



# Training Key® #698

## First Responder Considerations in Cases of Suspected Neonaticide

Cases of suspected neonaticide (homicide of a newborn) have unique challenges compared to other child homicide investigations. Beginning with law enforcement's initial response, a specialized and informed approach is critical.<sup>1</sup>

### Introduction

*Case Example 1:* Paramedics responded to a 9-1-1 call concerning a teenage girl who had collapsed and was hemorrhaging. The history reported by the girl and her family was that she was having a heavy menstrual period. She was transported to a hospital, where she underwent an examination that indicated she had recently given birth. Law enforcement was notified and searched the residence where they located the baby wrapped in a towel underneath a jacket in the bedroom closet. After being questioned at the hospital by an officer, the girl reported that she delivered the baby into the toilet and deliberately left him there for several minutes to ensure that he was dead. Afterward, she placed the baby in a trash bag, took a bath to clean up, and then placed him in her bedroom closet and fell asleep. When she got up, she had suffered a great deal of blood loss and collapsed on the floor. Her mother and brother were in the residence, but asleep during the incident. The medical examiner concluded that the infant died as a result of drowning.

*Case Example 2:* Police responded when the remains of a newborn were found in a cardboard box inside a shed. An adult male found the child and subsequently told his wife, who then called the police. He advised police that he had been suspicious of his 19-year-old daughter due to a sudden change in her appearance, but that over the last few months she had repeatedly denied being pregnant. His daughter was immediately interviewed by the officers, who were informed that the baby had been stillborn. Further investigation revealed that after experiencing labor pains at

work, the offender returned home and delivered the baby while her siblings were home. Afraid of being overheard, she bit on a towel to avoid making noise. She used scissors from under the bed to cut the umbilical cord. After ensuring that her sisters had left for dinner, she placed a bag containing the infant inside a cardboard box and left it in the shed. Shortly thereafter, her boyfriend arrived and they watched TV until her sisters returned around 11 p.m. The autopsy report revealed that the infant had been stabbed nine times.

Neonaticide is commonly defined as the killing of a newborn within 24 hours of birth.<sup>2</sup> Accurate occurrence rates of neonaticide are very difficult to obtain, due to the crime's covert nature and the fact that there is no national data collection of these cases.<sup>3</sup> Typically, only those cases that involve medical complications, unsophisticated crime scenes, or obvious body disposal efforts come to the attention of law enforcement and/or medical professionals.<sup>4</sup> However, what is known is that the first day of life reflects the greatest risk for homicide, with rates at least 10 times greater than at any other time of life.<sup>5</sup>

The typical neonaticide offender is often thought to be a young woman in her late teens who is unmarried. However, neonaticide offenders are of every race, age, educational level, and marital and socioeconomic status. Women in their thirties and forties also commit neonaticide, as well as women who are married.<sup>6</sup> Most, if not all, cases of neonaticide begin with the discovery of an unplanned pregnancy. Fear is the most common initial reaction and is a distinct factor in the motivation of neonaticide. Other motivations in-

clude personal gain, convenience, removal of burden, hindrance to education or career goals, unknown paternity, or shame of sexual activity. Older and/or married offenders are less concerned about illegitimacy and premarital sex, but more often are worried about the “irresponsibility” the pregnancy represents (e.g., “You already have a child you can barely take care of”).<sup>7</sup>

Typically, law enforcement is notified of a potential neonaticide by one of two ways:

1. a newborn’s body is discovered, or
2. a female requests medical care with symptoms of heavy vaginal bleeding or abdominal pain/discomfort.

Upon notification, first responders should be prepared to investigate these incidents as possible homicides. Red flags for the potential of a neonaticide are (1) a female reportedly giving birth unattended in a non-medical setting and has presented without an infant, or (2) the discovery of a newborn’s body, which has been hidden previously or disposed in a trash-like manner. Officers who first report on scene have a unique opportunity to secure potentially important evidence and observe and document initial statements and behaviors. Initial statements may be the purest, although perhaps not truthful, account of an incident. Thus, they may contain facts or details that are not provided in later interviews or interrogations.

## The Path to Neonaticide

Various behaviors have been identified as being nearly universal among all neonaticide offenders: (1) fear, (2) concealment, (3) isolation, (4) denial, (5) dissociation, (6) panic, (7) homicide, and (8) post-offense behavior.<sup>8</sup>

**Fear, Concealment, and Isolation.** The first step begins as many as 8 months prior, when the offender discovers she is pregnant. As a result, many offenders attempt to conceal their physical changes and reduce the possibility of questions regarding their appearance. For example, some offenders change their dressing habits and wear baggy clothing or attire unfit for the season (e.g., oversized sweatshirts in warm weather). Others change their eating habits in an attempt to stop further weight gain. Additionally, offenders have stated that they placed unwrapped but unused sanitary products in their bathroom trashcans to prevent any questions about their menstrual period.

**Denial.** Most offenders engage in what is referred to as magical thinking throughout the pregnancy, which allows them to avoid thoughts of the pending birth or what might happen afterward.<sup>9</sup> The level of denial can vary, and ebbs and flows from full awareness to compartmentalization. For example, one offender is quoted as saying, “My stomach was pretty out there. I don’t know why it was that I felt like nobody else could see my stomach.”<sup>10</sup> Another offender described her refusal to think about the pending birth “as if I was just going to stay pregnant forever.”<sup>11</sup> Some schools of thought suggest that neonaticide of-

fenders’ denial is so strong that many do not know that they are pregnant.<sup>12</sup> However, an FBI BAU sample of over 50 neonaticide cases found that all of the offenders were aware of their pregnancies in spite of their propensity to deny it.<sup>13</sup> Evidence of awareness was observed in a variety of ways, including confirming the pregnancy to another person and/or documentation such as emails, diary entries, letters, and past medical records. Furthermore, nearly half of the offenders in the BAU study had previously been pregnant, which suggests familiarity with the signs and symptoms of pregnancy.

**Dissociation and Panic.** At the onset of labor, neonaticide offenders rarely seek medical care or assistance from others. Instead, many go into a residential bathroom or bedroom and deliver the child alone, often quietly and in secret. During labor and delivery, many offenders describe dissociative-like experiences characterized by the inability to remember details, limited amnesia (i.e., flashes of memory), blacking out, and/or viewing themselves outside of their bodies.<sup>14,15,16</sup> The BAU study found that a formal diagnosis of dissociative disorder in neonaticide offenders is rare, occurring in less than 10% of the cases.<sup>17</sup>

Upon delivery of the child, offenders experience intense panic. Having made no plans for the birth or care of the child, and with the possibility of discovery, most neonaticide offenders intentionally give birth silently by exerting enough self-control not to make a sound despite experiencing intense pain.<sup>18</sup> A silent delivery is often necessary given that in a majority of cases, the offender is giving birth while others are nearby. At first, potential witnesses may provide very little information regarding the primary crime scene. For example, those living with an offender almost never report hearing screams or cries during the delivery. Instead, witnesses often state that around the time of delivery, the offender only reported menstrual or stomach problems, spent an unusual amount of time in her room or bathroom, and resumed her normal activities soon after delivery and disposal. However, witnesses can provide behavioral evidence indicating intentional concealment and an offender’s unwillingness to ask for assistance and help. This information, when combined with the importance the offender placed on maintaining secrecy, can be compelling evidence at prosecution.

**Homicide.** Upon delivery, offenders most often cut the umbilical cord with a tool (e.g., scissors, razor blade, or nail file) and the baby is typically placed in some type of container (e.g., plastic bag or towel). Most neonaticide victims die from asphyxial-related causes (e.g., suffocation, smothering, drowning), abandonment, or a combination of both.<sup>19</sup> The most common instruments used to asphyxiate the child include the mother’s hands, containers, bags, towels, or toilet water.<sup>20,21</sup> The deaths are more likely to result from inaction by the mother as opposed to violent action, which is more often seen in the killing of older infants and children.<sup>22</sup>

**Post-Offense Behavior.** Body disposal efforts can be quite varied and can range from immediate disposal of the infant's body (usually in a trash-like manner) to long-term storage of the body in personal surroundings. Given the small size of an infant and the frequency of deliveries into bathroom toilets, many newborns are placed in a bag and put in a trash container.<sup>23</sup> Law enforcement should keep in mind that a period of postpartum recovery is rarely displayed by these offenders. Many resume their normal routine and reengage in activities that they had temporarily stopped due to the pregnancy. For example, it is not uncommon to hear that just prior to or while in labor, an offender participated in physically demanding activities (e.g., playing basketball, dancing). Post-offense, offenders often return immediately to school and/or work. They are often aware that any unexplained absences will be viewed suspiciously and thus the possibility of discovery increases.

### **Initial statements**

During the initial response, first responders are typically tasked with assessing the circumstances of the incident and deciding what other resources may be needed. During this assessment, officers typically ask general questions of those involved to include witnesses, victims, and potential offenders. Law enforcement should be aware of the unique and counter-intuitive offense characteristics of neonaticide. An officer's own personal experience or perception about pregnancy and childbirth may be quite different from an offender's. For instance, the offender's continual denial of pregnancy and physical and emotional resiliency can be difficult to understand and hard to believe. Additionally, law enforcement's initial contact may be impacted by the woman's fear and shame associated with the unwanted pregnancy, her altered perception during delivery, and the description she gives of the newborn upon birth.<sup>24</sup> An understanding of these characteristics will better prepare a first responder for soliciting information, asking the correct questions, and interpreting a woman's initial statements. First responders should also consider limiting the number of initial interviews of the offender. At the beginning of the investigation, officers should approach the offender with a caretaking demeanor and avoid an accusatory tone.

For example, law enforcement should be prepared that the offender may present like a victim, since she may still be physically and emotionally recovering from the birth. Thus, officers should allow an offender to fully process and discuss her feelings, concerns, and fears that occurred during the pregnancy and birth. This may help establish an initial rapport between law enforcement and the offender and build bridges to more difficult questioning.

Law enforcement should be prepared for the possibility that the offender might be unresponsive, unemotional, or overly emotional during her initial statements. During her statements she may describe the

newborn as an object, using words like "it" or "thing," or refer to the labor as a heavy period, miscarriage, or stillbirth. Officers should document these statements in their reports exactly how they were said and not attempt to paraphrase by adding words like "newborn" or "child." These initial descriptions provide insights into the offender's level of attachment to the child, or lack thereof, as well as her behavior during the pregnancy.

Officers should give consideration to the demeanor and tone that is most effective with these types of offenders. A calm and nonjudgmental officer, both in word and physical demeanor, will have much more success at building rapport and reducing an offender's anxiety. Officers should avoid questions that begin with "How could you..."; "You had to know that if..."; and "What kind of person are you...". If she reveals details of the birth, homicide, or body disposal, officers should avoid expressing disgust or disbelief.

Open-ended questioning in a non-accusatory and sympathetic tone often elicits more information as well. This technique typically requires an offender to expand beyond a simple yes-no answer. For example, instead of asking, "Did you know you were pregnant?" ask "When did you first think you might be pregnant?" Instead of "Did you do anything once the baby was born?" as a substitute ask, "What did you do once the baby was born?" In addition, officers should concentrate on asking non-leading questions, as specific or direct questions can give the offender information to develop potential defenses, such as the umbilical cord being wrapped around the neck. For example, officers should avoid asking questions like, "Was the cord wrapped around the neck?" but instead ask "How was the baby connected to you after the birth?" Keep in mind that inaction by the mother can be just as compelling as what did occur.

These techniques may be difficult because it can appear the officer is more concerned about the offender than the victim. However, this non-accusatory, non-parental posture accomplishes several goals: it begins the process of establishing rapport between the offender and law enforcement and may increase the likelihood the offender will cooperate with subsequent interviews, searches, and other requests by law enforcement.

During her initial statements, the offender may discuss recent medical visits or her sexual history. Officers should attempt to obtain information about the offender's personal physicians as well as any health centers, clinics, and hospitals she has visited in the last year. It is not uncommon for offenders to receive some type of medical care during the pregnancy, during which the pregnancy may have been confirmed. On the other hand, some offenders who seek medical care during the pregnancy did so for some other health issue or ailment (e.g., back pain, yearly physical, urinary tract infection) and did not reveal the pregnancy to the doctor.

Offenders may be more willing to discuss the details of the homicide and body disposal than their sex-

ual history. This may be counterintuitive to law enforcement since disclosures of premarital sex would seem to be much less serious than allegations of homicide. However, it appears the shame of premarital sex or multiple partners is still prevalent in the offender's mind. Her statements or lack of cooperation may be critical in establishing motivation.

An offender's interactions with medical personnel while on scene and at the hospital may be the first time she discloses any possibility of being pregnant. Concern about her physical condition may result in her being more open regarding various symptoms she had during the pregnancy, what she experienced during labor and delivery, and any other health issues or health care she received over the last few months. Although officers may naturally distance themselves during these personal interactions between the offender and medical professionals, being present, monitoring, and documenting these statements may be particularly helpful to an investigator during the interrogation phase when confronting her denial. However, if the medical professional asks the officer step out of the room, he or she should do so and not try to overhear the private conversation. It is important to remember that even though the officer is accompanying the offender, the offender's rights under HIPAA must still be protected, especially when the medical professional asks for privacy to protect those rights. In addition, inquiries should be made regarding resuscitation efforts of the newborn by either the offender or responding emergency personnel as mouth-to-mouth resuscitation, chest compression, or administration of oxygen will actively inflate the lungs, whether the child was dead or alive.<sup>25</sup>

Another consideration for officers is to determine the whereabouts of the offender shortly before the delivery to ascertain if any surveillance cameras captured her image. This can include, but is not limited to, recordings from schools and retail/department stores. These images provide a clear visual display of her pregnant state, and can be helpful when presented to the offender and other supporting witnesses.

In preparation for the execution of a search warrant and to ensure evidence is not concealed or destroyed, officers should obtain information and secure computers, cellular telephones, tablets, and any other portable electronic devices belonging to the offender or those to which she had access. In addition, inquiries should be made regarding the offender's emails addresses, social media sites, passwords, and any other online identities. Some offenders conduct Internet searches related to pregnancy or post direct or indirect references to physical status and symptoms. In addition, notes, writings, diaries, and letters written by the offender should be secured, as they can reveal her anxiety and conflict over the pregnancy and her concern for the future. This evidence can prove critical in getting past an offender's denial, as well as in establishing an awareness of and desire to conceal her pregnancy. Any forensic examinations should cover

the entire pregnancy period not limited to the time-frame around the birth.

Officers should observe and document the initial statements made by the offender's family members and close friends, making note of their demeanor and the relationship dynamics. These witnesses can provide details of the offender's behavior over the last several months and around the time of the birth and homicide. For example, those who are in the same living space as the offender almost never report hearing screams or cries from the offender. Instead, family members often state that around the time of delivery the offender only reported menstrual or stomach problems, spent an unusual amount of time in her room or bathroom, and resumed her normal activities soon after delivery and disposal. Denial of pregnancy often extends beyond the offender to family members and close friends.<sup>26,27</sup> Even if some question the offender about pregnancy, she will deny the signs that are often easily visible to others.

## Crime Scene Considerations

**Crime Scene Investigation.** A thorough crime scene investigation is very important in cases of neonaticide because the usual causes of death, asphyxia and exposure, leave little or no physical signs on an infant's body. Law enforcement should photograph and document the body in the state in which it was found, as well as the body recovery process. This documentation may become valuable later when establishing or refuting medical evidence or certain behaviors by the offender such as cleaning or wiping the newborn after birth. In some cases, various items may be found with or near the victim such as bags, clothing, paper towels, or receipts. These items should be collected and documented as they could be greatly beneficial in cases where the mother has not yet been identified. Law enforcement consultation with a pathologist while still on scene is helpful in determining causes of death as some, such as drowning and certain forms of asphyxia, are dependent on scene findings.<sup>28</sup>

**Multiple Scenes.** Neonaticide cases may involve multiple crime scenes because the pregnancy, labor, delivery, homicide, body disposal, and placental disposal may all be separate evidence recovery areas. These areas should be treated with the same forensic scrutiny as the homicide scene. Each scene should be photographed, documented, and searched thoroughly; once the scene is released, it can never be regained. All areas within the offender's residence, regardless if it is also the delivery location, should be searched to include conducting trash pulls. External property, such as a garage, crawl space, backyard, outdoor trashcan, or vehicle, should also be searched for potential evidence. Most neonaticide offenders, if not interrupted, will attempt to clean up the labor and delivery scene; thus, forensic resources such as alternative light sources and appropriate chemical reagents for biological material, should be considered.

**Delivery Location.** The delivery location and surrounding area should be well documented. Bathrooms are the most common delivery location, with birth directly into the toilet in most cases.<sup>29</sup> Specific information about the toilet should be documented to include make, model, measurements, water level, and water flow. Diligent efforts should be made to locate and recover the placenta and severed umbilical cord and provide them to the pathologist for examination. If the placenta was not immediately recovered, the offender should be asked about its location. Evidence of underlying placental diseases or infections may suggest stillbirth or natural causes of death, and evidence of cord injuries or tears will suggest live birth or traumatic death.<sup>30</sup> The placenta may be a crucial piece of evidence in certain cases and cause of death and overall health of the baby while in the womb may be ascertained through its examination rather than through examination of the body. Any artifacts discovered with the body and placenta such as bags, blankets, and other containers, should also be collected and provided to the pathologist or crime lab for examination.

## Conclusion

Neonaticide cases can present unique challenges compared to other child homicide investigations. These cases highlight the disturbing reality of the crimes that women are capable of committing, and offender behavior is often counter-intuitive compared to socially acceptable experiences in childbirth and parenting. However, well-informed officers who first report on scene can observe and document potentially valuable statements and crime scene evidence. By increasing the understanding of common motivations and behaviors among neonaticide offenders, law enforcement is better positioned to conduct more comprehensive investigations, which ultimately result in successful prosecutions of these cases.

## Acknowledgment

This *Training Key*® was developed by Crime Analyst Joy Lynn E. Shelton of the FBI's Behavioral Analysis Unit III- Crimes Against Children and Detective Luke VanHoose of the Kentucky State Police. For additional information on the topic, contact Joy Shelton at joy.shelton@ic.fbi.gov or luke.vanhoose@ky.gov. If you would like to consult with BAU III on your case, please contact Joy Lynn E. Shelton at the email above or via your local FBI field office.

## Endnotes

<sup>1</sup> The considerations discussed within this article are the result of BAU III's behavioral research and operational experience in these cases. For over a decade, BAU III has been studying cases of mothers who have killed their children. In addition, BAU III frequently provides investigative and prosecutorial suggestions to law enforcement agencies involved in this unique and challenging type of child homicide.

<sup>2</sup> Phillip J. Resnick, "Murder of the Newborn: A Psychiatric Review of Neonaticide," *American Journal of Psychiatry* 126, no. 10 (1990): 1414–1420.

<sup>3</sup> Cynthia Dailard, "The Drive to Enact 'Infant Abandonment Laws'—A Rush to Judgment?" *The Guttmacher Report on Public Policy* 3, no. 4 (2000): 1–3, 11.

<sup>4</sup> Marcia E. Herman-Giddens, Jamie B. Smith, Manjoo Mittal, Mandie Carlson, John D. Butts, "Newborns Killed or Left to Die by a Parent: A Population-based Study," *Journal of the American Medical Association* 289 (2003): 1425–1429.

<sup>5</sup> Mary D. Overpeck, Ruth A. Brenner, Ann C. Trumble, Lara B. Trifilliti, and Heinz W. Berendes, "Risk Factors for Infant Homicide in the United States," *New England Journal of Medicine* 339 (1998): 1211–1216.

<sup>6</sup> Joy Lynn E. Shelton, Tracey Corey, William H. Donaldson, and Emily Hemberger-Dennison, "Neonaticide: A Comprehensive Review of Investigative and Pathologic Aspects of 55 Cases," *Journal of Family Violence* 26 (2011): 263–276.

<sup>7</sup> Joy Lynn E. Shelton, Yvonne Muirhead, and Kathleen E. Canning, "Ambivalence toward Mothers Who Kill: An Examination of 45 U.S. Cases of Maternal Neonaticide," *Behavioral Sciences and the Law* 28, no. 6 (2010): 812–831.

<sup>8</sup> See Lara Riley, "Neonaticide: A Grounded Theory Study," *Journal of Human Behavior in the Social Environment* 12 (2005): 1–42; and Joy Lynn E. Shelton, Tia A. Hoffer, and Yvonne Muirhead, *Behavioral Analysis of Maternal Filicide*, Springer Briefs in Behavioral Criminology (New York, NY: Springer, 2014).

<sup>9</sup> Velma Dobson and Bruce D. Sales, "The Science of Infanticide and Mental Illness," *Psychology, Public Policy, and Law* 6, no. 4 (2000): 1098.

<sup>10</sup> Riley, "Neonaticide: A Grounded Theory Study."

<sup>11</sup> Holly Auer and Charity Vogel, "Trapped by Pregnancy, Young Woman Turns Desperate: Unwanted Baby Placed in Dumpster," *The Buffalo News*, October 27, 2003, 1A.

<sup>12</sup> Cheryl L. Meyer, Michelle Oberman, and Kelly White, *Mothers Who Kill Their Children: Understanding the Acts of Moms from Susan Smith to the "Prom Mom"* (New York: New York University Press, 2001).

<sup>13</sup> Shelton et al., "Neonaticide: A Comprehensive Review of Investigative and Pathologic Aspects of 55 Cases."

<sup>14</sup> Elliot L. Atkins, Joseph P. Grimes, Gregory W. Joseph, and Julie Liebman, "Denial of Pregnancy and Neonaticide during Adolescence: Forensic and Clinical Issues," *American Journal of Forensic Psychology*, 17, (1999): 5–33.

<sup>15</sup> Shelton et al., "Neonaticide: A Comprehensive Review of Investigative and Pathologic Aspects of 55 Cases."

<sup>16</sup> Riley, "Neonaticide: A Grounded Theory Study."

<sup>17</sup> Shelton et al., "Neonaticide: A Comprehensive Review of Investigative and Pathologic Aspects of 55 Cases."

<sup>18</sup> Schwartz, L., & Isser, N. (2000). *Endangered Children: Neonaticide, Infanticide and Filicide*. Boca Raton: CRC.

<sup>19</sup> Tracey S. Corey and Kim A. Collins, "Pediatric Forensic Pathology," in J. Thomas Stocker and Louis P. Dehner eds., *Pediatric Pathology*, 2nd ed. (Philadelphia: Lippincott Williams and Wilkins, 2001), 247–286.

<sup>20</sup> Julio Arboleda-Florez, "Neonaticide," *Canadian Psychiatric Association Journal* 21 (1976): 31–34.

<sup>21</sup> Harry Bloch, "Abandonment, Infanticide and Filicide: An Overview of Inhumanity to Children," *American Journal of Diseases of Children* 142 (1988): 1058–1060.

<sup>22</sup> Maureen Marks, "Disorders and Their Context: Infanticide," *Psychiatry* 8 (2008): 10–12.

<sup>23</sup> Shelton et al., "Neonaticide: A Comprehensive Review of Investigative and Pathologic Aspects of 55 Cases."

<sup>24</sup> Characteristics of altered perception include lapses in memory, missing pieces of time, blacking-out, anxiety, panic, fear, and pain, feelings of being out of control, numbing, detachment, and depersonalization.

<sup>25</sup> Pekka Saukko and Bernard Knight, *Knight's Forensic Pathology*, 3rd ed. (New York: Oxford University Press, 2004).

<sup>26</sup> Steven E. Pitt and Erin M. Bale, "Neonaticide, Infanticide, and Filicide: A Review of the Literature," *Journal of the American Academy of Psychiatry and the Law Online* 23, no. 3 (1995): 375–386.

<sup>27</sup> Doris C. Vallone and Lori M. Hoffman, "Preventing the Tragedy of Neonaticide," *Holistic Nursing Practice* 17, no. 5 (2003): 223–230.

<sup>28</sup> Shelton et al., "Neonaticide: A Comprehensive Review of Investigative and Pathologic Aspects of 55 Cases."

<sup>29</sup> Ibid.

<sup>30</sup> Hiroshi Shiono, Atoyo Maya, Noriko Tabata, Masataka Fujiwara, Jun-ichi Azumi, and Masahiko Motta, "Medicolegal Aspects of Infanticide in Hokkaido District, Japan," *American Journal of Forensic Medicine and Pathology* 7, no.2 (1986): 104–106.

## questions

The following questions are based on material in this *Training Key*®. Select the one best answer for each question.

1. Red flags for the potential of a neonaticide include

- (a) *unattended deliveries*
- (b) *births in a non-medical setting*
- (c) *discovery of a newborn's body that has been hidden or disposed of in a trash-like manner*
- (d) *all of the above*

2. Neonaticide offenders can be

- (a) *young teenagers.*
- (b) *married women.*
- (c) *women in their thirties or forties.*
- (d) *all of the above.*

3. Neonaticide offenders are often very vocal about their pregnancy, sharing the information with their family and friends.

- (a) *True*
- (b) *False*

## answers

1. (d) All of the above.

2. (d) All of the above.

3. (b) False. Most neonaticide offenders attempt to hide their pregnancy, often by concealing their physical changes in an attempt to reduce the possibility of questions regarding their appearance. In addition, many may exhibit “magical thinking” that allows them to deny they are even pregnant.

