

Infanticide: Who Is To Blame? A Look into Andrea Yates

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Abstract: In 2001, Andrea Yates systematically killed her five children in one day, raising postpartum psychosis to the forefront of American news cycles. The family pressure and overwhelming household responsibilities that Yates experienced were rooted in pervasive societal expectations surrounding motherhood. The incident represented a failure of the American healthcare and legal systems. Consistent missteps in Andrea’s medical treatment culminated in a deadly episode of psychosis, which, combined with flaws in the criminal proceedings and inconsistent definitions of insanity, led to public outrage. Throughout these events, the media painted Yates as a poster child for postpartum illness, increasing and reaffirming existing stigma. While the media coverage inspired significant discourse, her case did little to create systemic changes. Examining the circumstances influencing the Yates case highlights the concerning factors that allow women and families to keep falling through gaps in the United States’ social support and medical/legal systems.

Introducing the Yates Story

On June 20th, 2001, NASA engineer Rusty Yates said goodbye to his wife and five children and went to work, unaware that his typical Wednesday would soon be turned upside down. His wife Andrea, a stay-at-home mother responsible for taking care of six people simultaneously, called him at work saying he must come home immediately. Rusty arrived to find his five children dead. Andrea had strangled and drowned them. In a single day, Rusty’s world was shattered. Andrea’s subsequent trial caught the nation’s attention, opening discussions about insanity as a legal defense and inadequate research on postpartum illnesses. Andrea Yates’ case surfaced the gripping questions: “How did this happen?” and “Who is responsible?”

A Loving Mother or a Murderer: Who is Andrea Yates?

A multitude of interwoven factors, developing over nearly a decade, culminated in Andrea’s shocking actions on June 20th, 2001. When Andrea and Russell “Rusty” Yates married in 1993, Andrea gave up her job as a nurse to raise their family (McLellan 2006; Willey 2021). Over the next seven years, she gave birth to five children and suffered a miscarriage. The middle-class Yates family led a chaotic life in the Houston suburb of Clear Lake City, sometimes living in camping trailers or a converted bus (Cochran 2022; McLellan 2006).¹ Andrea was the sole caretaker of all five children, as well as her father, who suffered from Alzheimer’s disease. On top of her caretaking responsibilities, she single-handedly homeschooled all the children and managed the household (McLellan 2006). Through all of this, Andrea was diagnosed with clinical

¹ While the Yates’ family was part of the middle-class, it remains unclear if their socioeconomic status was the sole reason for their unconventional lifestyle. It was likely a combination of their financial status and unorthodox familial and religious beliefs.

depression and began to live in a state of self-doubt and inadequacy about her role as a mother (Hyman 2004).

The Yates' religious beliefs deeply impacted Andrea's parenting style. The family hosted a Bible study three nights a week and followed the teachings of Michael Woroniecki, a Christian fundamentalist preacher (McLellan 2006). Woroniecki taught that parents—particularly mothers—were responsible for ensuring the salvation of their children. He believed that parents should elect to commit suicide rather than cause their children to go to hell (McLellan 2006). As Andrea's depression worsened, she and Rusty consulted Woroniecki about their family. However, his preaching only exacerbated her insecurities, convincing her that she was an evil mother. This belief stemmed from Woroniecki's messages that she must save her children, which intensified Andrea's preexisting feelings of inadequacy and led to her decline in mental health.

Andrea's deteriorating mental state reached its peak with numerous visits to the hospital. After the birth of her first son, Noah, Andrea started experiencing violent hallucinations of stabbings (McLellan 2006). Her condition worsened after the birth of her fourth child, Luke, when she attempted suicide by overdosing on sedatives. Concerned for her well-being, Andrea's family admitted her to the hospital. However, due to limitations in her insurance coverage, her doctor discharged her before the symptoms had fully subsided. Her psychiatrist prescribed antidepressants to help treat her suicidal ideations. However, she did not take them, resulting in another suicide attempt during which she claimed she heard voices telling her to "get a knife" (McLellan 2006, 1952). Finally, once Andrea held a knife against her throat and self-harmed, her doctor prescribed a new medicine with an antipsychotic agent. This was the first medicine that proved effective. Despite the new prescription, her mental health history meant she remained at high risk for psychotic episodes. Her psychiatrist explicitly cautioned her that having another child would almost certainly provoke another psychotic episode, as the previous ones had occurred after two of her children's births. Nevertheless, Andrea soon gave birth to her fifth child, Mary.

As time passed, Andrea's symptoms grew increasingly erratic, and her doctors failed to find an effective treatment. Andrea's father passed away a few months after Mary's birth, leading to an episode where Andrea stopped daily activities like talking, drinking water, and nursing; she also began to pull out her hair (McLellan 2006). Andrea's family admitted her to the hospital for the third time after she claimed that video cameras were watching her at home and television characters were speaking to her. Even though her other symptoms remained unresolved, Andrea's doctor discharged her after she began eating more. Once home, her condition continued to decline. Unusual behavior, such as filling the bathtub in case she "needed it," prompted her family to readmit her over concerns for her wellbeing (McLellan 2006, 1952). Her psychiatrist weaned her off the antipsychotic drugs being used to treat her, even as Andrea's symptoms worsened. Her psychiatrist's sole reason for this decision was that the drugs were "bad medicine," but they offered no further explanation as to why this was the case (McLellan 2006, 1952). Andrea's psychiatrist also rejected the idea of electroconvulsive therapy,² as it was reserved for people with "severe mental illness" (McLellan 2006, 1953). It remains unclear why they did not classify her condition as severe. Instead of electroconvulsive therapy, her psychiatrist sent her home and told her to "think positive thoughts." Just two days later, Andrea killed all five of her children (McLellan 2006, 1953).

After Rusty Yates left for work on the morning of June 20th, 2001, Andrea methodically drowned each of their children, starting with two-year-old Luke, then three-year-old Paul, and

² Electroconvulsive therapy is the electrical stimulation of the brain while the patient is under anesthesia. It is most commonly used in patients with severe depression or bipolar disorder who have not responded to other treatments (American Psychiatric Association n.d.b).

five-year-old John. After each child died, she carried them into her bedroom and covered them with a sheet (O'Malley 2002). She then drowned six-month-old Mary, during which her oldest child, Noah (age seven), asked her, "What's wrong with Mary?" (O'Malley 2002, n.p.). After realizing what was happening, he ran away. Andrea chased Noah through the house, dragged him to the tub, and drowned him. She immediately called both Rusty and the police.

Once they arrived, Andrea told the police what she had done, her confession revealing the extent of her mental illness. She admitted that she had contemplated killing her children for the last two years. In her explanation, Andrea reiterated Woroniecki's teachings. She claimed Satan marked her, and the only way to save her children from hell was to kill them, as Satan would be destroyed once the state punished her (McLellan 2006). Once in jail, she asked to have her head shaved so others could see that Satan had engraved 666 on her skull. This request exemplifies how strongly Andrea believed the hallucinations were reality; she convinced herself that shaving her skull would prove that what she was experiencing was real.

Despite seeing satanic teddy bears and ducks on her cell walls, Andrea did not believe she had a mental illness because she never cried, a sign she associated with depression. Before her arrest, Andrea had been diagnosed with postpartum depression (PPD) and clinical depression (McLellan 2006). While various doctors have since diagnosed her with postpartum psychosis (PPP), major depression, schizophrenia, schizoaffective disorder, and bipolar disorder, PPP is generally considered the most definitive. When her attorney, George Parnham, first met with her, she was mutely rocking back and forth in her cell (McLellan 2006). Parnham's initial interaction with Andrea, coupled with her seeing satanic imagery, showcase her mental state during the day of the murders.

What Happened to Andrea Yates?

Since her arrest, Rusty has maintained that Andrea's illness and neglectful medical care caused her crimes, stating that she was a good mother who loved her children (Robinson 2015). Rusty claimed that the trial was the "cruellest thing he had ever witnessed," adding that Andrea's doctor and hospital "miserably failed [them]" (CNN 2002, n.p.; Robinson 2015, n.p.).³ He cited their insurance coverage as the only reason they chose their doctor. Rusty believed that keeping her in the hospital longer or giving her proper medications could have prevented the killings, as there was little they could do to stop Andrea's actions once her doctors released her from the hospital. Rusty urged others not to prioritize saving money over quality treatment as his family paid the ultimate price for that decision (CNN 2002). While he stood by Andrea's side, Rusty faced significant criticism for leaving Andrea unsupervised with the children despite being advised against it due to her condition.³ Rusty remained a loyal partner until 2004, when he filed for divorce (History.com Editors 2020).

Andrea's case drew national attention, raising debate over multiple divisive issues, such as the death penalty and the insanity defense. Throughout the media frenzy, the prosecutors in Andrea's trial argued for the death sentence, claiming she failed to meet the state definition of insanity. The prosecution relied heavily on the "expert" witness testimony of psychiatrist Park Dietz. They chose Dietz because he had testified in many high-profile cases, including that of Jeffrey Dahmer—the serial killer who dismembered seventeen people—whom he declared legally sane. However, Dietz had not treated a patient in 20 years, lacked expertise in postpartum disorders, and had never seen a case of postpartum depression with psychotic features (McLellan

³ Nonetheless, Rusty faced no legal consequences, such as criminal negligence. This is a striking contrast to how mothers are often treated — a double standard that will be delved into further in this study.

2006). While neuropsychologist Dr. George Ringholz stated Yates was “acutely psychotic,” Dietz proclaimed that she was sane and categorized her hallucinations as obsessional intrusive thoughts (Hyman 2004, 204; McLellan 2006). In his testimony, Dietz connected Andrea’s case to a mother who drowned her children in an episode of *Law & Order* (Hyman 2004; McLellan 2006). He argued that Andrea avidly watched the show and consciously copied the idea from the episode when plotting to kill her children, implying that she was sane. Dietz’s extrapolation reinforced Andrea’s guilt to the jury, making her actions appear premeditated. After less than four hours of deliberation,⁴ the jury declared Andrea Yates guilty on March 15th, 2002, and sentenced her to life in prison (Cochran 2022).

In 2005, Yates’ conviction was appealed after Dietz’s testimony was proven false, granting her a new trial (Cochran 2022). The episode Dietz claimed Andrea copied did not exist; he had mistakenly combined two episodes. As Dietz was an expert witness, the three appeal court judges decided his testimony heavily influenced the jury’s decision and granted Andrea a retrial (Charatan 2005). On July 26th, 2006, Andrea was declared not guilty for reason of insanity and was committed to a state mental hospital, where she has since resided (Cochran 2022). If Andrea is not guilty for reason of insanity, who is truly responsible for what occurred? How did others' actions, or lack thereof, seal the fates of her children?

What is Postpartum Psychosis?

Postpartum psychosis (PPP), also known as puerperal or postnatal psychosis, is the most severe form of postpartum psychiatric illness (NHS n.d.b). Onset can occur as early as 48 to 72 hours post-delivery but can also develop anytime in the first few weeks after giving birth (MGH Center for Women’s Mental Health n.d., hereafter MGH n.d.). PPP is not considered its own diagnosis in the DSM-5, the standard classification of mental health disorders in the United States (U.S.) (American Psychiatric Association n.d.a). Instead, PPP is considered a subset or version of postpartum depression (PPD), which is used as an umbrella term for “baby blues,”⁵ prenatal/postpartum depression or anxiety, PPP, and the postpartum development of panic disorder, PTSD, or OCD (Mental Health America of Ohio n.d.). Since medical professionals consider PPD to encapsulate PPP, there is very limited research done on PPP specifically.

PPP is diagnosed based on a pattern of symptoms under the umbrella term of PPD instead of on the biological and psychological factors that define postpartum illness. Women who have been diagnosed with PPP specify four common facets of their experience: confusion, lack of recognition, breastfeeding, and trauma (See Appendix). From a clinical perspective, PPP appears suddenly and is characterized by delusions, hallucinations, rapid and extreme changes in mood, and bizarre behavior. With a prevalence of one to two per 1000 women post-childbirth,⁶ the medical community considers PPP a psychiatric emergency that resembles a rapidly evolving manic episode (Stockley 2018). Earliest signs include restlessness, irritability, and insomnia. Later signs include rapidly shifting depression and elated mood, disorientation, confusion, and erratic or disorganized behavior (MGH n.d.). Symptoms include delusional beliefs that center on the infant, seeing or experiencing things that are not real, or feeling depressed, high, or anxious. Auditory

⁴ There is no set time for how long a jury can or will deliberate for, but for severe criminal trials they may deliberate for days. Therefore, coming to a consensus in a few hours showcases the impact of Dietz’s testimony.

⁵ “Baby blues” are considered a very minor form of PPD, or a mild depression. “Baby blues” are characterized by mood swings and sadness. These symptoms are expected and normalized because approximately 70-80% of new mothers experience “baby blues” (American Pregnancy Association n.d). This normalization only adds to the misunderstanding and minimization of PPD (and PPP) symptoms.

⁶ While not all birthing people are women, this case study utilizes the medical statistics of cisgender females who identify as women and/or mothers. The gendered terms woman and mother will be used throughout as they are the terms widely used in the available and reviewed literature.

hallucinations that instruct the mother to harm herself or the infant are also common (MGH n.d.; Stockley 2018). Consequences of PPP are impaired mother and infant bonding, infant abuse and neglect, and risk of recurrent psychotic illness (Stockley 2018). As the most severe risks include infanticide and suicide, inpatient treatment is recommended (MGH n.d.; Stockley 2018).

Postpartum psychosis (PPP) has many biological and psychological risk factors. Mothers with a previous diagnosis of schizophrenia, an existing diagnosis of bipolar disorder, or a family history of PPP in a first-degree relative are at higher risk for developing PPP (Stockley 2018). Those with both bipolar disorder and a first-degree relative with PPP have a 74% likelihood of developing the disorder. Psychological risk factors such as trauma, psychological distress, antenatal stress, personality factors, and stressful life events also play a role in PPP development (Stockley 2018). Women who experience stressful life events the year before delivery are three times more likely to develop PPP than those who do not. When combined with outside influences, the presence of these biological and psychological risk factors impacts how susceptible a mother is to developing PPP.

These outside influences, which include sociological factors, cultural pressures, and unmet social and emotional support needs, can impact the likelihood of women developing PPP (Stockley 2018). First-time mothers, as well as those with negative birth experiences or poor support during labor, are at increased risk. Andrea Yates had many risk factors for PPP: trauma from a miscarriage, unmet needs for support in caring for her family, psychological distress from feelings of inadequacy, and a history of mental illness. While there is some research on PPP risk factors, little evidence exists on effective prevention once these risk factors are identified.

Both prevention and treatment are difficult due to the lack of research surrounding PPP. Medical professionals currently approach PPP prevention through mood stabilizers or antipsychotics (Doucet et al. 2011). Lithium is the primary mood stabilizer used and is administered before or within a day of delivery.⁷ Research shows that lithium may decrease relapse rates from 50% to 22%, with higher rates amongst those who discontinue lithium during pregnancy (Doucet et al. 2011). While lithium is also the most commonly used treatment, the evidence on the efficacy of taking lithium after delivery is both inadequate and conflicting.⁸ All other potential treatments, including the use of antipsychotics, lack sufficient research to validate their benefits (Doucet et al. 2011).

What are the Impacts of Insufficient Research?

Insufficient research surrounding women's health is not a new phenomenon, nor is it exclusive to PPP and postpartum illnesses. Historically, medical studies have excluded female participants in medical research, as researchers considered men representative of the human species (Merone et al. 2022). As a result, researchers did not take anatomical gender differences into account during study design or analysis (Holdcroft 2007; Merone et al. 2022). Simply put, research and data collected from men are generalized to women (Merone et al. 2022). Public health researcher Dr. Kate Young synthesizes that excluding women from medical and scientific knowledge production means that healthcare systems are now "made by men for men" (Jackson 2019, n.p.).

The gender gap in medical research disadvantages female patients. Women must wait longer for diagnosis and pain relief, experience higher rates of misdiagnosis, and receive

⁷ Lithium has many side effects and the potential for lithium toxicity. Lithium toxicity can cause confusion and blackouts, difficulty speaking, muscle spasms and weakness, feeling lightheaded, problems with eyesight, and more (NHS n.d.)

⁸ Other potential treatments for PPP include electroconvulsive therapy, hormone replacement therapy, progesterone, and propranolol (Doucet et al. 2011).

ineffective or harmful treatments. Additionally, the likelihood of being discharged during a severe medical situation, as Andrea experienced, is greater for women compared to men (Merone et al. 2022). The Yentl syndrome is a term that describes the gender gap in healthcare and medical research, outlining how women must prove themselves as unwell as their male counterparts to be taken seriously by medical staff. This is another factor in delayed care. Medical professionals often dismiss women's pains as psychological; thus, women are colloquially characterized as "crazy" when they do not respond to treatment as expected (Merone et al. 2022). The exclusion of women in studies has led to a lack of knowledge about women's symptoms. This limited knowledge invalidates women's experiences and contributes to the construction of the "difficult patient" archetype women experience (Young, Fisher, and Kirkman 2018). Since women's symptoms are different from men's, they are seen as difficult when they do not respond to treatment as expected. This perspective contributes to the cycle of invalidation and misdiagnosis. Furthermore, the problem is not simply fixed by adding women. Experiments must ask and answer questions that center women's issues and experiences in order to adequately understand their symptoms and treatments.

Gender-based discrepancies in the study of illnesses that uniquely affect women are an active issue plaguing the healthcare industry. For example, funding for research on coronary artery disease is greater for men than for women, even though at-risk women suffer higher rates of mortality than at-risk men (Holdcroft 2007). Treatment for acute myocardial infarction (MI) is another clear example of how research disparities impact women's health outcomes (Merone et al. 2022). MI presents different symptoms for men than for women, and without female research participants in MI studies, they are underdiagnosed and experience higher rates of mortality. Androcentricity in medicine has led to discrepancies in diagnosis, patient management, and an increased likelihood of barbaric treatments for women, including forced clitoridectomies,⁹ mandatory bed rest, and diagnoses of "hysteria" (Merone et al. 2022).

While the gender gap extends to drug development and trials, efforts are being made to reverse this trend. In 1994, the U.S. National Institute of Health issued a guideline for the study and evaluation of gender differences in clinical trials. Before this guideline, researchers had purposefully excluded women from the early trials of most drugs (Holdcroft 2007). While researchers justified this exclusion with safety concerns over women's health, it led to the approval of drugs where the efficacy and side effects for women were unknown. In 2005, research conducted by the Society for Women's Health Research revealed that eight out of 10 prescription drugs were withdrawn from the U.S. market due to health risks specifically affecting women (Simon 2005). Gender discrepancies have not only resulted in poor health effects but have also wasted substantial funding, as exemplified by products being removed from the market (Simon 2005). Medical research must safely and accurately incorporate women into their studies to improve healthcare outcomes and the safety of women and their children.

What are the Impacts of the "Super Mom" Archetype?

The "Super Mom" is a modern phenomenon in the U.S., where a mother is expected to manage and run a household while simultaneously holding a job. Merriam-Webster defines a "Super Mom" as "an exemplary mother who performs the traditional duties of housekeeping and child-rearing while also having a full-time job" (Merriam-Webster.com Dictionary n.p.). The expectation for women to assume the sole role of caretaker for their children is a relatively recent

⁹ A clitoridectomy is considered female genital mutilation. This is a treatment that was given in the past but is no longer prescribed or considered acceptable (Strawbridge and Creighton 2010; World Health Organization n.d.)

and unique societal expectation particularly prevalent in Western societies. The responsibility of childcare was previously spread to extended families or even entire towns (Quindlen 2001). Starting with hunter-gatherer tribes, both parents and “alloparents”—grandparents, siblings, and friends— all cared for and raised children (Schulte 2016). Over time, society continued to value motherhood as a full-time position and a crucial role in communities. The concept of moral motherhood arose in the 1800s and was based on the idea that a mother’s job was to raise the next generation as “moral citizens.” This perspective shifted dramatically through the 20th century, from the scientific focus of the 1920s to the anti-maternalism of the 1940s (Schulte 2016). Anti-maternalist arguments undermined many of the traditional foundations of motherhood, rejecting the notion of the self-sacrificing mother and the perception of motherhood as an all-encompassing role (Plant 2015). This viewpoint is the foundation from which the “Super Mom” concept arose in the 1970s, a time when women fought for the right to work outside the home. Published in 1963, Betty Friedan’s *Feminine Mystique* was the catalyst for the “Super Mom” movement, which narrated the dissatisfaction of women in America following World War II (Churchill 2023). Friedan claimed housewives were discontent with their lives, and women were being denied their “basic human need to grow” (Churchill 2023, n.p.). Women’s fight for careers spurred much of the second-wave feminist movement.

While this fight for equality was aimed at liberation, it inadvertently added a second set of responsibilities and expectations upon women, thus creating the archetypal female (Davis 2021). She is “both a career woman and a housewife—whose to-do list spans cooking, cleaning, parenting, earning a substantial paycheck and sexually satisfying her husband—all without a hair out of place” (Davis 2021, n.p.). This expectation has led many mothers to believe that no matter what they are doing, it is not enough. While most women do not end up in Andrea’s situation, her overwhelming responsibilities are sadly not unusual, as mothers often take on multiple roles. The U.S. government perpetuates disproportionate maternal responsibility through the historically meager federal social safety net, which relies on mothers to serve as the primary support system, a role they have traditionally fulfilled and continue to uphold (Davis 2021).¹⁰ Even in households where men participate in parenting, they often do more enjoyable and less arduous tasks (Davis 2021). For example, while fathers may take their kids out for a fun activity, the mother is frequently expected to put away their toys or clean their diapers (Davis 2021). Therefore, even when parents do “equal” amounts of work, the work requires different amounts of effort, making it unequally burdensome.

The expectation of the “Super Mom” leads many women with postpartum illness to experience significant guilt (Taylor 1995). Media, literature, and messages directed toward women portray childbirth through a rose-colored lens, claiming children will “bathe in the glow of maternal love” (Taylor 1995, n.p.). This romanticization is an example of the emotional norms that media and literature portray about postpartum motherhood. Many women experience guilt when their lived experiences diverge from these social expectations. Numerous mothers, such as Andrea Yates, experience doubts surrounding their adequacy as a person. The belief that good mothering should be analogous to altruism and self-sacrifice often leads to anger and resentment for many women. Societal norms dictate that mothers should put their needs second, serving others at the expense of their own happiness. Historically, anger as an emotion in women was considered a violation of gender norms and was synonymous with mental illness (Taylor 1995). This means

¹⁰ Mothers’ responsibility to provide a “safety net” was only exacerbated during COVID-19. Specifically with the closure of schools, mothers were expected to educate their children and provide childcare instead of the government. The lack of government provisions only exacerbated the overburdening of working mothers (Smith 2020).

that mothers are not given space to deal with the difficulties of motherhood because society views their anger as mental illness rather than an appropriate response to the pressure they face. The guilt and shame associated with postpartum depression (PPD), including postpartum psychosis (PPP), is the greatest barrier for women seeking help (Manso-Córdoba et. al. 2020).

As previously mentioned, Women who have had PPP cite a lack of recognition of the ailment's gravity as a significant facet of the illness (Stockley 2018). Lack of recognition is categorized in two ways: keeping up appearances and misinterpreting the problem (See Appendix). Due to the unrealistic expectations around postpartum, many women assume their symptoms — such as exhaustion or “baby blues”— should be expected because society has normalized them. Mothers also feel pressure to maintain appearances due to the societal judgment they face if they cannot balance managing a household, raising children, and holding a job with ease. This expectation stops mothers from reaching out for help (Stockley 2018). Societal standards not only normalize postpartum illness symptoms but discourage women from seeking treatment for them.

How did the Media Respond to Andrea Yates?

From news outlets to national organizations to “mommy blogs,”¹¹ many people commented on Andrea's case. She became a nationwide controversy as the poster child for the causes and consequences of PPD. Feminists supported the insanity defense, viewing her case as a call to action for issues in the U.S. healthcare system, an opportunity to voice maternal frustration, and a chance to break the myth of the eternally-giving mother (Hyman 2004). Conversely, political conservatives thought that mental illness could not excuse her actions. They even suggested that feminists were promoting Andrea's actions by not holding her justly accountable. In public spaces, the former group supported the insanity ruling for Andrea's case, while the latter group called for the death penalty (Hyman 2004). This conflicting discourse shows how the role of mothers has been a divisive issue in society.

The Yates case prompted discussion on overlapping problems in the U.S. healthcare and legal systems. Kim Gandy, then the president of the National Organization for Women (NOW), believed the prosecution pursuing the death penalty illustrated that “Texas was unable to appropriately judge the relationship between mental illness and criminal responsibility” (Hyman 2004, 195). NOW joined other organizations in hosting rallies demanding Yates receive medical care. Gandy also believed that Yates' case would encourage more research on postpartum depression and psychosis. She added that the case drew attention to significant shortcomings in the U.S. healthcare system, especially given Yates' discharge despite her psychotic state (Hyman 2004).

Many feminists believed Yates illustrated the conflicts between maternal ideology, like the “Super Mom” myth, and the daily features of motherhood. They hoped to show how impossible cultural standards cause women to believe they are failures as mothers. These feminists used Andrea as an example of these standards. Andrea faced “Super Mom” expectations: she did not receive help from her husband with childcare, could not afford to hire extra childcare help, and managed her children's spiritual education and schooling even following her diagnoses of severe mental disorders. These compounding pressures convinced her that she was an incompetent mother rather than someone who required mental resources and household support. Anna Quindlen wrote on *Newsweek 90* about the impossible standards mothers are expected to adhere to and the toll they take (Quindlen 2001). She explained the nearly universal reaction of mothers to the Yates case:

¹¹ The term “mommy blog” refers to blogs authored by mothers who chronicle their personal parenting lives or write about their children (D'Arcy 2012).

“She’s appalled; she’s aghast. And then she gets this look. And the look says that on some forbidden level she understands” (Quindlen 2001, n.p.).

Contrarily, conservatives believed people were justifying Andrea’s actions as an understandable consequence of her familial responsibilities, arguing that doing so essentially promoted her actions (Hyman 2004). *National Review Online*’s Deroy Murdock believed Americans have a nonchalant attitude towards infanticide and consistently try to excuse mothers’ crimes. Murdock claimed that this attitude shows that people in the U.S. value infant life less than other life. He also believed that infanticide should be considered the same as murder. Shannon May, a pro-life conservative and contributor to *Rightgrrl!*, stated that insinuating any mother could be driven to murder their children was appalling (Hyman 2004). Conservatives viewed Andrea’s case as an evil criminal act rather than a mental health issue that called for changes in legislation and medical systems.

Regardless of one’s position on the case, Andrea was an ideal profile for discussing topics like mental illness while omitting other issues, such as race. As a middle-class, stay-at-home, feminine-presenting white woman, Andrea was continuously given a level of grace in the media not often granted to women of other identities. In “A Cry In the Dark,” the profile piece featured in *O, The Oprah Magazine*, Andrea is called a “clean-living, all-American woman” (O’Malley 2002, 1). A *Daily Mail* article prefaced Andrea as a “former nurse and stay-at-home mom” before stating that she drowned her five children (Robinson 2015, n.p.). This framing is unique because, in U.S. media, non-white murderers are frequently dehumanized and not introduced as whole people with previous pursuits (Jardina and Piston 2021). Andrea was afforded certain privileges because of her race, socioeconomic status, and gender presentation. If Andrea Yates did not have these advantages, she likely would not have been afforded the same understanding, and the ruling of her case may have been different.

How does the Law Treat Mothers?

The U.S. legal system assumes that a person accused of a crime is both innocent and sane until proven otherwise. Therefore, defendants must demonstrate insanity (Rhodes and Segre 2013). Medically, the term “psychosis” is considered a gross impairment in the testing of reality, yet psychosis itself does not determine the legal definition of insanity or its use as a defense (Hamilton and Harberger 1992; Rhodes and Segre 2013). The gap between the medical and legal definitions of insanity means that rulings of insanity are not purely based on psychosis, leading to discrepancies in trial outcomes.

Furthermore, the U.S. does not have a fixed legal definition of insanity across all states, further contributing to the vastly different rulings for similar cases. Four states do not recognize insanity as a defense, and all others fall under three definitions: the Durham Rule, the M’Naghten Rule, or the Model Penal Code (Rhodes and Segre 2013). The Durham Rule, used only in New Hampshire, attempts to objectively define insanity through medical diagnosis. This rule states a person is not criminally responsible if the unlawful act resulted from a specific mental disorder (Rhodes and Segre 2013). Due to the ambiguity and wide range of potential diagnoses, this rule has been largely discontinued. The M’Naghten Rule defines insanity in two parts: either the accused did not know the nature of the act when committing it or the difference between right and wrong (McLellan 2006). More comprehensively, the Model Penal Code combines the Durham and M’Naghten rules together with the “irresistible impulse” test. In simple terms, the code states that someone cannot be held responsible for their actions if they were mentally ill when committing a crime and/or could not recognize the criminality of the act or conform their conduct to the

requirements of the law. (Rhodes and Segre 2013). Legal and medical definitions of insanity vary between states, resulting in different treatments and court verdicts, which compounds existing stigmas around mental illness.

Yates resided in Texas, which only observes the second half of the M’Naghten rule, meaning insanity is defined solely by whether the defendant knew the act was right or wrong when committing it. (McLellan 2006). In this definition, right and wrong is more ambiguous than in other legal definitions. Concerning Andrea Yates’ case, she knew her actions were “wrong” but felt morally compelled to do them. This feeling is common among many women who commit infanticide; they do so because it “must” be done to fulfill some higher purpose, regardless of whether they know killing their child is wrong (Hamilton and Harberger 1992).

It can be challenging to prove insanity as a defense for infanticide because most patients recover from the psychiatric portion of postpartum psychosis (PPP) by the time they appear for trial (Hamilton and Harberger 1992). This problem is further complicated by the DSM-5 not recognizing PPP as a diagnosis independent of postpartum depression (PPD). Establishing this distinction would be transformative because PPD does not specify psychosis, making it insufficient in demonstrating insanity (Rhodes and Segre 2013). Other countries do not have the same struggle with legal defense; in fact, in an international context, the U.S. is uniquely punitive with regard to infanticide due to postpartum illness (Rhodes and Segre 2013). Developments in medical standards and laws are needed for the U.S. to properly address the causes and effects of PPP.

The UK separates infanticide from other charges through the British Infanticide Act of 1922.¹² The law is built on the principle that women who kill their child before the age of one do so because “the balance of her mind is disturbed by reason of her not having fully recovered from the effect of giving birth” (Friedman and Resnick 2007, 138). When enacted, the consequence of murder in England was a mandatory death penalty, and infanticide was significantly more frequent than it is today (Milne 2022). The act was designed to save women from this fate, specifically after increased support arose around the plight of the accused women (Milne 2022). The public increasingly recognized women as victims facing death, while the men who caused or contributed to her situation faced no consequence (Milne 2022). Thus, the British Infanticide Act was born from popular protest. Though the law does not function the same way in modern days as when it was adopted, the principles of the act set precedence for similar laws around the world.

Versions of this act have been adopted in 22 other countries, leaving the U.S. behind in both legislation and expectations surrounding women (McLellan 2006). The majority of infanticide laws have followed British precedence regarding a decreased penalty if the child is under a year old (Friedman and Resnick 2007). The British Infanticide Act specifically states that women who kill their children during the first year of life can only be charged with manslaughter, not murder, mandating both parole and psychiatric treatment for the mother (McLellan 2006). U.K. legislation shows how infanticide can be treated as a separate category of crime, while in contrast, U.S. law does not separate these categories. Furthermore, U.S. legislation does not recognize PPP as a mitigating factor for infanticide. (McLellan 2006). Women face significant barriers to claiming the insanity defense due to multiple definitions of insanity, the DSM-5 not considering PPP an independent diagnosis, and laws around infanticide trailing behind international precedence.

The pervasive stereotype of the perfect mother also hinders a mother’s defense in criminal proceedings. In criminal cases, jurors are tasked with determining if a defendant's behavior falls below the standard of “the reasonable person” and is thus negligent or worse (Fentiman 2018).

¹² While Parliament has since revised the act, the establishment of the act set worldwide precedence (Friedman and Resnick 2007).

The “Super Mom” encourages an idealized image of motherhood as the expectation for “the reasonable person.” Society holds women to a higher standard than men, and mothers to an even higher standard than that (Fentiman 2018). These unconscious standards create drastically different expectations in criminal cases for “the reasonable person” based on gender. The result is that mothers are charged with, convicted of, and punished for a disproportionate amount of crimes (Fentiman 2018).

This standard for mothers has become so extreme that, like in the criminal case of Melissa Rowland, they have been found guilty of murder even when bearing little to no responsibility for the death. After declining a cesarean section, Melissa delivered a stillborn and was subsequently charged with the murder of her child (Fentiman 2018). This example showcases how these standards have criminalized maternal selfishness, or prioritizing the mother’s health and safety over the child’s. Mothers are also prosecuted for homicide or child abuse when a male partner kills or injures their child. For example, Ginger McLaughlin was convicted of criminal neglect when her husband killed their infant (Fentiman 2018). However, in a similar situation, Rusty directly defied the doctor’s orders and left his wife alone with their children while she was in the middle of a psychotic episode, yet received no legal punishment. Furthermore, in cases where the mother experiences domestic abuse, their abuse is often used against them. Judges and juries frequently consider mothers guilty of child abuse by omission because they “chose to stay” (Fentiman 2018, n.p.). The legal standard of a “reasonable person” has become synonymous with the perfect mother, leading female parents to take the blame for all actions, even those against themselves. This pervasive standard distorts the judgments of all those incorporated in the legal system—including police, prosecutors, judges, media, and jurors—and leads to severe injustices (Fentiman 2018).

In addition to the distinct expectations that mothers experience, identities like race, gender, sexual orientation, and gender expression contribute to a defendant’s perceived culpability in criminal cases (Rahrig 2022). Systemic racism is pervasive in the U.S. criminal legal system, with Black people constituting a disproportionate amount of the prison population.¹³ The difference in how the law and social services treat Black and white mothers can be seen very clearly through the drastically different treatment of Andrea Yates and Temecia Jackson, another Texas mother. Andrea suffered from postpartum illness and had contemplated killing her children, yet she was still left alone to take care of them. Meanwhile, in 2023, Jackson had her two-week-old daughter taken away because she followed her midwife’s care protocol for her baby’s jaundice instead of admitting her to a hospital (Campoamor 2023). The pervasive double standard criminalizes women of color for less serious situations. The cases of Yates and Jackson exemplify how a mother’s race influences their treatment in the criminal legal system, highlighting the importance of using intersectionality to analyze mothers’ experiences.

Masculinity is another critical determinant in criminalization, intersecting with other determinants like race and gender. Juries find it challenging to picture women—assumed to possess traditionally feminine qualities—as violent or threatening to society (Rahrig 2022). This view compounds with a defendant’s sexual orientation, as lesbians are considered more masculine than most straight women, and gay men are considered more feminine than most straight men. Race is also gendered. A study at Pennsylvania State University showed that juries perceive Black people as more masculine than white people, who are, in turn, more masculine than Asian people (Rahrig 2022). This trend persists across genders, masculinizing Black women. In contrast, white

¹³ Black people account for 13.4% of the U.S. population but 38.1% of the prison population; conversely, white people account for 76.3% of the U.S. population but only 57.9% of the prison population (Rahrig 2022).

women are perceived as “ladies” and can maintain a level of femininity and status that Black women are denied. Elaina Rahrig at Georgetown University examined cases of capital defendants to determine how these factors influence culpability and public perceptions (Rahrig 2022). Rahrig’s case studies found that juries were more likely to perceive defendants with more “masculine characteristics” as guilty (Rahrig 2022, n.p.). In one example, two lesbian women committed a crime together, but the jury viewed the more masculine presenting defendant as guilty, while her more feminine counterpart was not (Rahrig 2022). Thus, being Black, masculine-presenting, lesbian, or male are all factors that lead jurors to believe someone is guilty or more capable of a crime. In contrast, “feminine” traits such as being straight, white, or feminine-presenting often lead jurors to perceive defendants as “frail and docile” and thus innocent (Rahrig 2022, 8). Andrea Yates’ identity as a straight, feminine-presenting, white woman undoubtedly affected her case, as she was allowed more grace and characterization as the victim.

Epilogue: What Now?

Since her second trial in 2006, Andrea Yates has remained in Kerrville State Hospital, a mental health facility in Texas (Willey 2021). To this day, Rusty claims she was a “loving mother who just fell to this disease” (Pagones 2023, n.p.). George Parnham, her attorney, claims she is doing “remarkably well,” spending her time making crafts and anonymously selling them. She also watches videos of her children, saying she is continuously thankful for their time together while grieving for them daily (Cochran 2022, n.p.). Each year, Andrea is given the option of reevaluation for release, and without fail, she has declined this evaluation.

While Parnham believes the Yates case “laid the blueprint on motherhood and mental health of women,” others view her case as a missed opportunity (Cerulli 2004; Pagones 2023, n.p.). Andrea’s case could have been a teaching moment for the nation regarding the complexities of mental health and the failures of healthcare and law. Instead, the media branded her as the poster child for postpartum depression (PPD), increasing the stigma surrounding it by linking the diagnosis to insanity and murder. Simultaneously, the media minimized the other issues that compounded her situation, such as religious and societal pressures, lack of child support, and healthcare failures (Cerulli 2004). Instead of having positive impacts, her case may have hindered other women from seeking help if they identify with PPD symptoms, potentially wanting to distance themselves from Yates to avoid being perceived as insane (Cerulli 2004). While her case could have been a catalyst for significant reform, the missed opportunity has led many other mothers to fall through the cracks in U.S. systems, resulting in eerily similar outcomes.

The repercussions of Andrea’s case can be seen as recently as 2023 in the chillingly similar example of Lindsey Clancy. On January 24th, in Duxbury, Massachusetts, she strangled and killed her three children: five-year-old Cora, three-year-old Dawson, and eight-month-old Callan (Papadopoulos 2023). She then attempted to kill herself by jumping out of the second-story window in her home, resulting in severe spinal injuries that left her paralyzed (Papadopoulos 2023).

Lindsey’s case bears a resemblance to Andrea’s beyond just the methodical style of killing their children. Lindsey, who was also a white mother and a (labor and delivery) nurse, had been seeking mental health treatment for anxiety and postpartum illness (Baker 2023). Her treatment consisted of up to 13 psychiatric medications, likely leading her to have suicidal and homicidal thoughts and eventually suffer a psychotic break (Baker 2023). Lindsey even discussed with her doctors that she was having adverse reactions to her medications. They proceeded to prescribe her additional medications before properly weaning her off the old ones. On January 1st, 2023, she

checked herself into McLean Hospital, a psychiatric facility, but was released just five days after new prescription changes were made (Baker 2023). She continued to express feeling unwell at doctor's appointments until the incident on January 24th. In two cases set 20 years apart, mothers were sent home from mental health facilities before they were ready, were incorrectly prescribed medications and treatment options, and had healthcare professionals invalidate their health concerns.

The media's response to Clancy's case was also similar to Yates'. In March of 2023, the second headline of an online search for "Lindsay Clancy" yielded "Mass. Mom Lindsay Clancy Was 'Mom Everyone Wanted to Be.' Now She's Accused of Killing Her 3 Kids" (Baker 2023, n.p.). This headline was followed by paragraphs filled with testimonials about what an exceptional mom she was, including details of the backpack and supplies she bought her children, outfits she dressed them in, and her perfect social media image. One testimony even included how she kept in shape by pushing Dawson in a stroller while Cora peddled next to her in "a red tricycle that perfectly matched the color of her tiny bike helmet" (Baker 2023, n.p.). Like Rusty Yates, Lindsay's husband, Patrick Clancy, asked the public to forgive her and blamed her actions on the illness, emphasizing how strong their marriage was (Pagones 2023). The eerie similarities between these two cases exemplify the limited progress made in reform through the last two decades.

Lindsey began her trial on May 2nd, 2023, 20 years after Andrea's case. As a healthcare provider, Lindsay knew what signs to look for, asked for and received help, yet still ended up killing her children (Baker 2023). When mothers do everything right, something is still going critically wrong. Who is responsible? When will the overwhelming pressure put on mothers finally be deemed too much? Changes to healthcare, legislation, and societal standards must be made to reduce the factors of postpartum illnesses, otherwise, chilling stories like Andrea Yates' will continue for decades to come.

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Appendix A: Facets of the lived experience of postpartum psychosis (PPP) as identified and described by women (Stockley 2018, 50).

Superordinate themes	Subordinate Themes	Specifics
“What is happening?”	A. “I just didn’t sleep”	<ul style="list-style-type: none"> - Significant lack of sleep during the onset of PPP - Difficulty initiating sleep, often due to anxiety, even when baby not around - Sleep deprivation may also be a causal factor
	B. Not feeling or acting like self	<ul style="list-style-type: none"> - “Out of character” behavior - Compromised sense of identity - May be seen by others as well - Difficulty identifying PPP due to less distinct or describable symptoms - Frustration communicating behavior changes with healthcare professionals
	C. Anxieties relating to the baby	<ul style="list-style-type: none"> - Anxious thoughts concentrating on the baby’s wellbeing - The need to protect the baby from harm - Lack of confidence in ability to look after the baby - Fear the baby might be taken away - Fears they had or would harm or kill the baby
	D. “There’s something not right”	<ul style="list-style-type: none"> - Feelings that something was not right, by themselves and others - Inability to be specific about what was not right contributed to confusion - Implicit sense of illness but absence of explicit understanding - Professional misinterpretation as well
	E. Losing touch with reality	<ul style="list-style-type: none"> - Distortions to reality - Auditory and visual disturbances - Unusual and distressing beliefs - Suspicious or paranoid thinking - Spiritual background to those who do not identify as spiritual
Lack of recognition of the seriousness	A. Keeping up appearances	<ul style="list-style-type: none"> - Some women were able to present themselves as if nothing was wrong - Women tried to conceal and ignore their experiences

		<ul style="list-style-type: none"> - Distinct link between fear of baby being taken away and creating the impression everything was alright - Leads to delay in the detection of PPP
	B. Misinterpretation of the problem	<ul style="list-style-type: none"> - Many symptoms of PPP are attributed to something else - Exhaustion often attributed to being a new mother, “baby blues”, or a physical complication - Misinterpretation of the problem was also made by professionals - PPP symptoms overlooked by woman herself, family, friends, and health professionals
Breastfeeding	A. Difficulties related to feeding	<ul style="list-style-type: none"> - Women may struggle with breastfeeding for many reasons such as circumstantial barriers <ul style="list-style-type: none"> - Baby being in the hospital - Physical difficulties - Difficulties with breastfeeding had a significant impact on women - Desire to breastfeed instead of using formula
	B. Anxieties related to breastfeeding	<ul style="list-style-type: none"> - Perception of bullying by healthcare professionals - Feelings of failure amongst those who are unable to breastfeed - Fear and beliefs that baby was not having needs met - Dominant message: “breast is best” - Distress associated with being a bad mother due to difficulties breastfeeding - Anxiety about being unable to breastfeed
Trauma	A. Birth trauma	<ul style="list-style-type: none"> - Loss of control at birth often from a medical intervention such as <ul style="list-style-type: none"> - Induction - Emergency cesarean sections - Preeclampsia - Infections - Birth trauma helps explain how people make sense of the onset of PP in the context of the trauma that preceded it
	B. Compromises to the baby’s wellbeing	<ul style="list-style-type: none"> - Babies required time in the Special Care Baby Unit - Babies stopped breathing - The fear associated with these experiences - Worry about it happening again - Perception of being responsible for what happened

	<p>C. Childhood trauma (mother)/distress and traumatic events</p>	<ul style="list-style-type: none">- Many women experienced previous traumatic events:<ul style="list-style-type: none">- Child abuse- Problems within childhood family setting- Difficult relationships with mother- Miscarriages- The impact of these traumas on their experience with the onset of PPP is critical
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