DENIAL OF PREGNANCY AND NEONATICIDE DURING ADOLESCENCE: FORENSIC AND CLINICAL ISSUES

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The authors, a lawyer and three mental health professionals, examine the phenomenon of pregnancy denial and neonaticide among adolescent girls in light of several recent and highly publicized cases. As counsel and forensic experts for the defense in an adjudicated case, the case of "Lisa," the authors had the opportunity to explore and address the psychological and legal issues underlying the defendant's account of the events surrounding the death of her infant. A review of the psychological literature in the areas related to pregnancy, denial of pregnancy, childbirth, and neonaticide provided validation and support for the defendant's otherwise unbelievable story. The processes of forensic psychological evaluation and legal consultation, as well as the interaction of these two disciplines, are explored. Specific emphasis is placed upon the importance of the forensic psychologist's role in discerning the pertinent psychological issues of the case and educating counsel as well as the court.

INTRODUCTION

Over the Memorial Day weekend, 1997, Lisa gave birth to a baby girl in the shower of her boyfriend's parents' condominium at the seashore in New Jersey. At birth, the baby appeared stillborn to her, although forensic evidence asserted a first breath of life. Two pathologists agreed, however, that the mother likely saw no signs of life since the baby was neurologically depressed and its breathing obstructed. Both pathologists agreed that the mother did nothing affirmative to terminate life but that death occurred as a result of her neglect.

Lisa was a seventeen-year-old high school senior who was a few weeks from graduation. She lived with her parents in their upper-middle

class Pennsylvania suburban neighborhood. Her relationship with her parents, as an only daughter of three siblings, was very close, particularly with her mother. She was a successful high school athlete and was never the subject of criminal, juvenile or disciplinary proceedings of any kind.

However, during the previous year, Lisa had been involved with a young man, Robert, 19, who was described as "troubled" and who had a history of serious drug abuse. In retrospect, Lisa realized that her involvement with Robert stemmed from her desire to help him with his problems and to keep him off drugs. Shortly after their relationship began, Robert informed Lisa that he had been kicked out of his parents' home. Without notifying her parents, Lisa allowed Robert to spend the night in the basement of her parents' home. Lisa later reported that during that evening, Robert forced himself on her and raped her. Because she was not permitted to have overnight male guests, Lisa was afraid to tell her parents about the rape. In addition, Lisa had been a virgin and she felt ashamed and partly responsible for what had happened. Despite her attempts to end the relationship with Robert, Lisa was unable to free herself from his domination. She endured a second rape some four months later when Robert forced himself into Lisa's home while her parents were away. After the rapes, Lisa became introverted and quiet. She withdrew from academic and social interests. She showed less concern about her appearance which, as for many teenage girls, had previously been extremely important to her. Although her parents noticed the change in their daughter, their efforts to learn what was troubling her were brushed off with, "Everything's fine."

Over the course of her pregnancy which spanned from the beginning of her senior year in early September, 1996, through her delivery in May, 1997, no formal prenatal care was undertaken. At least once a month for various reasons, Lisa reported to the school nurse with complaints which, on numerous occasions, were noted in her medical records as menstrual cramps and spotting. While Lisa did intermittently suspect that she might be pregnant during the months following the second rape, she was able to

rationalize and deny this fact. This was possible, in part, because of her continuing monthly "menstrual" cramps and bleeding. In February, 1997, Lisa bled profusely and she reasoned that she had had a miscarriage. At other times, Lisa attributed the irregularities in her cycle to having contracted a sexually transmitted disease, possibly AIDS. Also, the fact that Lisa gained a total of only ten pounds during her entire pregnancy facilitated her denial of the pregnancy. While these circumstances seem hard to believe, it is important to bear in mind that Lisa was a naive, 17-year-old girl who felt ashamed and afraid and who confided in no one.

In May, when labor started, Lisa mistakenly believed that she was five months pregnant (from the second rape) and miscarrying, when, in fact, she was nine months pregnant, and a full-term baby was delivered. It was 3:00 a.m. on May 26; Lisa was at the seashore with her new boyfriend and his family for the Memorial Day weekend. Lisa was experiencing severe abdominal cramps, vomiting, and increasingly heavy vaginal bleeding. She got in the shower. The only way to relieve her abdominal pain was to push on her stomach. Within a short time, Lisa had given birth to a full-term baby girl. Lisa later reported that the newborn was not making any sounds and did not appear to be breathing. Lisa continued to bleed as she cut the umbilical cord with a razor. She wrapped the newborn in her shirt and towel, leaving the head sticking out. She then placed the newborn in her overnight bag and told her boyfriend that she needed to go home.

The next day, Lisa was confused and disoriented; she was partially amnestic for the delivery. Lisa passed out during the ride home. She reportedly blocked out the whole incident until she unpacked her bag and was confronted with the shocking reality. At that time, Lisa hid the newborn's body in a box in her garage. The following day, she was taken to the hospital. Upon examining Lisa, doctors saw signs of the pregnancy and recent delivery. Lisa denied having given birth, insisting that she had only experienced heavy bleeding. The police were notified, and, after in-

tensive questioning, Lisa admitted what had happened and led police to the baby's body.

On the same weekend approximately two counties away, another high school senior, Melissa Drexler, was attending her high school prom. Press accounts indicated that Drexler went into the ladies' room during her prom and, after about an hour, delivered a full-term baby which was placed in a trash can. The cause of death was suffocation. Drexler is reported to then have returned to the dance floor where she requested her favorite song, danced with her date and enjoyed the rest of the evening. Drexler also comes from an upper-middle class suburban family setting.

These two cases in New Jersey were approximately one year after the case of Amy Grossberg and Brian Petersen. Grossberg and Petersen are alleged to have induced delivery of their baby in a motel room and disposed of the infant in a dumpster outside the motel where delivery took place. The infant's body was discovered with cranial injuries.

Grossberg and Petersen were indicted in Delaware for first degree murder. Prosecution initially stated that the death penalty would be sought. Grossberg's anguished parents pleaded on national television for leniency. After two years of highly publicized legal maneuvering, Petersen agreed to plead to a reduced charge of manslaughter in exchange for his testimony against Grossberg. On the eve of the trial, Grossberg accepted a manslaughter plea as well. At sentencing, Amy Grossberg received a sentence of two and one-half years without parole. Brian Petersen was rewarded for his agreement to assist the prosecution and was sentenced to eighteen months in prison without parole.

Drexler was charged with first degree aggravated manslaughter, exposing her to twenty years imprisonment. After two years of negotiations, Drexler was sentenced to fifteen years incarceration and will be eligible for parole after three years. Under standard New Jersey parole analysis, Drexler's release after three years is likely given her age, background and lack of a criminal record.

The first author (Dr. Atkins) has been retained by defense counsel in yet another case, involving a teenaged girl, Marianne Biancuzzo, and the death of her newborn infant in Arizona. This case shares many of the same characteristics and patterns as those already mentioned. The state charged Marianne Biancuzzo with first degree murder. At trial, she was found guilty of the lesser charge of negligent homicide. She is facing a sentence of anywhere from probation to 3.75 years in prison.

Although Lisa was initially charged as a juvenile, the State decided that it wanted to try her as an adult. The State's plea offer was that Lisa waive jurisdiction of the juvenile court and plead guilty to the crime of manslaughter, a second degree offense with a maximum exposure of ten years and a presumptive term of imprisonment of seven years. The state agreed it would not seek any period of parole ineligibility and would argue for the presumptive term of imprisonment. At sentencing, Lisa's counsel, assisted by her mental health professionals, presented evidence which convinced the Court to reduce her sentencing status to the equivalent of a third degree offender.[1] After a full day sentencing proceeding which included three hours of psychological testing, analysis and opinion, Lisa was sentenced to a prison term of four years with no parole minimum. Lisa was paroled after ten months in state prison.

SOCIAL OPINION AND THE ROLE OF THE MEDIA

The Grossberg-Peterson case has received national media attention. Grossberg and her mother have been interviewed on national TV. The TV program "Law and Order" has already aired a show based, in part, upon the news accounts of the Grossberg-Peterson case.

The Drexler case and our case, likewise, received complete print media and TV coverage both locally and regionally. Both cases have also received national attention through such shows as "Geraldo" and "American

[1] NJSA 2C:44-1 (1) (2)

Journal." As each case is sensationalized, it is reinforced in the public's mind that each is yet another baby killing case. Lost are the many factual distinctions between the cases and the clients which cause one case to be charged as murder, a second as aggravated manslaughter and a third as manslaughter.

Many television programs focusing upon neonaticide and infanticide have invited psychologists and psychiatrists not involved with particular cases to offer their opinions relating to the "rash" of neonaticide/infanticide cases splashing across the headlines. The media seeks to explain through these experts how such crimes can occur particularly in affluent settings involving young women not fitting a typical criminal profile. The dichotomy presented by the media is that these young women are seen as having all available resources at their behest and, as a result, without excuse for their conduct.

Many of the expert opinions offered to date have focused on the broader sociological and cultural issues. These experts have focused on the mental disconnect which occurs during the birthing process which renders the mother physically unable to assist her infant in distress but which law enforcement interprets as criminal neglect causing death. This body of knowledge also attempts to soften the sense of societal outrage which the prosecution attempts to exploit by focusing upon the infant as a helpless victim.

It is only through the considered evaluation and expert testimony of forensic mental health practitioners that the court can better understand this conduct. Throughout this educational process, the unique features of each individual case can be distinguished from the focus on severe punishment as a deterrent which emerges from societal opinions and is fueled by sensationalized media coverage.

Both the shocking nature and apparently increasing frequency of these cases of neonaticide raise many questions for social scientists about this phenomenon. Forensic psychologists find themselves in the unique role of

having to respond to both the psychological and the legal implications inherent in these cases. From a psychological perspective, questions arise about the teenage mother's ability to cope with the reality of her pregnancy, the potential for denial of the pregnancy, the secrecy and failure to tell anyone about the pregnancy, and, ultimately, the death of the infant. In Lisa's case, which we had the opportunity to evaluate psychologically and represent legally, her apparent lack of awareness that she was pregnant seemed incredible. Yet, with further investigation, it readily became apparent that she was a young girl who was profoundly overwhelmed and who escaped into pervasive denial in order to cope with events in her life.

From a legal perspective, the findings that comprised the psychological opinion were of primary importance in the outcome of this case. The role of the forensic psychologist can be multi-faceted, depending upon the nature of the case, the stage of the proceeding, and the objective sought.

In this article, pertinent psychological and legal issues will be addressed as they relate to the role and function of the forensic psychological expert. From the psychological standpoint, the phenomenon of neonaticide and the denial of pregnancy will be reviewed, in general and in its striking relation to Lisa's case. From the legal standpoint, the potential points of impact for the forensic psychologist will be examined, including the determination of juvenile versus adult jurisdiction, pretrial preparation, trial testimony, involvement in the presentencing phase and the sentencing hearing, and responding to the media attention generated by these cases.

PSYCHOLOGICAL ISSUES

Pregnancy

Metastasio et al. (1), in their study of the psychological aspects of pregnancy, addressed the conflicts and complications associated with pregnancy in general. The authors concluded:

Pregnancy is a stage of maturation crisis which, like other moments of crisis in a woman's life (adolescence and menopause), is characterized by phases of regression, the weakness of mental defenses and transformation of the image of self.

The challenges facing pregnant adolescents are compounded by the inherent complications and challenges of adolescence itself. Challenges arise as the transition is made from childhood into adulthood. As this process of transition is often fraught with conflict and difficulty, the added stressors related to pregnancy expose the pregnant adolescent to a significantly greater degree of adaptational problems than their nonpregnant counterparts. Studies of pregnancy during adolescence are consistent in their documentation of a significant increase in levels of depression.

Barnett et al. (2), in a study of twelve- to eighteen-year-olds, found that forty-two percent showed significant depression during the third trimester. The researchers found depression to be associated with stress and lack of social support. The presence of a social support system was found to be negatively associated with depressive symptoms, especially in those adolescents who are highly stressed. Kitamura et al. (3) studied the incidence of depression in early pregnancy and found risk factors for depression that included parental overprotection, unwanted pregnancy, younger age and a negative psychological response to the news of the pregnancy.

It is clear that there are predictable challenges and conflicts associated with pregnancy for any woman. Research, however, has documented the degree to which these conflicts and challenges are dramatically heightened during adolescence. Further compounding and exacerbating the stresses and complications of adolescent pregnancy are those pregnancies which have resulted from rape. The literature consistently documents higher levels of depression, anxiety and conflict surrounding the pregnancies of women who have been raped. Raphael-Leff (4), in her study of psychiatric disorders associated with childbearing found:

Three somewhat overlapping subgroups of women, who may be particularly at risk during pregnancy, include women with conflicted pregnancies, women with untimely pregnancies, and women who have 'wrong' pregnancies (e.g., from rape or incest).

Freiberg and Bridwell (5), in their study of rape and pregnancy, describe the grief process for a woman who is confronted with feelings arising from a pregnancy that has resulted from rape. While emphasizing that the grieving process does not necessarily follow a sequential pattern, a woman may move back and forth among feelings of denial, depression and anger before resolution is attained. The authors describe the process of pregnancy and childbirth as experiences that may serve to reactivate the earlier emotions surrounding the initial traumatic event (i.e., the rape).

In Lisa's case, the depression risk factors described by Kitamura (3) were clearly evident. These included her parents' over-protective stance and Lisa's resulting inability to tell her parents for fear of disappointing them. Moreover, the pregnancy, which resulted from a rape, was unwanted. Lisa's young age and negative response to the possibility that she was pregnant, further added to her depression and the breakdown of her defenses.

Pregnancy Denial

Among the complications associated with adolescent pregnancy are the adolescent's denial of the pregnancy. While denial of a pregnancy might seem to many as impractical, irrational and, perhaps, even impossible, the many conflicts inherent in adolescent pregnancy cited above can and do often lead to the utilization of various defenses, including denial. Brezinka et al. (6), in their study of denial in pregnancy, assessed the defense mechanisms and coping strategies which contributed to the negation of pregnancy of twenty-seven women. In eleven women, pregnancy was denied until delivery; in nine women, denial ended between twenty-seven and thirty-six weeks; in seven women, the denial of the pregnancy ended

between twenty-one and twenty-six weeks of gestation. The authors found that these women reported irregular, sometimes menstruation-like bleedings during pregnancy; few women reported actual symptoms of pregnancy, such as nausea and weight gain. The authors concluded:

> Denial of pregnancy is a heterogeneous condition with different meanings and different psychiatric diagnoses in different women. Stressors (e.g., separation from partner, interpersonal problems, etc.) do play an important role as precipitating factors for the development of an adjustment disorder with maladaptive denial of pregnancy.

Brezinka et al. found that a large number of acute and/or chronic psychological stressors were present in the lives of all of these women prior to or at the beginning of their pregnancy. They also noted the utilization of the defense mechanism of rationalization and commented:

> There is no clear dividing line between conscious coping and unconscious defense mechanisms (not only denial) and there are fluid transitions described as 'middle knowledge.' Similar coping strategies and adjustment reactions can be observed in seriously ill patients.

Brezinka et al. cited other studies that were consistent with their own very surprising finding that the women who denied their pregnancy had "strong family bonds and a basically positive and optimistic attitude toward babies born unexpectantly." Bonnet (7), in her study of neonaticide, described this process:

> A mechanism of psychic protection—the denial of pregnancy—explains how they could ignore their pregnancies for that length of time. Although their bodies changed shape, their periods stopped, and they experienced bulimia, they were unable to make a connection between these changes and a fecund sexual relation-

ship. Nor did they perceive the presence of the fetus. All of these normal signs of pregnancy were rationalized away.

In conclusion, research seems to suggest that pregnancy denial is a real phenomenon implicated by several internal and external influences. Not only does research provide evidence for the actual occurrence of pregnancy denial, but these findings also shed light on the processes that lead up to the denial.

A review of the current psychological literature, thus, allows us to better understand Lisa's account of the events and circumstances surrounding her pregnancy. With a history of parental enmeshment and overprotection, an ongoing problem with anorexia and a pregnancy resulting from rape, Lisa fits the criteria of those adolescents who would experience significant levels of depression during their pregnancy, and, as a mechanism of defending themselves from these overwhelming feelings, deny the fact that they were pregnant. Lisa regarded her erratic menstrual bleeding as a result of a possible sexually transmitted disease, possibly AIDS. She reasoned that her weight gain, though only ten pounds, was due to her state of depression. Her abdominal pains were thought to be menstrual cramps. Lisa regarded her periodic bleeding as a sure sign that she could not be pregnant.

The literature is even more compelling in providing information regarding the events that took place during the birth itself.

Childbirth

The psychological literature contains many studies describing the experience of childbirth and the factors associated with the emotional and physical complications associated with childbirth. In their study of the childbirth experience, Waldenstrom et al. (8) found that women, in addition to experiencing severe pain during childbirth, experienced various degrees of anxiety, as well as panic, during the birth process. The authors found that women frequently lost the perception of time and often had

"missing pieces" in their memory. In a study of the birthing experience of adolescents, Lena et al. (9) found that fifty-nine percent of the adolescents stated that they were not prepared for labor and delivery, compared with twenty-six percent of the adults.

Reynolds (10) described childbirth as "a very painful experience, often associated with feelings of being out of control." He studied the degree to which childbirth can be psychologically traumatic for some women. He posits that a traumatic birthing experience represents a variant of post-traumatic stress disorder. Reynolds applied the features of a posttraumatic stress disorder to the process of childbirth and offered the following:

1) During childbirth an individual would feel threatened by death or serious injury and respond to this threat with feelings of fear or helplessness.

2) The process of childbirth can be so frightening that an individual can experience depersonalization.

3) A woman, in reaction to a traumatic birth, would have a tendency to relive the experience through flashbacks, for example.

4) A woman would exhibit avoidance behavior and may exhibit hypervigilence, as she tries to ensure that the traumatic event is not repeated.

5) These symptoms persist for more than a month and affect the woman's ability to function.

Reynolds also cited evidence that previous traumatic events may serve to predispose women to a traumatic birth experience. He addressed the likelihood that a woman who had experienced a sexual assault would be predisposed to reliving the initial trauma during the process of labor and delivery.

Once again, the literature provides information consistent with Lisa's account of her experiences during labor and delivery. In addition to the physical pain, Lisa experienced the lost perception of time, amnesia, anxi-

ety and panic that are typical of labor and delivery under normal circumstances. In addition, because of the unique circumstances surrounding her pregnancy and delivery, Lisa also experienced a traumatic stress reaction which included feelings of fear, helplessness, depersonalization and loss of control during the delivery of her baby. Following the delivery, Lisa's tendency to relive the experience, her nightmares, her avoidant behavior and her intense psychological and physiological distress in reaction to exposure to cues symbolizing or resembling an aspect of the birth process, were all illustrative of her posttraumatic stress reaction.

A review of the literature on neonaticide also reveals information consistent with Lisa's account of the events surrounding the delivery process.

Neonaticide

Sadoff (11) investigated neonaticide and concluded:

> There is little in the literature and the experience of the author to indicate that mothers kill their children in a cold-hearted, calculating manner. Mostly, the killings are done in a state of fear, panic, depression, psychosis, or in dissociative states.

Green and Manohar (12) studied neonaticide and denial of pregnancy. The authors found that denial of pregnancy is a common accompaniment of neonaticide and described the most numerous group in their study as consisting of "sexually and emotionally immature women, under strong social or parental pressure against an illegitimate child, who make no premeditated plans to kill the infant but panic following birth." These findings provide evidence for a direct link between pregnancy denial and neonaticide.

The literature is consistent in describing the elaborate psychological mechanisms utilized by these women as an effort to convince themselves—and others close to them—that they could not possibly be pregnant. Medvecky and Kafka (13) studied the psychiatric aspects of neonati-

cide and suggested the following three categories: a) those with rational motivation in a crisis situation, b) those due largely to personality developments and troubles combined with a low intellectual level and c) those characterized mainly by reactive elements similar to the crime of manslaughter.

Bonnet (7) discusses two groups of women who commit neonaticide. In the first group, labor takes these women by surprise and, upon delivery, in a moment of extreme panic, they commit neonaticide. By killing their newborn child, these women are able to continue with their denial of reality. Because their newborn ceases to exist, they never have to face the reality which had previously been denied. The second group of women who also deny their pregnancy, deliver an "unknown object" or mass." This object is not associated with themselves, neither physically nor emotionally. Because they have denied their pregnancy, they feel no emotional ties toward this "object."

Bonnet (7) cites examples of the denial being extreme enough that the individual does not even realize when labor has begun. Bonnet also addresses the issue of negligence, wherein death was caused by the absence of first aid. She refers to this as "passive neonaticide" and comments:

> These women, in fact, did not exercise physical violence on the person of the baby. Some of them sometimes even tried to protect it by covering the infant with a cloth before abandoning it in a public place.

In both of these situations, the link between the denial of the pregnancy and the killing or abandoning of the newborn is evident. The denial of the pregnancy leads to the inability to associate emotionally or physically with the fetus. The mother becomes indifferent toward the fetus, and, upon delivery, still may not accept the reality of the infant. Moreover, severe pregnancy denial often results in either partial or total amnesia for the delivery.

Bonnet (7) addressed the often chaotic and traumatic events surrounding deliveries under these circumstances:

> These violent deliveries provoked a loss of blood that put the women's lives in considerable danger. They were often found in a coma by their relatives or friends. Total amnesia systematically followed these events, preventing reconstitution of the tragic moment. These women were not lying when they said they don't remember; they were not trying to cover up the facts. The amnesia was the result of the denial of the baby's existence that has reestablished itself in the woman's psyche.

Lisa delivered a newborn daughter, herself, after denying the existence of the fetus. This denial, combined with the traumatic experience of childbirth, left her unprepared to deal with the reality of her newborn child. Lisa's situation, beginning from the rape and the denial of the pregnancy and ending with her inability to take responsibility for the newborn infant, are clearly consistent with descriptions of these phenomena in the extant psychological literature. The literature provides information which offers an explanation about Lisa's failure to act on behalf of her infant. For Lisa, the feelings of anxiety, panic and loss of control associated with childbirth under normal circumstances were compounded by the factors highlighted. These included her use of denial, the fact that these events occurred in isolation, and the fact that there was a tremendous loss of blood. All of these intensified her fear, panic and sense of horror, resulting in a state of mental confusion and paralysis postdelivery, that rendered her incapable of taking appropriate action.

The existing psychological literature on denied pregnancies and neonaticide brings forth the many important considerations for understanding the responses by a seemingly growing number of young women. First, it is necessary to understand the contextual issues of the event as well as the personality and psychological characteristics of the mothers and their sur-

rounding environment. Next, the denial of the pregnancy must be explored, including feelings of detachment and disbelief about the existence of the newborn. Lastly, each of the above circumstances must be investigated for their influence during the birthing process itself.

THE CASE OF LISA

Very early in the forensic evaluation process, it became clear that Lisa was severely depressed, acutely suicidal and evidencing many symptoms of a posttraumatic stress disorder as a result of her ordeal. She was haunted by the rapes as well as the terrifying delivery of her infant girl. During the evaluation sessions, she reported having flashbacks of those events. She was worried about her ex-boyfriend returning to harm her and she focused repeatedly upon mental images of the delivery, including the blood in the shower. As a result, Lisa refused to take a bath or shower without her mother being close by.

Also in line with her posttraumatic stress disorder, Lisa utilized excessive denial to ward off intolerable thoughts and feelings related to the rapes, the delivery, and her dead baby. In her despair, she withdrew from all those around her, relying solely upon her parents for all support. This served to exacerbate the overly dependent relationship she already had with her parents. Lisa's mother commented upon the regressive changes she observed in her daughter.

> She still sleeps with us. She can't take a shower by herself. I have to sit there with her; if I'm not there, she won't shower. She won't get into a tub at all. When the reality of everything hit her, she had a breakdown—she wanted to kill herself and was trying to rip the hair out of her head. She has a hard time with the date, the twenty-sixth (May 26, when the baby was born). We had to take her back to the cemetery so she could apologize to the baby. She has tremendous guilt that she didn't do things to save the baby.

Lisa's mother stated that Lisa continued to be awakened by her nightmares regularly. One night, she found Lisa, still asleep, on her hands and knees looking around the bathroom floor crying, "I can't find my baby! I can't find my baby!"

In addition to their relevance to the forensic evaluation, these issues demanded immediate clinical intervention. As a result, Lisa and her family were referred to a counselor for treatment of her depression, posttraumatic stress, and suicidality. As the forensic evaluation and consultation was rather lengthy, extending over a period of several months, regular contact was made with Lisa's treating therapist regarding her capacity to tolerate the process and to prepare her for the upcoming sentencing hearing.

Several other personality dynamics emerged as important in understanding how this could have happened to Lisa. Chief among these was the enmeshed, overly dependent nature of Lisa's relationship with her parents and family. Clinical interviews revealed a high degree of communication among members of Lisa's family, with frequent instances of boundary blurring and poor differentiation. As an adolescent, Lisa appeared to have subordinated any inclination for individuation and autonomy in exchange for goal-directed activities (i.e., excelling at soccer and academics) that were consistent with her perception of her parents' expectations.

Lisa's overreliance upon her parents, coupled with her self-doubts and insecurity about her own unique, individual self-worth, resulted in the development of perfectionistic tendencies and a strong desire to please her parents. Not surprisingly, Lisa developed anorexia as an adolescent. Regulating her intake of food, and ultimately her physical appearance, was one of the few ways that Lisa found that she could be successful and, in a naïve way, please her parents and society at large. Characteristically, Lisa's eating disorder emerged within the context of her enmeshed family system. Her preoccupation with food and her obsession with her own body image became the central and dominant focus of her life. As she focused

upon food, calories and her weight, Lisa did not have to make choices or decisions in reaction to the struggles and conflicts that required attention and emotional resolution. As with many anorectic girls, Lisa reasoned that if she could just be thin enough, everything would be all right.

Lisa's weight had been a concern to her from an early age. During her initial years in elementary school she had been teased for being overweight. She was called "earthquake" by her peers. By seventh grade, Lisa had begun starving herself to such an extent that she lost nearly thirty-five pounds in several months. An unintended consequence of Lisa's eating disorder was that her significant weight loss and low body weight resulted in her being removed from high level positions on her school and community soccer teams. Lisa's achievement in soccer had always been a source of pride for her and her family. These demotions were a devastating blow to her self-esteem, especially when she was told by her coach that she needed to gain twenty-five pounds to be competitive and rejoin the team. As for many girls struggling with anorexia, the circumstances in her life seemed overwhelming.

It was within this context of depression and low self-worth that Lisa became associated with the boyfriend, Robert, who raped her. Lisa's mother recounted how her daughter felt at that time:

> Her self-esteem was real low. She moped around; she didn't understand why the coaches were doing this....This was going on for a few months when she met Robert. The soccer had done so much for her self-esteem. It was the peer thing, too. Everyone knew she had been cut. Soccer was the only thing she had in her life at that time. She was devastated.

Robert had many troubles, including drug use and serious family problems. In retrospect, Lisa realized that she was drawn to him because she felt sorry for him and she believed that she could help him. She likely saw something of herself reflected in his problems and it made her feel

good to know that she was helping him. She recalled that she took him on as her "project."

Lisa knew that her parents were skeptical about her involvement with Robert. Yet she wanted to show them that she could handle herself. Thus, when he became violent and raped her, she felt too ashamed and guilty, for having not abided their concerns, that she felt unable to tell them and seek their assistance. Regarding her failure to tell her parents about the pregnancy, Lisa stated:

> I would have eventually told my parents. I thought I had time. I thought I was not even one month pregnant (in December). As the months went by and I wasn't showing, I continued to think I got pregnant in December. I thought I'd be showing soon. I knew I was going to tell my parents. In May, I was nine months pregnant, but I thought I was five months pregnant. Every day, I'd think this would be the day I'd tell them. But I'd never tell them. I couldn't get the words to come out of my mouth. I knew it would hurt my mom and dad, not because I was pregnant, but because of the way that it happened, that I was raped. I thought my dad would blame it on me. They never liked him (Robert). They always thought I could do better than him, that he had too much baggage. I was afraid they'd love me less than they did before. My mom took so much pride in the fact that I was a virgin. So did I. I hate Robert for taking away my pride. I thought everyone would hate me because I wasn't the person everyone wanted me to be or expected me to be and that I wouldn't be their little angel anymore.

However tragic and sympathetic the ordeal of Lisa and the other girls like her might be, the fact remains that a newborn has died. When the medical and legal systems become involved in these cases, difficult questions must be answered about responsibility for the death, whether through neglect or intentional acts. In many of these cases, as with Lisa, there is

little or no prenatal care, since the pregnancy is often denied. The obvious stress suffered by these teenage mothers surrounding their intolerable circumstances is an additional burden on the pregnancy and, potentially, the baby's health. When the infant is finally born, it is often unexpected and the mother is unprepared to manage the extreme physical and emotional demands of delivering the child by herself. While it is certainly true that Lisa's failure to receive proper prenatal care, emotional support for herself, and assistance with the delivery likely contributed to her infant's death, there are many mitigating factors which could reduce her legal liability. The forensic expert can be very useful in translating the important psychological issues inherent in these cases for consideration by the legal system. In order to provide the reader with ample hands-on knowledge about how these cases proceed and are negotiated in the criminal justice system, specific details from this case will be reviewed.

LEGAL ISSUES

To Fight or Not to Fight to Retain Juvenile Jurisdiction

Lisa was seven months away from her eighteenth birthday when she gave birth. As such, she was to be considered a juvenile by the court. In most jurisdictions, adjudication of delinquency is a two step process. At the first step, a determination is made as to whether the juvenile committed the offense. In most states, the juvenile can admit that the offense occurred but an adjudication of delinquency is not made until the court determines whether the juvenile is in need of rehabilitation. Under New Jersey law, this issue is further limited by the need to determine if the juvenile can, in fact, be fully rehabilitated prior to their nineteenth birthday.[2]

Psychological evaluation, testing and opinion testimony can clearly be instrumental in preventing an adjudication of delinquency. Regardless of whether the juvenile has, in fact, committed the offense, crimes such as

[2] NJSA 2A:4-14 et.seq.

neonaticide and infanticide are usually situational in nature and, absent some pathology on the part of the juvenile, clearly unlikely to recur. The psychologist can assist the defense, if able to support an opinion, within a reasonable degree of psychological certainty (or probability), that the circumstances giving rise to the offense were so unique and so situational that the juvenile will never be in a similar setting and, as a result, will not commit a similar offense. As such, the need for rehabilitation either does not exist or can be completed within a reasonable period of time. Without a finding of a need to rehabilitate, the second prong of the delinquency test is not met and the court must then acquit the juvenile.

In Lisa's case, this stage of the proceedings was preempted through negotiation. In essence, the state took the position that if the defendant elected to go forward in contesting removal from juvenile jurisdiction, "all bets were off" and the matter would be submitted to grand jury to return a potentially more serious indictment of aggravated manslaughter and possibly murder. The decision to be made, therefore, was if juvenile jurisdiction was lost by the defense, was the client exposed to a greater risk of being indicted for these more serious crimes, as had already occurred to Grossberg, Petersen and Drexler?

At this juncture, defense counsel is faced with the most important tactical decision affecting the juvenile client. Again, evaluation and input from a psychologist enables defense counsel to make an intelligent recommendation to the client about how to proceed. Given the particularly fragile emotional state of our defendant, it was determined that the risks of contesting juvenile jurisdiction were too great to expose the client to potential indictment on greater charges.

Our client accepted our recommendation and waived juvenile jurisdiction. In making this recommendation, the conclusion was reached that psychological testimony regarding Lisa more appropriately supported an argument that the aggravating factors were so substantially outweighed by the mitigating factors which the sentencing judge must consider that the

court, in the interests of justice, should spare Lisa the presumptive term of imprisonment and place her on probation or, in the alternative, sentence her as a third degree offender. As a result, our client elected to accept responsibility, plead guilty and place herself at the mercy of the court.

Pretrial Preparation and Trial

We will not directly address the expert's role in trial preparation since our focus is upon the sentencing phase. Nonetheless, except for the distinction that the psychological focus in preparation for trial is based upon the ability of the client to distinguish right from wrong, the testing, evaluation and reporting phases are the same and assist the client and counsel in making important strategic decisions. At this point, therefore, defense counsel and the psychologist should take inventory to assess all available resources to be used in presenting the most complete picture of the defendant's psychological history and condition.

In this regard, the role of the particular psychologist must be assessed. Did the psychologist treat the client prior to the criminal act? If so, a wealth of data will be available for comparative pre-crime and post-crime analysis.

Next, was the defendant ever treated either medically or with psychological therapy prior to the crime by any other psychologist or psychiatrist? This information should be immediately secured for analysis by the psychologist assisting the defense.

Next, if the psychologist did treat the client in the past or is currently treating the client, a decision must be made to bring in a forensic psychologist to conduct an independent evaluation. The treating psychologist should certainly testify, but only after the forensic psychologist has presented the independent diagnosis and evaluation of the client.

The need for an independent opinion is greatest where the client has had pre-offense treatment. Though this evidence assists in explaining why the crime occurred, the court's primary concern is the likelihood the

criminal conduct will recur. If the pre-crime condition of the patient is serious and was uncontrolled by pre-crime care, the treating psychologist will be cross-examined on the prior failure of such case to prevent the crime. The independent evaluator can offer a more objective proposal to the court of an aggressive course of treatment, in-patient if needed, for the client after sentencing and the type of safety-net criteria (i.e., probation reporting requirements such as disclosure of psychological reports to the probation department periodically confirming treatment, stability of condition, taking of prescribed medication confirmed through blood testing) that a court may set as conditions of release.

Various parties will have input into the sentencing phase of the proceedings. They are the prosecutor, the arresting officers or interviewing detectives, the defense attorney, the presentence investigator, the court and the evaluating psychologist. Of all these players, the psychologist will likely have spent the most time with the defendant and will have gained the greatest insight into the character of the defendant before the court. This overall opinion should be reinforced to the court with references to objective and projective test results, particularly the results of MMPIs.

Presentence Phase

A significant opportunity is presented to the client to put forth the best picture of her sentencing position in the presentence investigator's report by incorporating information supplied by the treating and/or forensic psychologist. Presentence investigators often have had either social work or psychological training and are generally receptive to such information. The psychologist, with permission of defense counsel and the client, should make every effort to contact the presentence investigator and, if possible, meet with him or her to share insight about the client derived from the treatment and/or evaluation process. From the perspective of the legal defense, the advantages of undertaking this step are many. First, to the extent that the presentence investigator may be inclined to agree with

some portion of the defense position, there is reinforcement through the forensic opinion and report. The investigator may feel more inclined to express an opinion favoring the client.

Next, if the presentence investigator disagrees with any position taken on behalf of the client, this disagreement will be flushed out prior to sentencing since the defense has the opportunity to review the presentence report in advance. With the contrary position disclosed, the defense is in the best position to respond.

Finally, the presentence report, itself, will incorporate all of the findings, test results and recommendations of the defense forensic expert which will then be submitted to the court well in advance of sentencing for the court to consider. These recommendations will then be reiterated and reinforced by defense counsel's written sentencing memorandum submitted to the court, again, in advance of the sentencing. By defining the issues in a way which focuses upon the defendant's mental and emotional motivations and well-being at the time the crime was committed and at time of sentencing, the focus for sentencing is then upon the defendant rather than solely upon the crime.

The Sentencing Hearing

Under New Jersey law, as in federal court and most states, mitigating factors to be considered by a court are enumerated in a sentencing code (14). These factors are typical of most sentencing codes which are based upon the model penal codes.

Of the thirteen enumerated mitigating circumstances in the New Jersey Sentencing Code, at least nine can be enhanced and supplemented through the use of psychological testimony. Using New Jersey's code as an example, these mitigating factors are as follows:

2: The defendant did not contemplate that his/her conduct would cause or threaten serious harm;

3: The defendant acted under a strong provocation;

4: There were substantial grounds tending to excuse or justify the d e-fendant's conduct, though failing to establish a defense;

7: The defendant has no history of prior delinquency or criminal a c-tivity or has led a law-abiding life for a substantial period of time before the commission of the present offense;

8: The defendant's conduct was the result of circumstances unlikely to recur;

9: The character and attitude of the defendant indicates that he is u n-likely to commit another offense;

10: The defendant is particularly likely to respond affirmatively to probationary treatment;

11: The imprisonment of the defendant would entail excessive hard-ship to himself or his dependent;

13: The conduct of a youthful defendant was substantially influenced by another person more mature than the defendant.

In sentencing proceedings, defense counsel should always consider the potential positive impact of live expert testimony and should utilize experts' written reports to base their arguments supporting mitigating circumstances. The effect of presenting live expert testimony affords the defense many advantages at this stage of the proceedings. In many cases, the government will either not conduct a rebuttal evaluation or, where one is conducted, no live testimony will be presented. The expert is available to answer any questions the court may have concerning the report and to reinforce the overall theme at sentencing; for example, that the defendant is suffering from a psychological condition as a result of the trauma of birth resulting in death (e.g., major depressive disorder, posttraumatic stress disorder, or mixed personality disorder) and that incarceration will prove counterproductive to therapy and rehabilitation.

In addressing the court's concern for the need to deter society in general, the psychologist can present pertinent literature regarding the incidence of neonaticide, countering the hysteria surrounding these cases generated by intense publicity. The psychologist can further emphasize the fact that the considered weight of psychological literature around the world supports the proposition that neonaticide should not be treated as a criminal offense. Several western industrialized countries such as Germany and Great Britain do not incarcerate mothers in these situational events.

As discussed previously, the psychologist can comment on the psychological literature that denial of pregnancy is a psychological coping mechanism, common particularly among juveniles who do not want to believe that they are pregnant and look for any small sign to reinforce the contrary (abdominal cramps interpreted as menstrual cramps when in fact the baby is kicking, or "spotting" which is misinterpreted as menstruating). The psychologist might be able to shed light on the reasons that the mother never sought assistance, and can explain how the objective testing corroborates the findings concerning the client's mental state.

Finally, if indicated from the forensic evaluation, the overall character and attitude of the defendant, the support network available to the defendant through family and inpatient and outpatient counseling and the ability of that defendant to respond affirmatively to nonincarceration probationary treatment with therapy are best presented through the voice of an expert in the psychological field.

OUTCOME AND CONCLUSION

Lisa's case went forward to sentencing in October, 1997. In excess of fifty letters of support were submitted to the judge. The sentencing hearing lasted five hours without interruption and consisted primarily of forensic testimony from Dr. Atkins, as well as testimony from a post-crime treating psychologist. The state argued that, despite the substantial mitigating fac-

tors, Lisa should receive the presumptive term of state imprisonment of seven years. At the conclusion of this evidence, the Court sentenced Lisa to four years in state prison.[3] The court noted that substantial mitigating factors supported the defense argument that she was entitled to a reduction in sentence and thus she was sentenced as a third-degree offender instead of a second-degree offender. The court, however, stopped short of granting the request for straight probation in large part because of the numerous similar cases of infanticide reported in the local media. The court noted that there were currently four such cases pending within a seventy mile radius of the courthouse at the time of sentencing.

Echoing the state's argument, the court stated that a message needed to be sent. A state prison term to deter others and punish this defendant was therefore imposed. Though the court requested that the Commissioner of Corrections place Lisa in the "least threatening" correctional facility available and afford her psychological therapy, Lisa spent almost two months in maximum security until space became available in a minimum security wing. Her therapy consisted of a five minute contact with a social worker for five minutes per week. The benefit from the "message" the state sends in these cases is outweighed by the hardship inflicted upon very young clients whose involvement in this situational crime brings them into the criminal justice system for the first time in their lives.

Mental health practitioners hold an important position in their capacity as educators to the court and ultimately to society-at-large about the often complex and always difficult issues surrounding cases of adolescent pregnancy, childbirth and infant death. Our experience with Lisa, in addition to what we have learned from the existing psychological literature, strongly points to a need for adoption of more balanced and rational responses in dealing with similar cases of neonaticide. Rather than submitting, or even adding, to the growing emotional and, at times, hysterical reactions of the

[3] As noted earlier, Lisa was eligible for parole after serving approximately ten months and was released.

public, forensic psychologists have an opportunity to inform and educate all concerned. In so doing, perhaps on a broad level, efforts at intervention will be more effective. And in those situations where neonaticide has occurred, the forensic professional can help the court to balance society's need for protection against the adolescent girl's likely need for treatment rather than punishment through incarceration. Obviously, cases will vary, as they have thus far, in the level of intentionality, willfulness, and psychopathology shown on the part of these young mothers. The forensic psychologist is uniquely qualified to assist in providing information that will clarify the issues and lead to a more just determination of these countervailing factors.

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