

Defending Depression

Intersectionality and American Infanticide

In the past decade, the diagnosis of postpartum mental illness has become the primary way in which Americans understand the actions of murdering mothers. This understanding of maternal violence is not only recent in American history, it is also quite exclusive. The majority of mothers that have successfully employed a postpartum defense in infanticide cases in the past century have been white, middle-class, married women, yet studies show that poor and minority mothers are significantly more likely to experience postpartum depression. Only a privileged subset of new mothers can avail themselves of mental health care should they experience postpartum disorders, and even fewer are able to use mental illness as a legal defense. Through the postpartum defense, the legal system replicates the class and racial inequalities of the mental health system: white, middle-class women are “good mothers” who tragically suffer from mental illness, while poor mothers are violent “deviants.” In this article, I review cases in which the postpartum defense has been used and examine the class and racial power dynamics that undergird the American discourse of postpartum mental illness and infanticide.

Introduction: Postpartum Depression and Feminism

“Is postpartum depression a feminist issue?” asks blogger Katherine Stone on *Postpartum Progress*, an award-winning women’s health website. In her post, she explores the affirmative answer given by another blogger on the feminist site *SheRights*. Stone cites at length: “By definition, postpartum depression is entwined with motherhood, which itself is extremely politicized and scrutinized: from how and where a woman gives birth, to whether and how long she breastfeeds, to her decision to stay at home or work, etc. It’s an issue that the

feminist community has become increasingly vocal about. So why the silence around postpartum depression?” (Stone).

These are important questions, but they ignore the one context in which Americans are not silent about postpartum depression: cases of maternal infanticide. In the early twenty-first century, postpartum disorders went from being a “problem that has no name” to the primary way in which Americans understand the mothers who kill their children each year. Using a series of case studies, I explore the historical links between feminism, postpartum depression, and infanticide. More specifically, I contend that there are three disparate strands of discourse that need to be linked in order to adequately address the sociocultural complexities of postpartum violence: feminist theories of intersectional motherhood, the developing medical consensus on postpartum depression, and the outdated and retrograde legal discourse of criminal psychology.

Whenever a mother is accused of killing her own child in this country, as a culture, we wring our hands. This handwringing is not accompanied by lamentations about how we ignore struggling mothers collectively, nor is it about the difficulties of creating of large-scale social services to help women. Rather, it is individualized; our national conversations about postpartum depression and maternal violence focus on individual mothers, whom we see as isolated embodiments of sickness or evil, a phenomenon known as the “mad versus bad” dichotomy (Meyer and Oberman 93). This conceptualization of murdering mothers drives their treatment by the medical and legal systems, and it prohibits a broader conversation about the social responsibility of prevention.

In the United States, roughly two hundred mothers kill their children each year, and it is not easy to predict the legal outcome when this happens (American Anthropological Association). Sentences for this crime can range from capital punishment to probation or even acquittal (Oberman 714; Connell 143). The wide range of possible sentences is determined as much by images and representations of the offending mothers as it is by the specific circumstances of each crime. When women kill, American society generally understands their actions through the “mad versus bad” dyad, positioning women who kill as necessarily either mentally ill or inherently evil. This belief translates into legal outcomes, ensuring that the less sympathetic “bad” women will receive harsher sentences (Oberman 714). Among industrialized nations, this dichotomous reading is peculiar to the United States. Some thirty nations around the world have “infanticide statutes” which define maternal infanticide as a different kind of crime from general homicide based on the presumed disorder of postpartum hormonal imbalances. Great Britain’s law, for instance, prescribes a charge of manslaughter and a sentence of psychiatric care for women who murder their own children under the age of one year, surmising that “at the time of the act or omission [neglect that led to death], the balance of her mind was disturbed

by reason of her not having fully recovered from the effect of giving birth to the child” (Butterfield 536).

As Great Britain weighed the merits of the Infanticide Statute in the 1920s, the American Psychological and American Medical Associations reached the opposite conclusion, striking postpartum psychosis from their official lists of disorders because “no distinct syndrome existed which showed a connection between a psychiatric disorder and childbirth” (Connell 152). Then as now, there were legal repercussions. The United States is currently the only Western country that will imprison an infanticidal woman who exhibits symptoms of “untreated postpartum psychosis” (Zittel-Palamara 82). American judges and juries indict, try, and sentence murdering mothers on a case-by-case basis, which enables the popular “mad versus bad” paradigm of female violent crime to hold sway in courtrooms. Legal scholars explain that this “ambivalence” is a result of “the conflict between traditional notions of motherhood and the tragedy of infanticide” (Connell 144).

But in recent years, an American consensus has begun to develop that is more in line with international statutes. In the past decade, “postpartum depression” has become a household phrase, in large part due to the extensive media coverage of the Andrea Yates infanticide trials of 2001 and 2006. This consensus is not without its problems, as feminist critics and medical experts have argued. A brief review of some of the infanticide cases in which the “postpartum defense” has been successfully employed reveals both how American society has slowly come to this consensus and how this consensus replicates historical problems of gender, class, and race.

Case Studies

Just before ten o’clock on the morning of August 18, 1949, twenty-two year-old Illinois housewife Dorothy Skeoch tied a plastic diaper around her six-day-old daughter’s neck, suffocating her to death. Although Skeoch denied the crime at first, claiming that a “colored man” had murdered her child in the course of a robbery, she quickly crumbled under police questioning and admitted her guilt (“Mom Admits Strangling Infant”). At her homicide trial some months later, family members testified that Skeoch appeared to be “insane” following the birth of her daughter, and expert witnesses confirmed that their descriptions of her behavior were in keeping with the diagnosis of “postpartum psychosis with infanticide, a mental disorder that frequently occurs with the delivery of a child” (People of the State of Illinois v. Skeoch). The jury of seven women and five men was unsympathetic to this little-known mental illness; they convicted Skeoch of murder and sentenced her to fourteen years in prison. The State Supreme Court later reversed this conviction on the grounds that the prose-

cution failed to disprove the defendant's claim of insanity. This reversal was largely based on the persuasive testimony of an expert witness who explained postpartum mental illness and additionally argued that Skeoch had displayed symptoms of prenatal depression, citing a letter that she wrote to her parents indicating suicidal thoughts before the birth of her daughter ("Jury Convicts Mother"; *People of the State of Illinois v. Skeoch*).

On November 22, 1965, while her Air Force captain husband was away on a mission, Maggie Young, a "despondent," thirty-eight year-old mother, drowned her four daughters "one by one" in the bathtub of her home in Hawaii (Shapiro). She then retrieved her son from his elementary school and murdered him in the same manner. The children ranged in age from eight months to eight years. Young did not try to hide her crime, and she quickly confessed. Her attorney began to prepare a defense based on postpartum mental illness while state psychiatrists began to examine the mother to determine her fitness for trial. Earlier that year, Young had spent two months at the local army medical center after a "mental breakdown," and psychiatrists appointed to assess her mental state after the murders determined that she had not recovered. She was operating under a "diseased and deranged condition," they determined, and she was therefore unfit to stand trial (Shapiro). Young entered a state psychiatric hospital, where she underwent intensive treatment. The following summer, as doctors reported that she had just begun to "respond to her treatment and was beginning to grasp the enormity of what she had done," Young hanged herself from the rafters of a shed on hospital grounds (Eisner; Shapiro).

In the summer of 1974, Joanne Michulski, a suburban mother of eight, decapitated her two youngest children on the "neatly kept lawn" of her suburban Chicago home (Rich 261). Michulski had experienced numerous bouts of postpartum depression, three of which resulted in brief hospitalizations. During these "real blue spells," as her husband referred to them, she would "lay on the couch, saying and doing nothing for long periods" (Rich 262, 261). Neighbors described Michulski as "withdrawn" and "quietly desperate" as she cared for her children, who ranged in age from two months to eighteen years at the time of the crime (Rich 261). The "blue spells" increased in frequency in the late 1960s and early 1970s as her husband traveled for work, leaving Michulski at home to care for the children on her own. Omitting most references to these family and social circumstances, the local media coverage, and the local courts, depicted Michulski as simply insane. Her case received national attention when Adrienne Rich, the second-wave feminist writer, included her responses to the murders in her widely-read book on motherhood, *Of Woman Born*. Rich asked readers to see Michulski's act as a cry for help from a mother who suffered the darker side of motherhood—a side all mothers knew—in silence. Michulski

was found not guilty of involuntary manslaughter and committed to a state hospital (260-262).

On her birthday in late April of 1987, 24-year-old Sheryl Massip reportedly tossed her colicky, six-week-old son into oncoming traffic. The driver swerved, narrowly missing the strange bundle in the road. Massip then beat her son with a blunt object, backed over him in her station wagon, and threw his body in a nearby trash bin. Massip initially told police that her son had been kidnapped by an armed “red-haired” stranger, only to confess her crime to her husband later that day (Lichtblau, “Ex-Husband Testifies”). During her trial, it became increasingly clear that Massip was not simply depressed; she was, in fact, psychotic, displaying severely disordered thinking. Her son’s constant crying exacerbated her feelings of inadequacy as a mother, and at some point during the final few weeks of his life, she began to experience increased psychological dissociation, including auditory and visual hallucinations. The morning of the murder, she went for a walk with her son, during which she reportedly heard voices that told her to “put him out of his misery,” whereupon she threw him into the street (Lichtblau “Woman Says ‘Voices’”). Her defense attorney claimed that the combination of a “sickly child and an unsupportive husband” triggered Massip’s psychotic break, and he pleaded with the jury: “When you look at Sheryl Massip, is she some thug, some child abuser, or some young woman, young wife, young mother trying to do the best she can?” (Haddad). Like Dorothy Skeoch before her, a jury initially found Massip guilty, but at her second trial, the court found her not guilty by reason of insanity, and she began receiving psychiatric treatment (*People of the State of California v. Massip*).

On September 23, 1994, a thirty-year-old British tourist named Caroline Beale was caught by security guards at JFK Airport in New York City carrying a dead baby in a shopping bag in the waistband of her pants. Beale explained that she had given birth alone in her hotel room the day before to what she believed was a stillborn baby; she cut the cord, stowed the body in the shopping bag, and carried it with her for almost twenty-four hours (Campbell 3-7). The DA charged Beale with second-degree murder and sent her to Riker’s Island. Yet had Caroline Beale given birth the following day, once she was on British soil, her crime would have been treated very differently according to the British Infanticide Statute. She would have been charged with manslaughter and immediately remitted to a psychiatric facility. Beale spent eight months in Riker’s Island and another ten months in custodial care in New York awaiting trial. Eighteen months after the death of her child, Beale pled to manslaughter, received credit for time served, and left the United States on probation, under orders to seek in-patient psychiatric treatment upon her return to Great Britain. Beale underwent extensive treatment at London’s Psychiatric Mother

and Baby Unit at Maudsley Hospital, renowned for its pioneering research on postpartum mental illness (Campbell 71; McDonagh 13).

There was apparently something attractive about the British legal response to the Beale infanticide case, because just a few years later, this medico-legal linkage of postpartum depression and infanticide crossed the pond with a resiliency that it had never achieved during any of the aforementioned trials that used a postpartum insanity defense. In 2001, in a tragic echo of the Maggie Young murders three decades prior, Andrea Yates sparked a national conversation about postpartum psychological disorders when she drowned all five of her children in the bathtub of her suburban Houston home. The day after the murders, her husband, Rusty Yates, sobbed and told the world that his wife was sick, not evil. At the time of the crime, Andrea Yates suffered from postpartum psychosis. In prison, she spoke of the “devil inside of her” that “tormented her children” and compelled her to kill them as part of a suicidal mission to bring the death penalty upon herself (Roche). In the two years preceding the murders, Yates had attempted suicide twice, been hospitalized for depression four times, and she had been prescribed antipsychotic drugs (Manchester 714). Just days after the murders, Rusty Yates, in a fit of insomnia, scoured the Internet looking for ways to understand this tragedy. On the website of a Honolulu newspaper, he found an article about the Maggie Young case of 1965, and he reached out to the reporter, who put him into contact with James Young. In a public statement, Young later argued that Yates did not need a prison sentence, nor did she deserve a first-degree murder charge. He explained: “My wife was charged with first-degree murder. But Hawaii justice recognized her illness and gave her the medical help she needed. Unfortunately, she did not survive the cure” (Shapiro). Young continued: “Medical science needs to recognize this condition earlier and help the mother before it develops into paranoid schizophrenia,” a diagnosis that many observers applied to Andrea Yates in early responses to her case, when “postpartum depression” was not yet a household phrase (Shapiro).

Amid massive media coverage, the Yates trial featured significant expert testimony describing Yates’s psychosis, including her belief that Satan was communicating with her children through television cartoons. Yates told psychiatrists that she had to kill her children to rid them of Satan, and then she must get the death penalty to rid herself of him (Ramsland). Perhaps predictably, the Texas legal system initially proved less understanding and more punitive than Hawaii’s thirty-odd years earlier. Yates was found guilty and sentenced to life in her first trial, but this first verdict was overturned based on false expert testimony presented by the state. Yates was tried again in 2006, by which time postpartum depression had become more well-known. She was found not guilty by reason of insanity, and she now resides in a Texas

state psychiatric hospital (Cohen).

Although Andrea Yates suffered from the much more severe postpartum psychosis, she became the face of postpartum depression in American culture. Since the Yates case, postpartum depression has become a common diagnosis. Recent studies agree that between one in seven and one in five new mothers experience postpartum mental illnesses, with symptoms ranging from comorbid anxiety to thoughts of self-harm and bipolar disorder (Wisner et al 194-195). Post-Yates, and the national media coverage that accompanied both of her trials, this diagnosis is one that almost always enters media coverage of murdering mothers. Recent clinical studies suggest that a full two-thirds of women who kill their children may be suffering from a postpartum mental illness (Dobson and Sales 1102). Both postpartum depression and psychosis increase the risk of infanticide, but current legal frameworks of homicide do not address these different kinds of murder very well, if at all. In this systemic context, the discourse of postpartum depression is a useful one that could enable courts, and juries, to understand this kind of maternal violence in all of its complexity.

The legal standard of insanity, however, generally fails to account for this kind of complexity, resulting in a wide range of punishments for the same crime. For instance, many infanticidal mothers invent kidnapping stories to cover their crimes, indicating that they knew their actions were wrong, which means that they would not meet the basic test of legal insanity in many states. Their initial lies serve as “proof” of their sanity to juries and within the so-called court of public opinion. However, postpartum disorders, particularly psychoses, often feature “sudden onset and dissipation,” meaning that the mother’s mental state at the time of the violent act and her mental state just afterward might be vastly different (Connell 149). Moreover, compulsion is a primary element of these hallucinations: infanticidal women with postpartum psychosis often indicate that they knew they were contemplating illegal, immoral acts, but they were uncontrollably compelled to murder by hallucinations and/or delusions (Manchester 745). Maggie Young and Andrea Yates, for instance, both confessed immediately to law enforcement; both women felt forced into criminal acts by hallucinations, and both argued that they should be executed from their crimes because they knew their acts were wrong at the times of commission. Finally, the basic insanity standards in the United States have no means of accounting for cases of altruistic infanticide, in which the infanticidal mothers believe that death is in their children’s best interests. In these kinds of “mercy killings,” which stem from depressive cognition, suicidal ideation, and often delusionally dismal estimates of the children’s futures, the simplistic legal logic of “knowing right from wrong” just does not apply (Wilczynski 55).

Feminism, Intersectionality, and Infanticide

Perhaps a greater problem with this new discourse of postpartum depression as legal insanity is that it places women solely within a narrow psychological framework that is based on outdated notions of gender. This kind of gender-specific, medico-legal analysis of women's behaviors has historical roots in the Victorian obsession with the deviant female body. This obsession translated into the medicalization of basic behaviors, resulting in specifically female diagnoses like premenstrual syndrome, hysteria, and menopause (Ehrenreich and English 120). At the end of the nineteenth century, these female experiences were defined as mental illnesses, and this medical discourse had a clear effect on how American society read women's crimes. This new medical model posited that all women have mental and physical illness inscribed in their reproductive and hormonal systems, producing a generalized medical and legal belief in the ever-present potential for female insanity (Morris and Wilczynski 215).

Although many of these diagnoses have been shed with time (namely, hysteria), the most recent manifestation of this gendered medical discourse is postpartum depression. Historically, experts have not been able to determine its exact causes. Hippocrates cited "excessive blood flow," while the international statutes of the twentieth century blame hormonal fluctuations and/or lactation (March 249). A troublesome thread running through this history is the isolation of the postpartum experience as a psychological phenomenon that happens largely within the new mother's head. The family, cultural, social, and economic contexts are completely missing from historical analyses, and this is replicated in the current national conversation about postpartum depression. Instead of understanding the contexts in which these depressed women mother, the rhetoric of postpartum depression instead focuses on their individual hormone levels.

In other words, intersectionality, or the study of how multiple systems of oppression and discrimination interact in a person or group's experience, is often ignored in discussions of maternal infanticide, despite the prevalence of research on how the experiences of American mothers differ according to demographic factors like race, class, and ethnicity. Indeed, scholars of African American motherhood have been arguing this for years (hooks 135; Collins 108; McIntyre 321-326), but medical scholarship has only recently begun to produce evidence that confirms the significance of an intersectional approach to postpartum experiences and mental disorders. Research shows that while previous depressive episodes are a major predictor of postpartum depression, the socioeconomic context of mothering is just as likely a factor in determining a new mother's propensity for depression in the postpartum period (Segre; Hagen 15).

It is not just that social context is a blind spot that needs to be corrected in the discourse of postpartum depression. This omission has in fact driven how Americans both conceive of and treat maternal violence. Andrea Yates, a white, middle-class, married, stay-at-home suburban mother, along with various white, wealthy celebrities like Brooke Shields who have recently admitted their own postpartum struggles, are the faces of postpartum depression in the United States. The other depressed, infanticidal mothers who consistently enter the public legal and legislative conversations about postpartum mental illness fit the same racial and class descriptions; but for their violence, these women fit the stereotypical, and exclusive, ideals of motherhood. In fact, these ideals themselves actually contribute to maternal depression; in a recent qualitative study of women who killed their children, the murdering mothers cited this very cultural idealization of motherhood, and their resulting feelings of failure that they could not live up to the ideal, as a contributing factor to their crimes (Stanton et al. 1454).

In her study of a past obsession with a specifically female malady, Laura Briggs argues that “thinking of hysteria as a racial discourse changes what we know about it as a gendered narrative” (250). The same is true of the postpartum insanity defense: thinking of it as a racialized and class-based discourse illuminates its problematic premises. A legal defense based on postpartum mental illness is generally only available to some women, and this availability is based on the pernicious structures of racism and classism that pervade the American legal system as a whole and corrupt the administration of justice in insanity cases in particular.

Studies show that poor mothers are, in fact, more likely to experience postpartum depression. In 2010, the National Institutes of Mental Health found that in a sample of low-income woman, over fifty percent of the mothers of infants less than fourteen months old met the criteria for a major depressive disorder, which is two to five times larger than the rate of depression in the general population of new mothers (“Low Income Urban Mothers”). The correlation with race and ethnicity is just as shocking: studies have found that up to 35 percent of African American mothers and 38 percent of Mexican-American mothers experience postpartum depression (Moses-Kolko and Roth 181; Martinez-Schallmoser et al. 329; Zittel-Palamara 81). But these are not the faces we see in empathetic media coverage of postpartum depression; poor and minority women are more likely to appear on the nightly news as “bad mothers,” if they make headlines at all (Douglas and Michaels 153).

The developing discourse of postpartum depression replicates the sexism, classism, and racism of the Victorian “medical model” of female experiences, thus invalidating the experiences of mothers who do not fit the ideal. Although African American women constitute a statistically significant proportion of the

mothers who kill their children each year in the United States, these women are the least likely to receive any kind of press coverage. Just two weeks after Andrea Yates killed her children, Robin Parker, a young African American mother, parked her car inside her closed garage, cranked the ignition, and killed herself and her three young children. With the exception of the minute local Associate Press coverage of the funeral, Robin Parker did not make the news, despite the fact that infanticide and postpartum depression were daily headlines in the weeks following the Yates murders. Parker was posthumously diagnosed with postpartum mood disorder by one of the leading experts on the subject (Hughes). Yet her case did not become a part of the ongoing national discussion on postpartum depression and maternal violence.

Even more recently, discussions of the motives of Lashanda Armstrong, the young African American mother who drove her van into the Hudson River on April 12, 2011, killing herself and three of her four children, involved speculation about maternal mental illness that was tempered by racial stereotypes (Burke-Galloway; Rosario). As NPR commentator Michele Martin said of Armstrong, “There’s also the racial aspect of this. . . . I was noticing the comment boards on some of the news organizations that have covered this story, and race did come into it, and people were saying, ‘Oh, what do you expect? She’s this young woman, she’s got all these kids, different fathers, and so forth’” (Martin). Because of the historical devaluation of African American motherhood and the racism of current maternal ideals, Armstrong did not qualify as a candidate for the ongoing public conversation about postpartum depression. And indeed, within a few days, the media coverage of this tragedy ceased altogether.

Yet there are signs that our traditional treatment of postpartum depression as the isolated, individualized problem of white, middle-class mothers is changing. Intersectional feminist theories of motherhood began to influence the scope of psychological studies at the same time that American women launched a frontal assault on idealized representations of motherhood and begun to tell their own stories very publicly, via “mommy blogs” and social media. Postpartum depression *is* a feminist issue, but the public attention to this topic is not being led by feminists. It is being led by American mothers, and they are changing the conversation. Their activism has included pressuring local media outlets to avoid hyperbole and condemnation in coverage of infanticide cases and writing to state legislators to support pre- and postnatal depression screening legislation (Maureen; Hale).

In response to maternal activism and recent medical studies, federal legislators have repeatedly introduced a bill that would require the Department of Health and Human Services to “expand and intensify NIMH research and related activities with respect to postpartum depression and postpartum psychosis” (Office of

Legislative Policy and Analysis). In 2006, New Jersey passed a bill mandating the screening of all new mothers for postpartum depression (Senate of the State of New Jersey). Even Texas, a state not known for its legal leniency (but perhaps reeling from the negative press surrounding Andrea Yates' first trial), considered a bill in 2009 that would recognize "postpartum mental illness" as a legitimate legal defense for women (Appel).

More recently, a "postpartum depression" chat (#PPDChat) on Twitter sponsored by the blog *My Postpartum Voice* that was dedicated to exploring the problem featuring the voices of women across the social spectrum. Social media has begun to serve as a sounding board for mothers, and this kind of focused online conversation is both therapeutic and treatment-oriented ("Our Programs"; Gaskell). Social media discussions always feature information about and offerings of various forms of aid to depressed mothers, ranging from self-administered screening tools, to sympathetic ears in online support groups, to "private peer support" in monitored forums for mothers who do not want to share their struggles publicly ("Tools for Moms"; LHale; "Our Programs"). As mothers speak honestly to each other online, researchers have started to listen, as well; social media has become a "promising tool for public health," as some scholars have begun to use tweets and posts to quantify and even predict postpartum depression (de Choudhury et al.).

And finally, in the spring of 2014, the coverage of Ebony Wilkerson, the troubled, pregnant woman who made national headlines by driving her minivan into the Atlantic Ocean with her children inside, has been more extensive and empathetic than we've ever seen in past treatments of African American infanticidal mothers. Wilkerson and her children survived due to quick-acting witnesses, and their statements have helped journalists piece together the various "warning signs" leading up to Wilkerson's apparent psychotic break. Family members cited instances of erratic, possibly psychotic behavior in the weeks leading up to the attempted infanticide, including some talk about keeping her children safe from "demons" that prompted her sister to call 911 the day before the fateful drive to the beach. Wilkerson was in the course of fleeing an abusive relationship with her husband, which, according to law enforcement officials and journalists, contributed to a pervasive paranoia that her family was unsafe and being followed (Rivera and Weiss). Her children later reported that when she drove onto the beach and into the water, she reassured them that she was "keeping [them] all safe" and that they were "going to a better place," statements that are consistent with the feminist criminological model of altruistic infanticide (Ball; Rivera and Weiss). Although the coverage ceased while Wilkerson awaits trial, reports have refrained from the usual inflammatory language of evil, instead depicting the 32-year-old mother as a "woman in crisis" suffering from psychosis linked

to postpartum and/or prenatal depression (“Ebony Wilkerson, 32, Signed Herself Out of Hospital”).

We can only hope that this journalistic empathy, which is usually reserved solely for white, middle-class mothers, indicates that the sociological and medical consensus on postpartum depression is going mainstream, and that this kind of analysis will play a role when Wilkerson stands trial for three counts of attempted murder. Yet the everyday administration of justice in cases of maternal infanticide is still based on age-old, race- and class-based assumptions about motherhood. Legal scholar Michelle Connell argues that American infanticide trials reveal a “legal system ill-equipped to recognize and draw lines when the question is one of gender” (144). More specifically, these infanticide trials reveal a sociocultural system that is unable to comprehend the intersections of gender, race, ethnicity and class in the experiences of violent mothers. Now that there is an ongoing public conversation about postpartum depression, we need to apply the insights of these various voices—mothers, feminist criminologists, the legislators who are now listening, the medical experts who propose localized social services specifically for struggling mothers—to the legal system, as well. It is time to connect these many strands of research. A comprehensive analysis of postpartum experiences that accounts for all of these factors will help to determine viable prevention programs, create stronger social support networks for childbearing women, and ensure access to justice for all violent mothers—not just the Andrea Yateses, but also the Robin Parkers, the Lashanda Armstrongs, and the Ebony Wilkersons—who have for too long been ignored, demonized, and left to suffer alone.

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