, and they do not inquire about the possibility of pregnancy, if her medical visit is for another reason (Meyer & Oberman, 2001). Meyer and Oberman speculate that if doctors were more educated about the phenomenon of neonaticide, they would be more apt to recognize that their patients are pregnant, even if the pregnancies are not reported or if their patients deny their condition.

Legislation

In response to highly publicized instances where infants have been discarded in public places, most states have passed laws, often called safe haven laws, which offer a safe, anonymous, and lawful means to relinquish a newborn. Safe haven laws are based on the premise that new mothers will not kill or discard their newborns if there are locations where the children can be safely left, with no fear that the mother will be prosecuted. As of 2004, 45 states² have

² Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri,

enacted safe haven laws, though the specifics vary from state to state. Only Alaska, Hawaii, Massachusetts, Nebraska, Vermont, and Washington, D.C. do not have safe haven laws (Alan Guttmacher Institute, 2004).

Age limits for a child to be left differ considerably. At one extreme, North Dakota permits a child up to one-year-old to be left with an appropriate authority. At the other end of the spectrum, states such as California, Florida, Kentucky, Mississippi, and Washington permit the relinquishment of an infant only up to 72 hours after birth. In most states, only a parent can leave the child, but 16 states allow someone acting on behalf of the parent to leave the child. Twenty-eight states allow the person leaving the infant to remain explicitly anonymous. Some have specific procedures to follow for acceptance. For instance, California, Connecticut, Delaware, and North Dakota provide identification bracelets to the infant and to the person leaving the infant, in order to facilitate reunification at a later date, if a reunion is sought. Eleven states request a medical history of the child. Fifteen states are required to investigate whether or not the child has been reported missing. States also vary by who is permitted to accept a relinquished infant, most often emergency service personnel and/or health care providers (Alan Guttmacher Institute, 2004).

The advocates of these laws believe that lives will be saved, crimes will be prevented from occurring, and more infants will be available for adoption (Dailard, 2000). Others have argued that these laws may not work, because the women who commit neonaticide often deny or conceal that they are pregnant, and do not arrange for the birthing process or for

Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

the care of the child after the birth (Dailard, 2000). Meyer and Oberman (2001) have argued that women who commit neonaticide usually do so in a state of panic and fear, so it is unlikely that they will be sufficiently calm to consider dropping off their newborn in a designated safe place.

The American Adoption Congress opposes safe haven laws because they believe that children are entitled to information about their families, including medical, ethnic, and religious histories. Safe haven laws often do not afford discarded infants the opportunity to access such information due to the anonymity of those leaving a child (American Adoption Congress, 2001).

As the news reports at the beginning of this paper suggest, the success of these laws is uncertain. As the National Conference on State Legislatures (2003) reports:

A number of states have begun to report on infants abandoned after the passage of the safe haven legislation. As of September 2001, approximately 33 babies had been legally relinquished including five each in Texas, Michigan, and Alabama, six in New Jersey, four in California, two in Connecticut, Minnesota, and Ohio, and one each in Kansas and South Carolina.

As of September 2002, state agency officials in California report that they have had 20 infants abandoned through the law since their legislation went into effect. New Jersey reported 10 safe haven infants, a 63% reduction in infant abandonment, since the passage of their law in 2000 (compared to 8 abandonments prior to the passage of the law). Illinois reported 2 safe haven abandonments since their law was enacted in 2001.

Unlawful abandonment continues to be a problem. As of September 2001, Texas reported at least 12 infants had been abandoned illegally since the passage of its law, but the abandonments occurred before the start of a public awareness campaign. None have been abandoned outside safe havens since this publicity. Louisiana reported that five infants had been abandoned illegally since passage of its

law. Three babies died, and the parents were prosecuted. At least five babies were illegally abandoned in California; two more of them were found dead. In Connecticut, one baby was discarded near a highway. Three babies had been abandoned illegally in Colorado.

As of September 2002, California reported 21 illegal abandonments and 17 infants abandoned found deceased. Illinois reported four infants illegally abandoned and found deceased.

Criminal Justice

Charging and Sentencing

Oberman (1996) attempted to analyze the allegations and sentencing of women accused of neonaticide. In looking at the charges brought against the women, only 29 of 42 were for murder. Murder charges require intent on the part of the killer, but usually there is not premeditation involved in cases of neonaticide; rather, the killers react with panic and impulsiveness (Oberman). The charges ranged widely, from the misdemeanor charge of unlawful disposal of a body to first-degree murder. She notes that there was a tendency toward more severe charges if the newborn was mutilated in any way.

Because of the limited availability of information regarding sentencing in neonaticide trials, she had a much smaller sample: only in 17 cases was such information available. The sentencing ranged from therapy and parenting classes to incarceration for over 30 years. Overall, Oberman (1996) suggests that killers of infants, both neonates and older infants, receive lighter sentences than do killers of adults and older children. d'Orbán (1979) also reported that women who commit neonaticide are more likely to receive lighter punishments

Oberman (1996) suggests that killers of older children and adults would doubtless face more severe charges and receive harsher punishments in general, but that the reasons for this

have not been thoughtfully considered. She suggests that there are a number of social dangers inherent in meting out lighter sentences to killers of infants than to killers of older individuals, a tendency that has not been discussed and evaluated. These dangers include:

- This implies that society values the lives of children less than we do the lives of adults.
- Wide discrepancies in sentencing threaten the integrity of the law.
- Because the majority of killers of infants are women, and discrepancies in sentencing of male perpetrators is virtually non-existent, there is a sexist undertone. Women are held less accountable than men for illegal acts, implying that women have less capacity for self-regulation.
- Because society does not acknowledge that we treat cases of neonaticide differently, we are missing the opportunity to consider the remarkable similarities in the cases (Oberman 1996).

Incarceration

In addition to punishment, incarceration can serve to protect society, as a deterrent and as rehabilitation. However, in the case of neonaticide, Atkins and colleagues (1999) argue that those who commit neonaticide are not in need of rehabilitation, and that they pose no risk to society or to their children, both already born and those not yet even conceived. Further, they assert that the act of neonaticide is unlikely to occur again because the circumstances surrounding the act are so unique, and, therefore, criminal rehabilitation and removal from society are usually unwarranted. In addition, because neonaticide usually occurs quickly and with no premeditation, there is little deterrent value in incarceration of women who commit neonaticide. Indeed, many women do not even realize they are pregnant or experiencing labor until after they have given birth (Atkins et al., 1999; Meyer & Oberman, 2001; Oberman, 1996).

Schwartz & Isser (2001) believe that judges should consider all the circumstances surrounding a neonaticide, such as fear and ignorance, when considering incarceration. They state that long prison sentences will likely have negative impacts on mental health, which is already fragile for many women who commit neonaticide. These authors believe that women who commit neonaticide should be held accountable for their actions, but also must be equipped with the tools necessary to prevent future crises. Therefore, they posit that therapeutic rehabilitation would perhaps be the most appropriate response to neonaticide, because the women who commit the act are more in need of emotional and mental rehabilitation than they are of criminal rehabilitation.

Neonaticide Laws

Currently, there are no statutes specifically addressing neonaticide in the United States: it is treated as any other homicide (Oberman, 1996). However, because of the unique circumstances differentiating neonaticide from other killings, it has been suggested that laws specific to this occurrence be developed (Fazio & Comito, 1999). Indeed, because there is so much variability in the sentences of those convicted of neonaticide, a law specifying neonaticide as a crime would decrease the variability of sentencing in such cases (Oberman, 1996). This would require extensive education of those in the criminal justice system about the underlying circumstances surrounding neonaticide and the preceding pregnancy (Meyer & Oberman, 2001). Specific laws can also prevent adolescents from being tried in criminal courts (Schwartz & Isser, 2001).

Conclusion

Discarded infants are a substantial social problem, and a number of factors contribute to the phenomenon. In this paper, we have discussed a specific and unique area of

discarded infants: victims of neonaticide. Neonaticide has existed throughout history, though motivations behind the act have evolved, at least to some degree. Unfortunately, the nature of neonaticide makes intervention difficult: women who commit neonaticide usually are socially isolated, they often deny or take action to hide that they are pregnant.

Neonaticidal women are usually young and unmarried, with no pre-existing mental disorders, and are part of a social network that does not provide sufficient emotional support. Developmental and social dynamics, such as emotional immaturity, social isolation, and pregnancy denial, are usually factors in the act of neonaticide. In all but one of the cases (that of Amy Grossberg) reported in the literature, the women experienced labor and delivery in seclusion.

Responses to the problem have not been met with a great deal of success. Safe haven laws, though rooted in magnanimity, have not proven to be effective because they are not designed in such a way that will affect the decisions and actions of those most likely to discard infants. These laws have also met with much criticism from adoption advocates. Punitive responses, while punishing a woman for her actions, will also not likely affect decisions or events leading to neonaticide. Some scholars have argued that while perpetrators of neonaticide should doubtless be held accountable for their actions, their situations demand therapeutic intervention rather than punishment.

Doctors, teachers, and social service providers are called upon to be alert when women, especially young women, exhibit characteristics putting them at risk of committing neonaticide. Action must be taken both before an unplanned pregnancy occurs and, if such a pregnancy does occur, before labor and delivery. Oberman (1996) suggested that, in the end, preventing neonaticide requires

that society somehow reduce the vulnerability that is felt by women who commit this act of desperation.

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