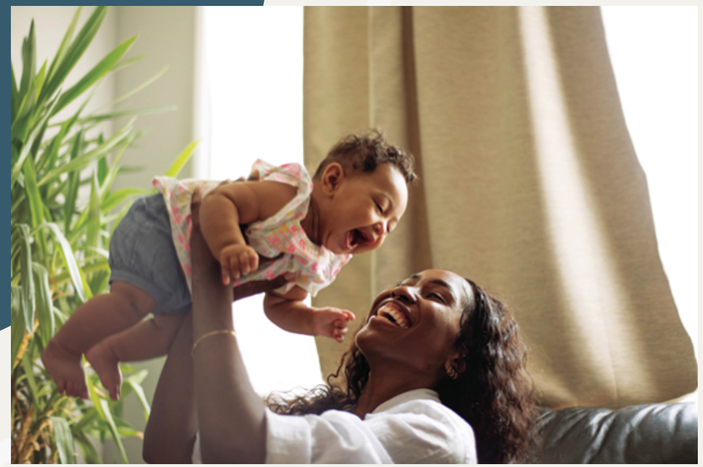

Breaking Point

Why do mothers hurt their babies?

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Welcome and Introduction

Warning

We will be discussing:

- Physical abuse of young children
- Description of physical injuries
- Discussions of mental health difficulties

Learning outcomes:

- Insights into the scale of the problem re physical abuse of babies and methodological issues.
- Insight into the differences between genders in the non-accidental injury of children
- To understand some of the psychological reasons why mothers harm and kill their babies.
- To cover risk assessment when a mother is suspected of harming her baby.
- To have a greater understanding of the role of denial and non-acceptance of harm by believed perpetrators.
- To introduce ideas about how risks can be managed in families where a baby has been harmed by their mother.

What do we mean by harm?

- **Physical harm**: bruises, broken bones, burns, cuts, internal injuries.
- **It can be caused by**: hitting, kicking, shaking, throwing, burning, scalding, drowning, choking etc.
- **It can cause** temporary or long-lasting pain and disability, in some cases death.
- **What do I see most often in family court?** Broken bones (ribs, skull, legs and arms) but also severe bruising and internal injuries (retinal bleeding, brain injury, lacerated liver).

A few facts and figures:

Physical abuse is a leading cause of death in children under one year in high income countries

Parents are most often the perpetrators (worldwide incidence study 77.8% of child homicides in I year committed by parents; Stokl et al, 2017)

Worldwide; baby girls most likely to be killed by parents (58.4% versus 46.8%). Overall risk increases for boys under 18

Risk of filicide is highest on the day of birth, another peak at 8 weeks and then steadily declines after 6 months

The incidence of identified non-accidental injury seems to be increasing: better detection?

Physical abuse estimated to account for about 12% to 20% of fractures in babies and toddlers

Evidence links physical abuse in childhood to physical disability and emotional difficulties in adulthood. E.g. inflicted head trauma commonly leads to long-lasting sequalae for the child

Overall incidence rate remains low: challenge for risk management:
low frequency / high severity

Gender and harm to babies

We don't know! Data often incomplete and perpetrator not identified (e.g. Stokl study, 2017)

Global study biological mothers commit most homicides of babies >1 (77.7% - Stöckl et al, 2017)

BUT UK study of convicted infanticides in England and Wales 1997-2006, found babies more likely to be killed by their father than by a mother in the approximate ratio 2:1 (Flynn et al, 2013).

Parental neonaticides (homicides within 24 hours of birth) almost exclusively perpetrated by biological mothers (e.g. concealed pregnancy).

Women more likely to kill young children (> 6). Girls and boys equally at risk from mothers.

Fathers outnumber mothers as perpetrators of abusive head trauma (e.g. shaking) in babies: ratio of 2:1 to 10:1 (Brown et al, 2019; Nuño et al, 2015; Scribano et al, 2013; Sieswerda-Hoogendoorn et al, 2013). No specific UK studies.

Biological fathers outnumbered 'stepfathers' as male-pepetrators of NAIs in babies. Almost no data on non-biological mothers – one study found stepmothers only committed 1% of child murders.

Mothers may be more likely to kill their babies through beating and suffocation

Stepparents tend to use more violence/ overt hostility

Mothers who kill their children tend to be overrepresented in the media

Characteristics of women perpetrators

- Broad generalization – no data specific to UK populations.
- Mostly based on filicide.
- In general women:
  - Younger women tend to kill young babies (neonaticide most likely to be teenage mothers – 11 times more likely). Women over 25 tend to harm older babies.
  - Tend to live alone or with parents rather than a partner.
  - Neonaticidal mothers less likely to have a history of mental illnesss and less likely to be psychotic or suicidal. Unlikely to have previous criminal histories.
  - Harm to babies is associated with lower levels of education, poverty and employment in women.
  - Tend to have histories of trauma, abuse and victimization (not all).
  - Less likely to have sought pre-natal care: 10.4x more likely to kill their baby (Koenen & Thompson, 2008)
  - Most women who accept killing or harming their babies, report regretting it and not seeking help sooner (Milia et al., 2022)

Perinatal Mental Health

Pregnancy and early post natal period is a risk for new and recurrent mental health problems. 10-20% occurrence (see Howard & Khalifeh, 2020). May be increasing.....

Systematic review found about three times increased risk of child maltreatment in parents with severe perinatal mental health problems - mostly women (Ayers et al., 2019)

Moderate perinatal MH problems may increase risks to the child if other risks present and lack of protective/compensatory factors. Important to look at cumulative risk and interaction with other risks

Large epidemiological study in Australia of mothers, MH did increase child maltreatment allegations even after other factors controlled for (2.64 times more likely; O'Donnell et al, 2015)

Many mothers who harm and kill their babies do NOT have diagnosable mental illness (Frederique et al., 2022). Methodoloical problems. Under-researched.

Post partum psychotic disorders

Sudden onset of psychotic symptoms following birth: 0.1% incidence

Limited data linking PPP to harm to babies: untreated PPP estimated to pose a 4% risk of infanticide (Resnick, 2016)

Research suggests PPP is associated with slightly higher rates of physical harm to the child, if negative delusions/thoughts about the child are involved (Chandra et al., 2006)

Women with histories of severe physical abuse themselves more likely to develop PPP (Kennedy & Tripodi, 2015)

Mothers with pre-existing psychotic disorders

- Bipolar, schizophrenia etc
- Pregnancy and parenthood can be a particular challenge for this group (e.g. medication; stigma; lack of social resources)
- American study of 55 mothers who have killed their children: 52.7% deemed psychotic (Lewis & Bunce, 2001)
- Child maltreatment in mothers with psychosis tends to be more impulsive (Stanton et al., 2000)
- Pathways to harm linked both directly to psychotic symptomology and indirectly (e.g. attachment problems, separation, social isolation, higher levels of stress, poor coping skills, impulsive control & problem solving

Depression

- Depression in mothers is linked to more hostile, negative parenting practices, lower warmth & disengaged parenting.
- Post-natal depression (PND) often linked with child abuse but evidence inconclusive. May be due to differences in definition.
- A large-scale Japanese study looked at depression in mothers and found that PND was not associated with abusive behaviours, but difficulty with bonding was (Choi et al., 2010).
- Similar finding in another recent study: hostile attributes towards the child's behaviour at one month predictive of abuse but PND not (Kita et al., 2020).

Other mood disorders

- No clear link between physical abuse and other MH diagnoses such as anxiety, OCD, PTSD.
- Mothers with OCD & anxiety particularly prone to worrying about harm to their children and having intrusive thoughts of doing so. Often share them with professionals BUT very rarely act on them (Booth et al., 2014).
- PTSD can impact upon bonding and sensitivity. Some evidence for increased aggression towards children in mothers with PTSD but evidence inconsistent (Ayers et al., 2019; McCarthy, Wakschlag & Briggs-Gowan, 2018). Might link to the cause of the trauma?

Personality Factors

- Personality problems are over-represented in women who harm and kill their babies.
- Meta-analysis: significant correlation between child maltreatment and emotionally unstable and antisocial PD in parents (Senberg et al. 2023).
- Particularly linked to emotional regulation difficulties
- In women, one study found 4/16 (25%) of mothers who had killed their babies 25% had a diagnosed PD (Klier et al., 2016).
- High levels of trait anger linked to higher child abuse potential – not linked to women specifically.
- Likely mechanisms: poor problem solving, low frustration tolerance, impulsivity, poor capacity for “mentalizing”, accurate attunement to the baby.
- Also, personality difficulties key risk factor for mood disorders such as depression and other stressors (e.g. parental burnout; low social support, low socioeconomic status).

Attachment patterns

- Attachment theory: based in earliest interactions with caregivers. Broadly stable across lifespan.
- Attachment style predicts quality of mother-baby dyad and beliefs about parenting and the baby (Mikulincer & Shaver, 2019).
- Link between attachment style and capacity for maternal maltreatment “almost unacknowledged” in literature (Lattanzi et al., 2020)
- Meta-anaylsis of 16 studies: positive association between insecure attachment and child maltreatment (Lo et al, 2019).
- One study (Barone et al., 2014) looks at attachment in maternal filicide: Attachment style unresolved, insecure and unclassifiable in mothers who have killed their baby. Strong themes of hostility and helplessness in the codes.Found that looking at attachment alongside other risk factors increased predictive value.

Other psychological factors

- **What do women say is going on for them emotionally when they harm or kill their children?**

- **Thematic analyses of studies where mothers have killed their babies** (Milia et al., 2022; Greenwood & Synott, 2023). Key themes:
  - Not ready to be a mother
  - Difficulties accepting reality of pregnancy
  - Fear, panic and/ or desperation – perceived necessity.
  - Misplaced and delusional altruism
  - Resentment and anger towards the child
  - Not revenge towards a partner? Different to men?

- **Confessions of parents who have caused abusive head trauma** (Edwards et al., 2020):
  - Frustration
  - Tiredness
  - Parental “burnout”
  - Perception of their baby as “difficult”
  - Hostile intentions attributed to the baby.

Other psychological factors (cont.)

- **Substance misuse:**
  - Drug and alcohol use is associated with increased risk of NAIs to children: not gender specific, research limited.
  - Mechanisms: disinhibition, less tolerance for baby, poor impulse control, lack of readiness for parental role, increased parenting stress--cumulative risk model? (Gusler & Moreland, 2023).
  - High level of co-occurrence with MH disorders: this group most likely to be referred to child protection services in USA (Hammond et al., 2017).

- **Learning disability/ cognitive impairment:**
  - Very little specific research, risk seems to be in combination with other risks (e.g. own trauma history, poor parenting history, MH problems; McGaw et al., 2010)

Prior Victimisation

- Experiences of domestic abuse, own histories of trauma & abuse as children can increase risk of abusive behaviours
- Likely to increase stress, mental health problems and trauma responses which reduce personal resources for coping as a parent.
- Lack of supportive partner in cases of domestic abuse
- Childhood victimisation/ abuse known to shape cognitive development; particularly, capacity for empathy & social processing misuse.
- Becoming a parent may be triggering/ bring up ambivalent feelings, particularly for women with sexual abuse histories (e.g. rape; childhood sexual abuse).
- Poor templates for parenting.
- Women who are defensive and avoidant about their victimisation at particular risk (Milner et al., 2010).
- BUT also capacity for growth and change: strengths model (Siverns & Morgan, 2019)

Social Circumstances

- Women who harm or kill their babies, are more likely to:
  - Have limited social support
  - Have limited access to community resources (Covid-19 lockdowns case in point)
  - Not have a partner
  - Feel overburdened
  - Often primary carers for their children, may have other caring roles.
  - Be unemployed and have limited finances.
  - Have unstable and/ or poor quality housing
  - Live in socially disadvantaged areas
  - Be part of a marginalized group (e.g. refugee; experienced racism)
  - Experience language barriers and cultural differences
  - Cultural expectations around gendered roles & meaning of “motherhood”

Characteristics of the baby

- Does seem to make a difference.
- Parents of babies with colic: 70% reported having aggressive fantasies towards the baby, 26% homicidal thoughts (Levitzky & Cooper, 2000).
- Premature and low birthweight
- Birth order: second or subsequent children more at risk, unless born to a teenage mother.
- Ill or disabled babies (systematic review Frederick, Devaney & Alisic, 2019)
- Age – newborns at greater risk.
- Gender does not seem to make so much difference to female perpetrators in the UK.

Denial

- Very common – similar to other behaviours which elicit social judgement.
- Again, hard to study – who admits to being “in denial”!
- Confessing to child abuse can have dire consequences: imprisonment, loss of job, removal of children, loss of relationships, loss of status etc.
- Confessional studies describe shame, fear of losing loved ones and opportunity to care for the child (Edwards et al., 2020)
- A complex, multifaceted psychological, social and relational process
- Denial also has a complex relationship to risk: no clear link with repeat offending in other areas of risk. Individualised approach.

Psychological Assessment

- Full personal history: childhood experiences, abuse/ victimization history, relationships with parents
- Detailed history of the pregnancy and birth (wanted baby? Trauma, reaction to physical changes, physical health).
- Personality assessment
- Meaning of the child interview (Grey, 2015): perception of the child, capacity to mentalise child's experiences, empathy, perceptions of parenthood.
- High risk markers: hostility, ambivalence, child blaming, withdrawal from child, lack of interest, hopelessness/ helplessness.
- Understanding of what has happened to the baby: insight into injuries, denial
- Capacity to engage in a therapeutic conversation.

Risk Assessment of Women

- No specific tools for this group
- No reliable actuarial measures
- Self-report measures limited validity (e.g. “CAPI”)
- Repeat offending rates are unclear and accurate, specific research very limited.
- Have to adapt what is available – carefully; with regard to gender.
- I use adapted amalgamation of other structure professional judgement tools; mainly HCR-20 and Child Abuse Risk Evaluation (see Agar, 2002; de Ruiter et al., 2020; White et al., 2014).
- Formulation driven approaches likely to be the best available (e.g “5 ps”)
- Should include protective, compensatory and risk reducing factors.
- Need to be upfront about limitations of predictive validity and reliability, especially across time.

Is rehabilitation possible?

Yes!

- **Needs careful risk assessment and risk management plans.**
- **Be clear on what needs to change to reduce risk and realistic about timescales/ possibility of change.**

FACTORS THAT IMPROVE PROGNOSIS: high levels of support networks, absence of personality difficulties, good “mentalisation” capacity, empathy for the baby, willingness to engage, insight into need for oversight.

FACTORS THAT REDUCE PROGNOSIS: continued ambivalence to the baby, substance misuse, interpersonal problems, lack of support network, untreated MH problems, personality disorder, anti-authority attitudes, poor insight into need to engage, impulsivity, high anger/ irritability.

What can be done to help?

- Therapy for MH difficulties.
- Increase coping skills and emotional regulation work (DBT; mindfulness)
- Substance misuse treatment
- Specific work to increase bond with the baby and parent reflective functioning (e.g. VIG)
- Relationship issues: strengthening existing relationships and/ or domestic abuse work.
- Activating support network and protective network around the child.
- Role of intensive health visiting and practical help: community resources.
- “Resolutions” approach (Turnall & Essex, 2006; Sepers et al., 2023)

Take home messages

Women do harm and kill their babies - rare but probably underestimated

Requires highly individualised, detailed risk assessments looking at full context including risk increasing and risk reducing factors

Take concerns and threats seriously

Pay attention to the meaning of the child to the mother: likely motives for harm

Likely to involve culmination of both psychological and social factors

Denial is common and not always linked to risk of repetition

Intervention is possible: social support networks likely to be key in successful reunifications

If considering separation vs reunification consider how risks can be managed and if they are situational or persistent. Can risks be addressed whilst keeping the child safe?

High risk markers: unwanted pregnancy, overburdened mother, social isolation, ill/small/premature/colicky baby, negative thoughts to wards the baby, lack of bond/empathy for the baby, severe mental illness and personality difficulties

Thanks for listening!

Any Questions?

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