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Postpartum Psychosis: A Way Out for Murderous Moms

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NOTE

POSTPARTUM PSYCHOSIS: A WAY OUT FOR MURDEROUS MOMS?

I. INTRODUCTION

To most observers, it seems like a moment of love, a normal pairing of mother and child, as the mother carefully bathes her newborn, or strolls the baby down the street in the direction of the nearby river. However, to most lay people and physicians alike, the signs of postpartum psychosis go unnoticed and the fine line between normalcy and the unthinkable has already been crossed. The apparently normal mother, in a bizarre and horrific moment, snaps, and kills her newborn child. Unfortunately, these frightening deeds are not all that rare.¹

Today, more postpartum emotional disorders exist than most people, including physicians, realize. Recent studies indicate that between fifty to eighty percent of new mothers experience some type of emotional stress or dysfunction following childbirth.² However, yes-

1. See infra notes 140-203 and accompanying text (discussing the recent cases which have utilized a postpartum psychosis defense).
2. See B. CIARAMITARO, HELP FOR DEPRESSED MOTHERS 118 (2d ed. 1982) (stating that from 50-80% of all women experience the "blues" after they give birth); Dalton, Prospective Study into Puerperal Depression, 118 Brit. J. Psychiatry 689 (1971) (discussing a study of mood changes through pregnancy and the puerperium); Davids, DeVault & Talmadge, Psychological Study of Emotional Factors in Pregnancy: A Preliminary Report, 23 Psychosomatic Med. 93 (1961) [hereinafter Davids, Preliminary Report] (studying the psychological adjustment of women during pregnancy and after delivery); Kumar & Robson, A Prospective Study of Emotional Disorders in Childbearing Women, 144 Brit. J. Psychiatry 35 (1984) (addressing questions about the measurement and prediction of postnatal emotional disorders); Lee, Postpartum Emotional Disorders, 1984 Med. Trial Tech. 286 (1984) (suggesting that up to 50% of all postpartum women have some type of emotional dysfunction); Mayberger & Abramson, The Psychodynamics of Transitory Postpartum Depressive Reactions, 17 J. Asthma Res. 59, 59 (1980) (stating that an important number of women undergoing childbirth experience a period of emotional stress during the first two weeks following delivery); Neugebauer, Rate of Depression in the Puerperium, 143 Brit. J. Psychiatry 421 (1983)
tery year's "baby blues" are gradually attaining legal significance in our society. Postpartum psychosis, a severe emotional imbalance affecting a small percentage of women, is being presented as a criminal defense. Although the number of women affected with this psychosis is relatively limited, the legal and social consequences of postpartum psychosis are significant. Within the last decade, the legal profession has begun to examine the possibilities of using post-

(reanalyzing an earlier study and arriving at an even higher rate for the frequency of puerperal depression); O'Hara, Neunaber & Zekoaki, Prospective Study of Postpartum Depression: Prevalence, Course, and Predictive Factors, 93 J. Abnormal Psychology 158, 158 (1984) [hereinafter O'Hara, Prospective Study] (stating that the period following delivery "has long been recognized as a period during which women are at higher than normal risk for depression"); Paykel, Emms, Fletcher & Rassaby, Life Events and Social Support in Puerperal Depression, 136 Brit. J. Psychiatry 339 (1980) [hereinafter Paykel, Puerperal Depression] (reporting a study of puerperal depression and indicating the importance of social stress in the incidence of puerperal depression); Pitt, "Atypical" Depression Following Childbirth, 114 Brit. J. Psychiatry 1325, 1325 (1968) [hereinafter Pitt, Atypical Depression] (stating that it is "common knowledge that women often get depressed after childbirth" and that the "blues" follow up to 80% of deliveries); Pitt, Maternity Blues, 122 Brit. J. Psychiatry 431, 431 (1973) (stating that the maternity blues occur after 15% to nearly 80% of deliveries); Reich & Winokur, Postpartum Psychoses in Patients With Manic Depressive Disease, 151 J. Nervous & Mental Disease 60, 60-62 (1970) (discussing various studies which have attempted to calculate the frequency of postpartum disorders); Stein, Milton, Bebbington, Wood & Coppen, Relationship Between Mood Disturbances and Free and Total Plasma Tryptophan in Postpartum Women, 2 Brit. Med. J. 457, 457 (1976) [hereinafter Stein, Mood Disturbances] (stating "[m]ild disturbances of mood occur in 50-70% of women in the postpartum period, when they may begin to cry for no apparent reason."); Touffexis, Why Mothers Kill Their Babies, Time, June 20, 1988, at 81 (stating that between 50% and 80% of mothers experience an "emotional letdown" after delivery); Watson, Elliott, Rugg & Brough, Psychiatric Disorder in Pregnancy and the First Postnatal Year, 144 Brit. J. Psychiatry 433 (1984) [hereinafter Watson, Psychiatric Disorder] (assessing the prevalence of psychiatric disorders throughout pregnancy and the first postnatal year); Yalom, Lunde, Moos & Hamburg, "Postpartum Blues" Syndrome: A Description and Related Variables, 18 Archives Gen. Psychiatry 16, 16 (1968) [hereinafter Yalom, Postpartum Blues] (stating that reported postpartum emotional disorder rates vary widely, with estimates from 5% to 80%).

3. The "baby blues" is a fleeting period of emotional letdown, in which the new mothers become sensitive, moody and tearful. See Condon & Watson, The Maternity Blues: Exploration of a Psychological Hypothesis, 76 Acta Psychiatrica Scandinavica 164 (1987); Harding, Postpartum Psychiatric Disorders: A Review, 30 Comprehensive Psychiatry 109 (1989); Pitt, Maternity Blues, supra note 2, at 431; Yalom, Postpartum Blues, supra note 2, at 16. For further discussion, see infra notes 31-36 and accompanying text.

4. Postpartum psychosis is rare, occurring in one or two of every one thousand deliveries. Murray & Gallahue, Postpartum Depression, 113 Genetic, Soc., & Gen. Psychology Monographs 193, 197 (1987); see also infra notes 48-53 and accompanying text (discussing the description and incidence of postpartum psychosis).

5. See, e.g., Mitchell v. Commonwealth, 781 S.W.2d 510 (Ky. 1989) (convicting defendant after she pleaded insanity due to postpartum psychosis); Commonwealth v. Comitz, 365 Pa. Super. 599, 530 A.2d 473 (1987) (finding defendant guilty but mentally ill for the murder of her infant son); see also infra notes 137-201 (discussing cases which have involved a postpartum psychosis defense).
partum psychosis as an affirmative defense. Recent cases which address the subject suggest that the defense has not been totally accepted, as indicated by the disparity in verdicts and sentencing measures. Therefore, it remains to be seen whether postpartum psychosis will become a credible consideration within the criminal justice system, or whether it will be classified with other novel and rarely used defenses like the premenstrual syndrome, XYY chromosome, and the "twinkle" defenses.

6. See infra notes 139-201 and accompanying text (discussing recent cases which have involved a postpartum psychosis insanity defense).


8. The XYY chromosome theory, which articulated the idea that males with an extra Y chromosome were more prone to antisocial and criminal behavior, was a popular idea in the late 1960's but was eventually proven unacceptable. See People v. Tanner, 13 Cal. App. 3d 596, 601, 91 Cal. Rptr. 656, 659 (Ct. App. 1970) (holding that medical testimony on the XYY abnormality is insufficient because the experts did not testify that the syndrome "results in mental disease"); State v. Roberts, 14 Wash. App. 727, 544 P.2d 754 (1976) (refusing defendant's request for continuance to allow additional psychiatric examination for symptoms of the XYY syndrome); see also W. Lafave & A. Scott, Criminal Law § 4.8, at 379-82 (2d student ed. 1986) (reviewing cases and literature on XYY syndrome as a criminal law defense); Note, The XYY Syndrome: A Challenge to Our System of Criminal Responsibility, 16 N.Y.L.F. 232, 246 (1970) (discussing the trial of John Farley, who unsuccessfully attempted to defend himself in New York on charges of committing a brutal murder and rape based upon an XYY genetic defense); Note, The XYY Chromosome Defense, 57 Geo. L.J. 892 (1969) (exploring the existing and potential legal issues inherent in the XYY anomaly).

9. In 1979, Dan White, a former San Francisco supervisor was accused of murdering Mayor George Moscone and Supervisor Harvey Milk. White was able to avoid a first degree murder conviction by pleading diminished responsibility. He claimed that he was unable to tell right from wrong due to a "mood disturbance" said to be caused in part by a junk food diet and extreme stress prior to the killings. "Although the jury may have accepted this 'twinkle defense' to avoid imposing a mandatory death penalty, the defense suggested an increasing trend towards the acceptance of biological and psychiatric legal defenses." Comment, Human Biology & Criminal Responsibility: Free Will or Free Ride?, 137 U. Pa. L. Rev. 615, 616-67 (1988) (authored by Deborah W. Denno); see Turner, Ex-Official Guilty of Manslaughter In
If postpartum psychosis is found to be a factor which influences criminal behavior in women, the legal profession must clarify its understanding of postpartum psychosis and decide whether to recognize it as a substantive defense or treat it, as any other mental disease, under the insanity defense. Consequently, this Note first discusses the history and status of postpartum disorders within the medical community and examines the diagnostic categories of postpartum depression, as well as postpartum psychosis and its possible causes. The Note then examines the defensive pleading aspects of postpartum psychosis, analyzing the recent cases where postpartum psychosis has been used as a defense and judicial reactions to its use, and noting several factors which may impede recognition of the defense within the American legal system. This Note concludes that postpartum psychosis should not be made a separate statutory affirmative defense to murder, as has been done in England, but that the insanity statutes already in place should be relied upon. When the facts fail to meet the jurisdictional test for insanity, evidence of postpartum psychosis should be a factor in mitigating sentences to stress treatment more than punishment.

II. DISCUSSION OF POSTPARTUM DISORDERS

A. Evolution of Postpartum Psychosis in Medical and Legal Communities

Postpartum mental illness has been recognized since the time of Hippocrates, who observed one woman who became “restless and later delirious following the birth of twins and who died on the seventeenth day.” While ancient Greek psychiatric journals reported

Slayings on Coast; 3000 Protest, N.Y. Times, May 21, 1979, at A1, col. 1; Both Sides Rest Their Cases in Moscone Murder Trial, N.Y. Times, May 15, 1979, at A14, col. 6; Ex-Supervisor Held Unable to Tell Right From Wrong, N.Y. Times, May 8, 1979, at A16, col. 6.

10. See infra notes 16-88 and accompanying text.
11. See infra notes 89-136 and accompanying text.
12. See infra notes 137-201 and accompanying text.
13. See infra notes 202-12 and accompanying text.
14. See infra notes 213-19 and accompanying text.
15. See infra note 18 and accompanying text (discussing the statutory recognition of infanticide in England).
POSTPARTUM PSYCHOSIS

on the subject, modern study of the psychosis really began in the late nineteenth and early twentieth centuries,\textsuperscript{17} which led to passage of English law.\textsuperscript{18} In the early twentieth century psychiatrists adopted a uniform classification system for psychiatric disorders, which placed disorders in categories defined by their symptoms.\textsuperscript{10} There has been considerable debate as to whether postpartum psychosis should be considered a specific syndrome or mental illness with its own clinical features, or whether postpartum psychosis should be listed under the general classification of psychiatric disorders.\textsuperscript{20} Hence, in 1987 when the American Psychiatric Association published the third edition of...
the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), postpartum psychosis was referred to as follows: "Postpartum Psychosis. See Schizophrenic disorder, Brief reactive psychosis, Major affective disorders, Organic brain syndrome," and thus, was no longer classified as a single and distinct comprehensive illness as it was in the nineteenth century.21

This expulsion of postpartum psychosis from the official nomenclature of psychiatric disorders, at first, seems rather harmless. Cases of mental illness after childbirth are simply placed into other categories. However, in retrospect, the fragmentation of postpartum psychosis has led to more serious problems both in and out of the medical profession. The declassification of this illness has led to the loss of discoveries of possible treatments and control of the disease, and has frustrated attempts at adequate and early diagnosis of the disorder.22

21. AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS 491 (3d ed. 1980); Hamilton, supra note 19, at 2-3; see also Brockington, supra note 20, at 829 (stating that “[m]any psychiatrists believe that the puerperium is not associated with any particular type of mental illness but that almost any psychiatric state may be precipitated by childbirth.”); Welner, Childbirth-Related Psychiatric Illness, 23 COMPREHENSIVE PSYCHIATRY 143, 143 (1982) (stating that since the early twentieth century, the “generally held view has been that childbirth-related psychiatric disorders are essentially no different from their nonchildbirth-related counterparts.”).

22. See Daw, Postpartum Depression, 81 S. MED. J. 207, 209 (1988) (stating that “[m]anagement of the postpartum mood disorders involves recognizing the syndrome, ruling out an organic cause, and instituting appropriate treatment”); Munoz, Postpartum Psychosis as a Discrete Entity, 46 J. CLINICAL PSYCHIATRY 182, 184 (1985) (stating that a typical psychosis is being classified as atypical); see also Lee, supra note 2, at 293 (stating that postpartum disorders must be immediately recognized and correctly treated by a physician for the safety of both the mother and the baby).

Two almost identical cases illustrate the lack of medical knowledge of postpartum psychosis in twentieth century America, especially when compared to nineteenth century England. In England, in 1847, Martha Prior gave birth and a few days later was diagnosed with postpartum psychosis. Hamilton, supra note 19, at 11. The baby was ordered to be kept away from Prior, and twenty-four hour surveillance was advised. Id. However, due to an unforeseen break in surveillance, Prior was able to kill her infant with a razor. Id. Prior was brought to trial and her case was described as postpartum insanity. The jury found her not guilty by reason of insanity. Id.

In 1976, over a century later, in the United States, Helen Winter crushed and beat her baby to death. Id. However, her case was handled in a radically different manner than the nineteenth century case. Winter's symptoms, crystal clear to nineteenth century medicine, were disregarded in modern society. Nobody recognized that she suffered from postpartum psychosis, even after her repeated attempts to get help. Id. at 12. She was found guilty of second degree murder, and sentenced to prison for two years, plus five years probation. Id. at 11-12.

One possible answer for this remarkable difference in outcomes for these very similar cases could be modern medicine's lack of knowledge of this illness, due in part to the fact that
The destruction of a separate identity for postpartum psychosis also has had an effect in the legal community. Defendants attempting to rely on an insanity defense based on postpartum psychosis must overcome the obstacle presented by the fact that the disease is not included in the psychiatric community's "bible"—the DSM-III. The American Psychiatric Association tends to set guidelines for the legal profession, and therefore, until postpartum psychosis is fully accepted by the psychiatric community, the legal community is not likely to recognize the diagnosis.

B. Diagnostic Categories

Research has revealed that there is a high frequency of mild to moderate symptoms of depression not only in the postpartum period, but also during pregnancy. The birth of a child is a joyful event,
yet it can also be highly stressful.26 The birth of a child leads to
dramatic changes in a woman’s life. She is faced with new responsi-
bilities, new skills to learn and new social and familial roles, along
with the significant physiological changes in her body as it readjusts
after the delivery. The woman making the transition to parenthood,
although usually undertaken willingly, is placed in a highly stressful
position.27

Many of the features of postpartum disorders are similar to
those of non-pregnancy related emotional illness, except for the rapid
changeability and unpredictability of symptoms and a tendency to-
ward relapse.28 There are a wide variety of symptoms and conse-
subsequently clinicians recognize three distinct levels of postpartum illness: maternity blues, postpartum depression and postpartum psychosis.29

Maternity blues (also referred to as the baby blues)30 has been described as a “trivial, fleeting phenomenon, so common as to be regarded as normal.”31 Maternity blues begins with brief episodes of weeping32 on the third to tenth day after the birth and may last “for
a few hours to a few days." Symptoms usually include mild depression, anxiety, an inability to think clearly, along with many other possible symptoms such as irritability, fatigue, insomnia, headaches, confusion, forgetfulness and elation. Many women who experience the maternity blues do not consider themselves ill during this time. Treatment of maternity blues consists mostly of empathic listening by doctors and family members and observing for signs of a more severe emotional disorder.

Postpartum depression, the second category of postpartum disorders, is more severe than maternity blues, and is less fleeting. Postpartum depression affects ten to fifteen percent of all mothers. The depression may start at childbirth as a continuation of maternity blues, or it may begin within a few weeks of delivery and may last from a few weeks to a year or more.

33. Lee, supra note 2, at 290. See Stein, Maternity Blues, supra note 30, at 119; K. Dalton, Depression After Childbirth 73 (1980); Harding, supra note 3, at 109;

34. See Stein, Maternity Blues, supra note 30, at 119 (stating the incidence of the maternity blues and a description of the various symptoms); Kane, Harman, Keeler & Ewing, Emotional and Cognitive Disturbance in the Early Puerperium, 114 Brit. J. Psychiatry 99, 100-01 (1968) (studying patients during pregnancy and the early puerperium, and the symptoms they displayed); Lee, supra note 2, at 290 (discussing the diagnostic categories and treatment of postpartum disorders); Murray & Gallahue, supra note 4, at 197 (discussing the incidence and symptoms of maternity blues); Pitt, Maternity Blues, supra note 2, at 431-33 (researching the incidence, symptoms and possible causes of the maternity blues); Yalom, Postpartum Blues, supra note 2, at 16 (1968) (describing the maternity blues syndrome).

35. Stein, Maternity Blues, supra note 30, at 120.


Because of the transient nature of the "blues," therapy is usually not necessary. However, supportive therapy may have preventative value because some women may develop depression later in life. See Cox, Connor & Kendall, Prospective Study of the Psychiatric Disorders of Childbirth, 140 Brit. J. Psychiatry 111, 111 (1982) (stating that "[w]omen with severe postnatal blues are particularly at risk of developing persistent depressive symptoms subsequently."); Davenport & Adland, supra note 26, at 296 (finding that women with prior histories of psychiatric illness have an increased risk for recurrence of a child-birth related psychiatric episode during the perinatal period, therefore "additional monitoring and ongoing psychotherapeutic support, preferably conjointly with spouse, are strongly recommended during this period."); Kendall, supra note 17, at 7 (stating that "women in whom the 'postnatal blues' phenomenon is prominent have a relatively high incidence of clinically significant depression subsequently."); Kumar & Robson, supra note 2, at 35 (finding in their study that many of the mothers "who had become depressed for the first time in their lives continued to experience psychological problems for up to four years after childbirth.").

37. Kendall, supra note 17, at 3; Lee, supra note 2, at 290; Robinson & Stewart, supra note 22, at 33.

38. See Kendall, supra note 17, at 3; O'Hara, Prospective Study, supra note 2, at 168; Pitt, Maternity Blues, supra note 2, at 431-433; Saks, Frank, Lowe, Berman, Naftolin, Phil and Cohen, Depressed Mood During Pregnancy and the Puerperium: Clinical Recognition and Implications for Clinical Practice, 142 AM. J. Psychiatry 728, 730 (1985).

39. K. Dalton, supra note 33, at 73-74. This depression usually begins within a few weeks of delivery and may last from a few weeks to a year or more. Kendall, supra note 17, at
nity blues, in which case involuntary tears turn into a general sadness and other symptoms of depression. This category of postpartum illness is characterized by irritability, anxiety, fatigue, lack of love for the child, and a sense of guilt and inadequacy related to the inability to function as a mother. Even when the mother is still able to function, the illness can affect the bonding between mother and child. Many potential etiological factors have been implicated in the development of postpartum depression including delivering an at risk infant, marital tension, and lack of social support. In addition, a variety of sociodemographic and personal history variables, such as parity and menstrual problems prior to pregnancy, have been associated with postpartum depression. Treatment of postpartum depression can include the use of both psychotherapy

3; Reich & Winokur, supra note 2, at 61.
40. Some scientific studies have raised the question of whether postpartum depression is qualitatively different from any other depressive illness at other stages in a woman's life. Murray & Gallahue, supra note 4, at 197 (finding that postpartum depressions are typical depressive illnesses); Kendall, supra note 17, at 3 (finding that although puerperal depressions have been described as atypical, "they are in most respects typical depressive illnesses."); Nott, Extent, Timing & Persistence of Emotional Disorders Following Childbirth, 151 Brit. J. Psychiatry 523 (1987) (concluding that the cause of postpartum depression is not hormonal or due to other physical changes. Instead, the onset of the condition could be attributed to the psychosocial aspects of the puerperium, the mother's own background and personality. This raises the question whether postpartum depression is substantially different from depression which women may experience at other times in their lives).
41. See K. Dalton, supra note 33, at 20-30; Brandon, supra note 36, at 613; Lee, supra note 2, at 290-91; Kumar, Neurotic Disorders, in Motherhood & Mental Illness 107, 111 (I.F. Brockington & R. Kumar eds. 1982); Nott, supra note 40, at 525; Robinson & Stewart, supra note 22, at 33.
42. Lee, supra note 2, at 290 (stating that psychiatric counseling is recommended because postpartum depression can interfere with the bonding process between mother and child).
43. Blumberg, supra note 27, at 149 (studying the relevance of the infant's condition to the mother's psychological and emotional state and concluding that the birth of an at-risk infant precipitates "psychological crisis").
44. O'Hara, Social Support, Life Events and Depression During Pregnancy and the Puerperium, 43 Archives Gen. Psychiatry 569-73 (1986) (hereinafter O'Hara, Social Support) (concluding that women experiencing postpartum depression reported marital dissatisfaction, low levels of support from spouses, relatives and friends during the postpartum period); Watson, Psychiatric Disorder, supra note 2, at 453 (finding a relationship between marital dissatisfaction and depression).
45. Paykel, Puerperal Depression, supra note 2, at 345 (concluding that the "most important causative factors appeared to be life stress and absence of social support.").
and antidepressant medications. 

C. Postpartum Psychosis

1. Description of the Disorder.—The third and most severe category of postpartum disorders, postpartum or puerperal psychosis, is rare, occurring only in one to two deliveries out of every thousand. The onset of this psychosis is immediate, usually occurring within two to three weeks of the birth. Symptoms include confusion, delirium, hallucinations, insomnia, emotional lability, fatigue and irritability. In addition to these symptoms (some of which are also seen in the other two categories), more serious symptoms which are unique to postpartum psychosis may occur. For example:

The [mother] may exhibit an atypical or brief reactive psychosis . . . . She often has difficulty coping with the care of the infant and may appear confused, bewildered, perplexed and dreamy, complaining of poor memory although performing normally in formal memory tests. Classically she shows signs of psychotic depression with manic or schizophrenic features and some cognitive impairment that suggests an organic disorder of the brain . . . . Excessive concern with the baby’s health, guilt about lack of love, and delusions about the infant’s being dead or defective are common. She may deny having given birth or report hallucinations that command her to harm the baby.

Since postpartum psychosis is not classified as a separate “diagnostic entity,” the majority of these psychotic episodes are diagnosed

47. See Harding, supra note 3, at 110 (suggesting the use of psychotherapy for minor depressions and antidepressants for greater depressions); Robinson & Stewart, supra note 22, at 33 (suggesting tri cyclic antidepressants as a helpful treatment, but recommending caution regarding the use of monoamine oxidase inhibitors and sedatives).

48. Davenport & Adland, supra note 26, at 289; Harding, supra note 3, at 110; Kendell, supra note 17, at 3; Kumar & Robson, supra note 2, at 35; Murray & Gallahue, supra note 4, at 197; Robinson & Stewart, supra note 22, at 32; see Herzog & Detre, supra note 16, at 229 (stating that estimates of postpartum psychoses range from one in 400 deliveries to one in 1,200).

49. Kendell, supra note 17, at 3; Lee, supra note 2, at 288; Murray & Gallahue, supra note 4, at 197; Robinson & Stewart, supra note 22, at 34.

While most psychiatric illnesses develop slowly over a period of weeks to even years, postpartum illness is characterized by sudden onset, developing in a period of time as short as hours or days. Hamilton, supra note 19, at 7.

50. Hamilton, supra note 19, at 4; Robinson & Stewart, supra note 22, at 34. Postpartum psychosis has been described as a mental illness with a “frenzied mind,” in which the patient has lost contact with reality. K. DALTON, supra note 33, at 38.

51. Robinson & Stewart, supra note 22, at 34.

52. See supra notes 16-24 and accompanying text (discussing the declassification of
under one of the major psychiatric disorders, as schizophrenic or affective psychoses.  

2. Treatment of Postpartum Psychosis.—Treatment for postpartum psychosis includes a variety of tranquilizers, antidepressants and hormones. Self-help groups may also play an important therapeutic role in the treatment of postpartum psychosis by providing support networks. Hospitalization is essential for all but a very few women. It is needed for the patient so that she may recover as speedily as possible, and to protect the life of her baby. During the hospital stay, supervised visits with the baby are encouraged for these mothers.

Affective disorders are cyclical, and some patients will experience subsequent psychotic episodes, especially those with a history of psychiatric illness prior to the pregnancy. Although initial recovery rates are high, a relapse may occur with a subsequent pregnancy.
The recurrence rate of postpartum psychosis varies from thirteen percent to twenty-five percent, therefore one in seven to one in four subsequent pregnancies may result in another postpartum psychotic episode.\(^1\)

3. **Etiology of Postpartum Psychosis.**—Despite the centuries of interest and the recent increase in research, especially in Great Britain,\(^2\) the etiology of postpartum disorders is not clear.\(^6\) In the early 1900's, all postpartum mental illnesses that required hospitalization were called "non-toxic deliria" and attributed to "exhaustive psychoses."\(^8\) Although physiological, psychological and social factors may contribute to the development of postpartum psychosis,\(^6\) the exact cause is still unknown.\(^6\) There has, however, been some agreement regarding the factors that do not contribute to the manifestation of the psychosis.\(^6\) The level of emotional disturbance following childbirth was found not to be associated with socioeconomic level, age, or parity.\(^6\) Prepregnancy stressors such as unplanned pregnancy, marital discord, poor identity with the mother, prenatal anxiety, and emotional problems may become aggravated during the

to one study, 95% of women treated for postpartum psychosis improve within two to three months. Robinson & Stewart, *supra* note 22, at 35; see also Murray & Gallahue, *supra* note 4, at 204 (stating that recurring affective disorders tend to be more serious and may occur in connection with or apart from subsequent pregnancy).

63. Murray & Gallahue, *supra* note 4, at 204.
puerperium, but do not by themselves account for the etiology of postpartum mental disorders.69

One view that emerged was that physiological factors caused postpartum psychosis.70 Because of the many endocrinal changes in women following pregnancy and childbirth, changes in body chemistry were said to cause postpartum psychosis.71 Some studies have measured progesterone, estradiol, and estrogen levels,72 but hormonal changes by themselves have not been found to be the cause of postpartum psychosis73 and no useful conclusions, either prognostic, prophylactic, or therapeutic have issued from this research.74

Another view as to the cause of postpartum psychosis to emerge was the stress theory.75 Childbirth is a very stressful process, and delivery of a child is “attended by many stressful somatic exper-

69. Murray & Gallahue, supra note 4, at 199.
72. Murray & Gallahue, supra note 4, at 203; see also Alder & Cox, Breast Feeding and Post-Natal Depression, 27 J. PSYCHOSOMATIC RES. 139, 144 (1983) (finding that breast-feeding mothers who had more normal endogenous hormone levels than other breast-feeding mothers were less likely to have depressive symptoms, therefore postpartum depression might be induced by hormonal changes). But see Lee, supra note 2, at 291 (stating that although progesterone levels fall after birth, there is no consistent pattern linking these levels to mental disorders).
73. Murray & Gallahue, supra note 4, at 203; see Daw, supra note 24, at 208 (stating that “[p]ast studies have looked at the effects of hormone changes, postpartum anemia, and genetics on postpartum depression. Yet there is no conclusive evidence to date that postpartum mood changes are due to any specific biologic factor.”); Hopkins, Postpartum Depression, supra note 68, at 505-06 (finding that a direct relation between pregnancy hormonal problems and postpartum depression is lacking); Karnosh & Hope, Puerperal Psychoses and Their Sequelae, 94 AM. J. PSYCHIATRY 537, 544 (1937) (concluding that the evidence did not support the proposal that endocrine disturbances were the cause of postpartum disorders); Murray & Gallahue, supra note 4, at 204-05 (stating that “[h]ormonal levels of estrogen and progesterone do not closely match the shifts in affective states nor the appearance or disappearance of depressive states.”); Nott, Franklin, Armitage & Gelder, Hormonal Changes and Mood in the Puerperium, 128 BRIT. J. PSYCHIATRY 379, 383 (1976) (noting the difficulties in trying to relate hormonal changes to mood changes and suggesting that further research should concentrate on the relations between hormonal changes and specific symptoms).
74. Murray & Gallahue, supra note 4, at 203; Swyer, Postpartum Mental Disturbances and Hormone Changes, 290 BRIT. MED. J. 1232, 1233 (1985).
75. Murray & Gallahue, supra note 4, at 201; see Atkinson & Rickel, Postpartum Depression in Primiparous Parents, 93 J. ABNORMAL PSYCHOLOGY 115, 115 (1984); Blumberg, supra note 27, at 139; Clarke & Williams, Depression in Women After Perinatal Death, 1 LANCET 916, 916 (1979); Cutrona, supra note 27, at 161; Dunner, Patrick & Fieve, Life Events at the Onset of Bipolar Affective Illness, 136 AM. J. PSYCHIATRY 508, 509 (1979); Herzog & Detre, supra note 16, at 229; Hopkins, Postpartum Depression, supra note 68, at 508-09; Watson, Psychiatric Disorder, supra note 2, at 453.
However, studies which have tried to correlate the occurrence of postpartum psychosis with the increased stress associated with deliveries have not been conclusive. It is recognized that "[s]tress comes in many forms and may be a factor in postpartum depression. Buffers to stress in the form of ego strength, family support and effective marital relationships have been studied for their contribution to postpartum depression but these psychosocial variables are not univocal in meaning or easily measured." Yet another study in the early twentieth century set forth the prevailing view as to the etiology of postpartum psychosis. This view denied that there was any specific mental illness or set of mental symptoms associated with childbirth. In 1926, it was suggested that the term "postpartum psychosis" should be eliminated as a separate diagnosis because of this view that no distinct syndrome existed which showed a connection between a psychiatric disorder and childbirth. As a result of this prevailing view, both the American Psychiatric Association and the American Medical Associations eliminated postpartum psychosis from their official lists of mental disorders.

Examinations of epidemiologic variables have not consistently identified indicators of postpartum disorder, making it difficult to target specifically women who are more likely to develop postpartum psychosis. At one time, postpartum depression was thought to develop only in primiparous women, but now parity is not thought of

76. Murray & Gallahue, supra note 4, at 201; see Daw, supra note 22, at 208; Selare, Psychiatric Aspects of Pregnancy and Childbirth, 175 PRACTITIONER 146, 146 (1955); Swartz, Biologically Derived Depression and the Dexamethasone Suppression Test, 23 COMPREHENSIVE PSYCHIATRY 339, 339 (1982); see also Murray & Gallahue, supra note 4, at 206 (stating that "the perception of the available social support and how adequate they appear to the one under stress is an important dimension in calculating the impact of stressors."). It is important for researchers to consider stress caused by childbirth because psychiatric illness is frequently associated with it. Murray & Gallahue, supra note 4, at 201; see Hopkins, Postpartum Depression, supra note 68, at 508 (citing studies which suggest that stressful life events, such as childbirth, are "significant factor[s] in the development of depression."); see also Rabkin & Struening, Life Events, Stress and Illness, 194 SCI. 1013 (1976) (assessing the relation of life events, although not specifically mentioning childbirth, to psychological illness).
77. Murray & Gallahue, supra note 4, at 201-02.
78. Id. at 203.
80. Id.
81. Id.; see also supra notes 16-24 and accompanying text (discussing the evolution of postpartum psychosis in both the medical and legal communities).
82. Murray & Gallahue, supra note 4, at 198-99.
83. See Kendell, supra note 17, at 4 (stating that postpartum psychosis is more common in primiparae than multiparae). "Primiparous" is an adjective which describes a woman who is
as an exclusive factor. Similarly, the socioeconomic level and age of the mother are no longer considered important exclusive factors. Women from all social classes and cultures are susceptible to these illnesses. However, some studies have held that women with a history of manic-depressive disorders prior to pregnancy have a higher risk of developing postpartum psychosis during the puerperium. Overall, epidemiology has failed to indicate a typical profile of the mother who is likely to develop postpartum psychosis.

In sum, the exact etiology of postpartum psychosis remains unclear, as the many studies disprove each other and indicate that the answer lies not in one particular view, but perhaps in a combination of factors. As one researcher explained:

One of the mysteries of postpartum depression is why so welcome and happy an event as childbirth, longed for by many women, the subject of daydreams and songs, should be associated with psychiatric risk, rising suddenly ten or twenty times in the first three months after delivery. Maternal emotional reactions preceding or following childbirth seem to flow from a complex interaction of personality, biological and situational factors, biochemical factors, and the relationships among mother, husband, and family.

III. DEFENSIVE PLEADING OF POSTPARTUM PSYCHOSIS

A. Insanity Approach

Commentators have continually suggested recognition of criminal defenses based on psychological dysfunction resulting from spe-
cific physical conditions. These commentators point out that an individual suffering from an illness with psychological complications may be no more responsible for his behavior during the illness than the defendant who is "insane" under the traditional tests. A crime consists of either an act or omission, and a requisite mental state. The underlying premise of our criminal law is that a person who commits a crime in the exercise of free will should be held accountable, and those who act involuntarily, suffering from a mental state. Legal responsibility or capacity." BLACK'S LAW DICTIONARY (discussing whether a subjective test or an objective test should be used to determine the validity of the defense of noninsane automatism or disassociation); Feldman, Episodic Cerebral Dysfunction, A Defense in Legal Limbo, 9 J. PSYCHIATRY & L. 193 (1981) (distinguishing between the defenses of insanity and psychomotor episodes); Note, Epilepsy and the Alternatives for a Criminal Defense, 27 CASE W. RES. L. REV. 771 (1977) (authored by C. Weinberg) (examining the pathological aspects of epilepsy and their potential as a defense to criminal action, problems of proof in establishing the existence of the disease and its effect on the defendant, and alternative criminal defenses applicable to epileptics).

90. Insanity is defined as "that degree of mental illness which negates the individual's legal responsibility or capacity." BLACK'S LAW DICTIONARY 794 (6th ed. 1990).

91. See Feldman, supra note 89, at 196; Note, supra note 89, at 787-803. For a discussion of the various insanity tests, see infra notes 95-120 and accompanying text.

92. An act, in terms of criminal liability, is defined as voluntary bodily movement. W. LAFAVE & A. SCOTT, supra note 8, § 3.2, at 197. It does not include "a reflex or convulsion; those during unconsciousness or sleep; those during hypnosis or resulting from hypnotic suggestion; and others which are not a product of the effort or determination of the actor, either conscious or habitual." Id. at 198 (quoting MODEL PENAL CODE § 201(2) (1985)). "Most of the modern recodifications do not contain such a list. Several, however, define a voluntary act as one performed consciously as a result of effort or determination." W. LAFAVE & A. SCOTT, supra note 8, § 3.2, at 198 n.26. The MODEL PENAL CODE § 1.13(2) defines "act" to mean "a bodily movement whether voluntary or involuntary." The RESTATEMENT (SECOND) OF TORTS §2 (1965) provides that: "The word 'act' is used throughout the Restatement of this Subject to denote an external manifestation of the actor's will and does not include any of its results, even the most direct, immediate and intended." Id. § 2, at 5; see also O.W. HOLMES, THE COMMON LAW 54 (1881) (noting that a bodily movement, to be an act, "must be willed"); Cook, Act, Intention and Motive, 26 YALE L.J. 645, 647 (1917) (defining an "act" as "a muscular movement (or movements) willed by the actor"); O'Connor, The Voluntary Act, 15 MED. SCI. & LAW 31 (1975) (assessing various definitions).

93. W. LAFAVE & A. SCOTT, supra note 8, § 3.2, at 195-96; see, e.g., United States v. Freed, 401 U.S. 601, 613 (1971) (Brennan J., concurring) (stating that the existence of a mens rea is the rule rather than the exception to the principles of Anglo-American criminal law). Before criminal liability can be imposed, the concurrence of the prohibited act and the specified accompanying mental state must be shown. Comment, Insanity-Guilty But Mentally Ill-Diminished Capacity: An Aggregate Approach to Madness, 12 J. MARSHALL J. PRAC. & PROC. 351, 351 (1979) (authored by Joseph D. Amarillo). The common law crimes all require an act or omission in addition to a bad state of mind. W. LAFAVE & A. SCOTT, supra note 8, § 3.2, at 195; see, e.g., In re Leroy T., 285 Md. 508, 403 A.2d 1226 (1979); Ex parte Smith, 135 Mo. 223, 36 S.W. 628 (1896); State v. Labato, 7 N.J. 137, 80 A.2d 617 (1951); Lambert v. State, 374 P.2d 783 (Okl. Crim. App. 1962); Proctor v. State, 15 Okla. Crim. 338, 176 P. 771 (1918).
disease which prevents them from acting rationally, are not held culpable. A defense raised by a criminal defendant will either be used to nullify or mitigate the specific mental state required for conviction of the particular crime.

The most widely used test for insanity in the American jurisdictions is the *M'Naghten* test. The test has been stated as follows:


95. Insanity, under any of the various tests in criminal law, is said to be that degree of mental disorder or disease which relieves one of the criminal responsibility for his actions. *Black's Law Dictionary* 794 (6th ed. 1990); see also McDonald v. United States, 312 F.2d 847, 851 (D.C. Cir. 1962) (stating that the term "mental disease or defect" indicates "any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls."). Legal insanity is a complete defense to the crime, for it implies that the accused is not responsible for his actions and results in exonerations or an excuse justifying acquittal. Jaffe, *The Diminished Capacity Defense*, 22 Trial, Sept. 1986, at 32, 35; Comment, *supra* note 93, at 376; see also Comment, *A Punishment Rationale for Diminished Capacity*, 18 UCLA L. Rev. 561, 566 (1971) (authored by Richard W. Havel) (stating that the insanity defense "draws a single line on the one side of which a defendant is held criminally responsible for his actions and on the other side of which he is completely exculpated."). The result of a successful insanity defense "is not acquittal and outright release of the accused but rather a special form of verdict or finding (not guilty by reason of insanity) which is usually followed by commitment of the defendant to a mental institution." W. LaFave & A. Scott, *supra* note 8, § 4.1, at 304.

On the other hand, a successful diminished capacity defense, discussed infra notes 131-36 and accompanying text, results in a verdict of not guilty of the crime charged, although conviction of a lesser crime is likely. W. LaFave & A. Scott, *supra* note 8, § 4.7, at 369. The ultimate result, then, is not an indeterminate commitment to a mental institution, but rather imprisonment following a conviction of a lesser offense with a lesser penalty than the crime originally charged. *Id.*

To establish a defence on the ground of insanity, it must be clearly proved that at the time of committing the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know what he was doing was wrong.97

This prevailing standard, sometimes referred to as the "right-wrong test," asks, in substance, whether the defendant knew98 what he was doing when he committed the crime.99 The law recognizes that certain people have limited reasoning ability,100 hence legal insanity has been made a substantive defense to criminal conduct.101 In order for a defendant to successfully plead an insanity defense, all of the elements of the test must be satisfied. Therefore, the defendant must show that she suffers from a mental disease or defect, and that a causal nexus exists between the mental disease or defect and the criminal conduct.102

Attempts to broaden the M'Naghten test by incorporating impairments in the defendant's ability to control his behavior led a few of the states to adopt the "irresistible impulse" rule, which is presented in addition to the M'Naghten standard.103 Under this rule,

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98. The word "know" has been at the center of the controversy and criticism surrounding the M'Naghten standard. Most critics assume that "know" refers only to formal cognition or intellectual awareness. To this end, these critics argue that there are few people who are not intellectually aware of their actions. Critics also point out that in most M'Naghten jurisdic-
tions, "know" is not defined at all, leaving the jury to decide its meaning. A. Goldstein, The Insanity Defense 49-50 (1967); G. Morris, The Insanity Defense: A Blueprint for Legislative Reform 12-13 (1975); R. Simon & D. Aaronson, supra note 94, at 14.
101. W. Lafave & A. Scott, supra note 8, § 4.1, at 304-05; Jaffe, supra note 95, at 35; Comment, supra note 95, at 566; Note, supra note 93, at 351, 376.
102. See W. Lafave & A. Scott, supra note 8, § 4.1, at 304-05.

The irresistible impulse rule was first recognized in Pennsylvania in 1846. R. Perkins, supra note 94, at 871; see Commonwealth v. Mosler, 4 Pa. 264 (1846). However, an Alabama decision, Parsons v. State, 81 Ala. 577, 2 So. 854 (1887), was the first case to unequivocally
jurors are instructed to acquit by reason of insanity if they find that the defendant was suffering from a mental disease or defect which kept her from controlling her conduct. The jury must make this finding even if they conclude that she knew what her actions were and that they were wrong.

Durham v. United States sets forth a second test, established in 1954. The Durham rule holds that "an accused is not criminally responsible if his unlawful act was the product of mental disease or defect." Also known as the "product" rule for insanity, this test did not gain wide acceptance in either the federal or state


Today an irresistible impulse test supplements the M'Naghten test in only three states, Colorado, Colo. Rev. Stat. § 16-8-101 (1990), New Mexico, State v. White, 58 N.M. 324, 270 P.2d 727 (1954), and Virginia, Davis v. Commonwealth, 214 Va. 681, 204 S.E.2d 272 (1974). See also R. Simon & D. Aaronson, supra note 94, at 251-63 (listing the type of insanity tests used in each state). At one time many other states (though never a majority) supplemented the M'Naghten test with the irresistible impulse test, but most of these states have since adopted the Model Penal Code test. See infra notes 113-15 and accompanying text (discussing the ALI Model Penal Code insanity test). Even a legislative adoption of the M'Naghten rule may be viewed as foreclosing recognition of the irresistible impulse supplement. State v. Craney, 347 N.W.2d 668 (Iowa), cert. denied, 469 U.S. 884 (1984); W. LaFave & A. Scott, supra note 8, § 4.1, at 320.

104. A. Goldstein, supra note 98, at 67; W. LaFave & A. Scott, supra note 8, § 4.1, at 320. While M'Naghten only considers the defendant's cognition, the irresistible impulse test permits the examination of the defendant's volition or self-control. See G. Morris, supra note 98, at 13.

105. A. Goldstein, supra note 98, at 67; W. LaFave & A. Scott, supra note 8, § 4.1, at 320; G. Morris, supra note 98, at 13. Unlike the "volitional prong" of the ALI test, see infra notes 115-17 and accompanying text, this test requires the lack of behavioral control or the irresistible impulse be sudden and not of long duration. See A. Goldstein, supra note 98, at 67-75.


107. Id. at 874-75.

108. The D.C. Circuit was the only federal court to adopt the Durham test for criminal responsibility. See supra note 107 and accompanying text; cf. infra note 109 (discussing the rejection of the Durham rule by state courts). It eventually rejected Durham and adopted the ALI standard because it found the Durham test unworkable. See Brawner, 471 F.2d at 975, 981-82; infra notes 113-15 and accompanying text (discussing the American Law Institute Model Penal Code test). Some federal circuit courts explicitly rejected the Durham rule. R. Simon & D. Aaronson, supra note 94, at 73; see, e.g., United States v. Freeman, 357 F.2d 606 (2d Cir. 1966); Wion v. United States, 325 F.2d 420 (10th Cir.), cert. denied, 377 U.S. 946 (1963); Andersen v. United States, 237 F.2d 118 (9th Cir. 1956); Howard v. United States, 232 F.2d 274 (5th Cir. 1956). "Other jurisdictions implicitly rejected it, by adopting the subsequent ALI standard." R. Simon & D. Aaronson, supra note 94, at 73; see, e.g., Wade v. United States, 426 F.2d 64 (9th Cir. 1970); Blake v. United States, 407 F.2d 908 (5th Cir. 1969), modified by U.S. v. Lyons, 731 F.2d 243 (5th Cir. 1984); United States v.
The Durham rule differed from previous insanity tests in that while most other tests emphasized an “incapacitating or debilitating condition—cognitive . . . volitional . . . impairment resulting from mental illness, Durham was unconcerned with any incapacitating condition other than the mental illness itself.”

The question for the jury would be whether the defendant’s acts were the result of a mental disorder and not whether the defendant “displayed particular symptoms which medical science has long recognized as not necessarily . . . accompanying even the most serious mental disorder.”

Criticism of the defense has centered on the lack of definitions for its key terms “product” and “mental disease or defect.”

A number of jurisdictions have adopted the rule of the American Law Institute (ALI) Model Penal Code, which combines and

Chandler, 393 F.2d 920 (4th Cir. 1968); United States v. Smith, 404 F.2d 720 (6th Cir. 1968); United States v. Shapiro, 383 F.2d 680 (7th Cir. 1967); United States v. Currens, 290 F.2d 751 (3d Cir. 1961).

In the decade following its adoption in the District of Columbia, the Durham rule was reviewed and rejected by 30 state courts. R. Simon & D. Aaronson, supra note 94, at 19. New Hampshire is the only state to still apply the Durham test of criminal responsibility. See State v. Jones, 50 N.H. 369 (1871); R. Simon & D. Aaronson, supra note 94, at 17-18; see also Durham, 214 F.2d at 874-75 (noting the similarity between the rule being adopted and the New Hampshire rule).

Critics claim this test is very broad and could effectively exculpate many defendants who would previously have been held liable for their criminal acts. Id.; see also Blocker v. United States, 288 F.2d 853, 862 (D.C. Cir. 1961) (Burger, J., concurring). In his concurring opinion, Chief Justice Burger noted that “[a]part from all other objections the product aspect of Durham is a fallacy in this respect: assuming arguendo that a criminal act can be the ‘product’ of a ‘mental disease,’ that fact should not per se excuse the defendant; it should exculpate him only if the condition described as a ‘mental disease’ affected him so substantially that he could not appreciate the nature of the illegal act or could not control his conduct.”

Critics of the defense also claimed that the undefined “mental disease or defect” part of Durham left the jury without standards to guide it. Id. § 4.3, at 323.

Critics of the defense also claimed that the undefined “mental disease or defect” part of Durham left the jury without standards to guide it. Id. § 4.3, at 328.

refines the earlier insanity tests. This test excuses criminal conduct which results from a mental disease or defect if the defendant lacked substantial capacity to appreciate the criminality, or wrongfulness, of his conduct or to conform such conduct to the requirements of law.

The first federal codification of the insanity defense was the Insanity Defense Reform Act of 1984. This new law, applicable only to defendants in federal court, altered the definition of insanity which developed gradually since M'Naghten and represented the fifth major attempt (following M'Naghten, irresistible impulse, Dur-
ham and the ALI standards) to determine the nature of criminal responsibility and the extent of the defense of insanity. This standard provided the affirmative defense that "the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts." The Act also shifted the burden of proof from the prosecution to the defendant, to prove his insanity by "clear and convincing evidence."

The insanity defense has been very controversial, and some jurisdictions have abolished it altogether, while others, especially following the not-guilty-by-reason-of-insanity verdict in United States v. Hinckley, have tried to restrict its use. Several jurisdictions have adopted an alternative verdict of "guilty but mentally ill" (GBMI). In the other jurisdictions, the GBMI verdict simply provides the judge or jury with an additional verdict in cases where mental illness is an issue. The GBMI verdict provides an alternative to the choice of guilty or insane. It recognizes a third category whereby a defendant is held criminally responsible while still taking into account the defendant's mental state at the time of sentencing. The GBMI verdict is entered when a defendant is mentally ill

118. R. Simon & D. Aaronson, supra note 94, at 45-46.
120. 18 U.S.C. § 17 (1988); see also R. Simon & D. Aaronson, supra note 94, at 23. Most states require the defendant to prove insanity "by a preponderance of the evidence," which is a lower standard than the federal standard of "clear and convincing evidence." R. Simon & D. Aaronson, supra note 94, at 23.
121. Idaho Code § 18-207 (Supp. 1987) (repealing the insanity defense but permitting evidence of mental disease or defect to negate an offense element); Mont. Code Ann. § 46-14-102 (1989) (stating that evidence of mental illness is admissible to negate an element of the offense); Utah Code Ann. § 76-2-305 (1990) (stating that mental illness is not a defense unless it negates a mental state required as an element of the offense).
but his illness is not sufficient to provide either a mentally ill defense negating an element of the offense, or an insanity defense. Upon a verdict of GBMI, a court may impose the “same prison sentence that would have been imposed had the defendant been found guilty of the offense charged.” The only difference between a GBMI verdict and a not-guilty-by-reason-of-insanity verdict is that under the GBMI verdict form, the defendant must have a psychiatric examination before starting a prison term and, in the event treatment is needed, the defendant will be transferred to a mental health facility. Legal commentators have suggested that this third verdict form will reduce the number of insanity acquittals. Others have suggested that the GBMI verdict will erode the insanity defense by confusing the jury and forcing it to make compromise verdicts.

This alternative verdict form has been used in at least two cases involving postpartum psychosis as the basis of an insanity defense. In those cases where a mother who is charged with killing her child argues insanity due to postpartum psychosis, a GBMI verdict would be very helpful. The medical profession’s unwillingness to recognize the disease makes the evidence uncertain. Therefore, a defendant is unlikely to meet the insanity defenses of most states. In states which recognize the verdict, GBMI can be a convenient alternative to a verdict of guilty. The GBMI verdict seems to be a perfect compromise, balancing the two sides of the issue; imposing responsibility on the mother and punishing her for the crime, while at the same time recognizing the seriousness of the disease and providing her treat-

(Stating that if the jury finds that the defendant fails to meet the jurisdictional test for insanity, it need not abrogate the defendant of criminal responsibility); see also R. Simon & D. Aaronson, supra note 94, at 187-200 (discussing the history and effectiveness of the GBMI verdict).

125. 2 P. Robinson, Criminal Defenses 310 (1988).
126. Id. at 310-11; see also Ind. Code Ann. § 35-36-2-5(a) (West 1986); Mich. Comp. Laws Ann. § 768.36(3) (West 1982).
127. 2 P. Robinson, supra note 125, at 311; see, e.g., Ind. Code Ann. § 35-36-2-5(b)(1)-(2) (West 1986); Mich. Comp. Laws Ann. § 768.36(3) (West 1982). As with the normal “guilty” verdict, the GBMI verdict requires that the defendant be found guilty of the offense charged. 2 P. Robinson, supra note 125, at 311. The “distinguishing feature” of the GBMI verdict is that “it allows the potentially mentally ill defendant to ‘be given such treatment as is psychiatrically indicated for his mental illness.’” Id.
128. See I. Keilitz & J. Fulton, supra note 103, at 43.
ment for her illness.

B. Diminished Capacity Approach

If the defendant using postpartum psychosis as an affirmative defense cannot satisfy the mental disease or defect requirement of any legal insanity test, for whatever reasons, she may seek a diminished capacity defense. This is a partial insanity defense which allows a defendant to show that, as a result of a mental disease or defect, the defendant did not have the capacity to form the required mens rea of a specific intent crime, such as the capacity to premeditate required for first degree murder. This defense makes evidence of an abnormal mental condition admissible even though the evidence would be insufficient to satisfy any of the insanity tests. The defendant's burden with respect to a diminished capacity defense mandates that she prove she lacked the specific intent required for the particular crime, or that she was incapable of forming the requi-

131. See supra notes 96-120 and accompanying text (discussing the various insanity tests for determining criminal responsibility).

132. The diminished capacity defense, however, is not available in most jurisdictions. See United States v. Brawner, 471 F.2d 969, 983 (D.C. Cir. 1979), reversing Durham v. United States, 214 F.2d 862 (D.C. Cir. 1954). The diminished capacity concept was also abolished by the Insanity Defense Reform Act of 1984, see S. Rep. No. 224, 98th Cong., 2d Sess. 222-31, reprinted in 1984 U.S. CODE CONG. & ADMIN. NEWS 3404-13, which rejected McDonald v. United States, 312 F.2d 847, 851 (D.C. Cir. 1962) (noting that mental disease or defect includes any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior control). The language “mental disease or defect does not otherwise constitute a defense” was added to the Insanity Defense Reform Act to insure that the insanity defense is not improperly resurrected in the guise of showing some other affirmative defense such as that the defendant had a ‘diminished responsibility’ or some similarly asserted state of mind which would serve to excuse the offense and open the door, once again, to needlessly confusing psychiatric testimony. S. Rep. No. 225, 98th Cong., 2d Sess. 229, reprinted in 1984 U.S. CODE CONG. & ADMIN. NEWS 3404, 3411. Consequently, there is hardly anything left of the Durham - McDonald rationale which formed the basis of the diminished capacity defense.

133. See W. LAFAVE & A. SCOTT, supra note 8, § 4.7, at 368-70. The diminished capacity defense is applicable when a crime is a specific intent crime. Arenella, The Diminished Capacity & Diminished Responsibility Defenses: Two Children of a Doomed Marriage, 77 COLUM. L. REV. 827, 828 (1977); Lewin, Psychiatric Evidence in Criminal Cases for Purposes Other Than the Defense of Insanity, 26 SYRACUSE L. REV. 1051, 1054 (1975). Specific intent crimes require proof that the defendant had a specific objective or engaged in a certain mental activity which went beyond mere intent to engage in the proscribed conduct. W. LAFAVE & A. SCOTT, supra note 8, § 3.5, at 224.

In those jurisdictions that have abolished the common law distinction between specific and general intent, the defense is limited “to any crime requiring proof of a particular mental state.” Lewin, supra, at 1064. If the diminished capacity defense was not restricted to specific intent crimes, it could result in the outright acquittal of a defendant charged with a general intent crime due to the absence of a lesser included offense. Arenella, supra, at 832 n.25.
site state of mind required for the particular crime.\textsuperscript{134}

In contrast to a successful insanity defense, the diminished capacity defense does not completely exculpate the defendant; she is convicted, but receives a conviction for a lesser-included offense.\textsuperscript{135} On the other hand, a successful insanity plea results in the defendant's institutionalization which completely exonerates the defendant of criminal responsibility.\textsuperscript{136} The need to protect society, and infants in particular, from future violent and dangerous conduct of women suffering from postpartum psychosis, can be achieved without complete exoneration of the defendant if the defense of diminished capacity is successfully pleaded.

III. ACTUAL PLEADING OF THE POSTPARTUM PSYCHOSIS DEFENSE

The lack of information on the many cases\textsuperscript{137} using postpartum psychosis as a defense is due to the fact that many of the cases are being decided at the trial court level or even before they go to trial and are therefore mostly unreported.\textsuperscript{138}

A. Recent Cases Which Have Utilized This Defense

1. Karen Rae Mitchell.—In Mitchell v. Commonwealth,\textsuperscript{139} the Supreme Court of Kentucky affirmed Mitchell's conviction for murdering her nine-month-old daughter.\textsuperscript{140} She relied on an insanity defense and was found guilty but mentally ill.\textsuperscript{141} She was sentenced

\textsuperscript{134} W. LAFAVE & A. SCOTT, supra note 8, § 4.7, at 368-69.

\textsuperscript{135} Id. at 369. If the crime contained no lesser-included offense, the result might be total acquittal, or the court, in its discretion, still could impose a conditional release with the requirement that the defendant receive treatment and supervision for a set amount of time. Id. at 363-76.

Insanity, a complete defense to a crime, implies that the accused was not responsible for her actions. See Jaffe, supra note 95, at 35. On the other hand, a successful diminished capacity defense does not relieve defendant of her responsibility for her actions, rather she is charged with a lesser included offense. Id. at 36.

\textsuperscript{136} W. LAFAVE & A. SCOTT, supra note 8, § 4.1, at 304-05.

\textsuperscript{137} Commentators have stated that there have been about 12 cases in the past five years in which postpartum psychosis was raised as a defense. See Russell, Guilty or Innocent? Postpartum Psychosis A Troubling Defense, PA. L. J. REP., Feb. 27, 1989, at 12, col. 1. For a discussion of some of these cases, see infra notes 139-201 and accompanying text.

\textsuperscript{138} Because of the problems faced when raising a postpartum psychosis defense, see infra notes 202-19 and accompanying text, many defendants will plea bargain and plead guilty to a reduced charge of manslaughter to avoid a murder conviction. Trigoboff, supra note 17, at 1, col. 4.

\textsuperscript{139} 781 S.W.2d 510 (Ky. 1989).

\textsuperscript{140} Id. at 511-12

\textsuperscript{141} Id. at 511; see supra notes 121-29 and accompanying text (discussing the GBMI verdict).
to twenty years in prison.\textsuperscript{142} The facts of the case state that Mitchell gave birth to a baby girl on March 9, 1987.\textsuperscript{143} Despite her happiness over the birth of her daughter, Mitchell became increasingly depressed over the months following the delivery.\textsuperscript{144} Mitchell, who believed she was failing as a mother and was suffering from postpartum depression, told others of her problems and the thoughts which plagued her, thoughts of suicide and fear that she might harm her baby.\textsuperscript{145} She was treated by various physicians and stayed for a short period of time in a hospital, during which time she suffered from anorexia, insomnia and severe depression.\textsuperscript{146} In October, she tried to strangle her baby with a cord, after which the District Court ordered that she not be left alone with the child.\textsuperscript{147} In December 1987, she threw the baby in a lake, but when the infant cried, she pulled her out of the water, suffocated the baby and threw her back into the lake.\textsuperscript{148} She voluntarily informed the police that she may have killed her baby.\textsuperscript{149} At trial she relied on an insanity defense, but the jury found her guilty of murder but mentally ill pursuant to a Kentucky state statute, K.R.S. 504.120, and was sentenced to twenty years in prison.\textsuperscript{150}

2. Sharon Comitz.—In a similar case, Sharon Comitz, a Pennsylvania pharmaceutical clerk, was convicted of drowning her infant son.\textsuperscript{151} The Superior Court of Pennsylvania affirmed the lower court’s decision that Comitz was guilty but mentally ill.\textsuperscript{152} The victim, Garret Comitz, was born to defendant Sharon Comitz on December 3, 1984.\textsuperscript{153} On January 3, 1985, exactly one month later, defendant drove the infant to a stream and dropped him into the water. The next morning, the infant’s fully clothed body was found lying face down in the water. The autopsy revealed the cause of death to be either suffocation or exposure to the elements.\textsuperscript{154} Comitz first told police on the day before her son’s body was found, that he

\begin{itemize}
\item \textsuperscript{142} Mitchell, 781 S.W.2d at 511.
\item \textsuperscript{143} Id.
\item \textsuperscript{144} Id.
\item \textsuperscript{145} Id.
\item \textsuperscript{146} Id.
\item \textsuperscript{147} Id.
\item \textsuperscript{148} Id.
\item \textsuperscript{149} Id.
\item \textsuperscript{150} Id.
\item \textsuperscript{152} Id. at 601, 530 A.2d at 474.
\item \textsuperscript{153} Id.
\item \textsuperscript{154} Id.
\end{itemize}
had been kidnapped from her parked car at the shopping center. However, the evidence uncovered in the investigation implicated Comitz in her son’s death, and she was charged with first and third degree murder. Comitz initially pled not guilty, then later agreed to plead guilty but mentally ill to the third degree murder charge.

The main focus during the testimony and argument at sentencing was on Comitz’s mental condition at the time of the murder, as well as her prognosis for the future. She had a history of postpartum depression which had been documented in hospital records following the birth of her first child, Nicole. Witnesses testified that Comitz also became depressed while pregnant with Garret, and continued to be depressed after the birth, after which her physician ordered her to take antidepressant medication. The psychiatrist for the defense who testified at the sentencing hearing said he believed that Comitz suffered from an atypical association which approached the display of multiple personalities. However, the psychiatrist for the Commonwealth testified that he thought Comitz was mentally ill but was not actually psychotic at the time of the murder.

On appeal from the judgment of sentence, the first issue was:

Whether a mother’s psychiatric condition is necessarily a ‘substantial ground tending to excuse... (her) criminal conduct’... where she has killed her newborn baby during a psychotic postpartum depression of sufficient severity to support a plea of ‘guilty but mentally ill’ and, whether appellant’s prior counsel were therefore ineffective for failing to include this question in their motion to modify sentence.

Comitz argued that she was entitled to a probation sentence because there were substantial grounds to excuse her conduct, namely that

155. Id. Comitz had so convinced herself of her story, that she passed two lie detector tests and finally admitted the killing only under hypnosis. Id. at 602, 530 A.2d at 474; Toufexis, supra note 2, at 83.
157. Id.
158. Id. at 602-03, 530 A.2d at 474-75.
159. Id. at 602, 530 A.2d at 474. Nicole was hospitalized when she was only seventeen days old because she was having difficulty breathing. Id. Examinations of the infant showed she suffered from both periods of cyanosis and a heart murmur. Id. Comitz however became extremely depressed and claimed she had held the baby’s nose so it would die. Thereafter, Comitz was hospitalized for postpartum depression. Id.
160. Id. at 602-03, 530 A.2d at 474-75.
161. Id. at 603, 530 A.2d at 475.
162. Id. at 604, 530 A.2d at 475.
163. Id.
she was suffering from postpartum psychosis at the time of the murder. The Superior Court held that the trial court adequately discharged its sentencing duties. The Superior Court went on to hold that a plea of guilty but mentally ill does not excuse one's criminal conduct and will not require a finding in favor of probation in every case.

A second issue raised by the defendant on appeal was whether the trial court erred in finding no explanation to excuse or justify the appellant's conduct. The Superior court found no error, because the duty of the court is to consider each of the psychiatric opinions and to decide which is correct, and it found that although Comitz had suffered an atypical dissociative reaction, she was aware at that time that her conduct would harm her baby.

The Superior Court of Pennsylvania affirmed Comitz's conviction of guilty but mentally ill to the charge of third degree murder and affirmed the sentence of eight to twenty years of imprisonment.

3. Sheryl Lynn Massip—Sheryl Lynn Massip was also tried on charges that she killed her six-week-old son Michael on April 29, 1987, by running over him with her Volvo station wagon. The horrifying facts of her case were as follows: On the day of her birthday, Massip first threw Michael in the path of an oncoming car, which swerved to avoid him. She then hit him over the head with a tool, put him under the family station wagon and backed over his head, then threw his body in a garbage can. Massip, like Comitz, told the police the baby had been kidnapped, but

164. Id. at 606-07, 530 A.2d at 476.
165. Id. at 606 n.5, 530 A.2d at 476 n.5.
166. Id. at 608, 530 A.2d at 477.
167. Id.
168. Id. at 609-10, 530 A.2d at 478 (citing Commonwealth v. Whitfield, 475 Pa. 297, 380 A.2d 362 (1977)).
170. Id. at 613, 530 A.2d at 480.
171. Secondary sources are being used in the following discussion of the Massip, Green, Thompson, Gentile and Householder cases due to the fact that all of these cases are unreported.
confessed to her husband that she had killed him. Massip also claimed she heard voices telling her to kill the child because he was the devil and "to put the colicky infant out of [his] misery." Her defense was that she was insane, suffering from postpartum psychosis. The Orange County jury rejected Massip's insanity defense, but Superior Court Judge Robert R. Fitzgerald reduced the second degree murder conviction to voluntary manslaughter, acquitted her on grounds of temporary insanity, and sentenced her to one year of outpatient treatment. The case is presently being appealed.

4. Ann Green.—A week before the Massip trial, in the Supreme Court of New York, a jury reached a very different conclusion. They acquitted Ann Green, a former pediatric nurse, of killing her two newborn babies in 1980 and 1982, and the attempted suffocation of her third child in 1985. Green also blamed postpartum psychosis for her actions. Green testified "that she had seen hands she did not recognize holding pillows over the newborns' faces." The first two deaths were not considered suspicious, one being attributed to a narrowing of the aorta, and the other to sudden infant death syndrome. It was not until she tried to kill her third child

174. Moss, New Defensive Measure, supra note 172, at 22.
175. Prokop, supra note 172, at 2, col. 4; see Cox, supra note 173, at 3, col. 1; Moss, New Defensive Measure, supra note 172, at 22.
177. The jury convicted Massip of second degree murder, which is punishable by fifteen years to life in prison. Prokop, supra note 172, at 2, col. 2.
179. Prokop, supra note 172, at 2, col. 1. If sentenced for voluntary manslaughter, Massip could have faced up to eleven years in a state mental institution. Id.
180. Id. at col. 4.
181. Berg, supra note 176; at 5, col. 1; Cox, supra note 173, at 24, col. 1; Sullivan, Jury Citing Mother's Condition, Absolves Her in Two Babies' Death, N.Y. Times, Oct. 1, 1988, at 29, col. 2. She was charged with two counts of intentional murder, the first in 1980 for the death of her daughter Patricia, and the second in 1982 for the death of her son Jamie. Zeldis, Post-Partum Psychosis—A Rare Insanity Defense, N.Y.L.J., Sept. 19, 1988, at 1, col. 1. She was also charged with one count of attempted murder of her son Larry, Jr. in 1985. Id.
182. Berg, supra note 176, at 5, col. 1; Zeldis, supra note 181, at 1, col. 1.
184. Zeldis, supra note 181, at 2, col. 3.
that doctors became suspicious.\footnote{Mansnerus, supra note 183, at C1, col. 1.} After the attempt on Larry’s life, the infant was brought to the hospital, at which time doctors confronted Green with the near-asphyxiation of the baby. Shortly thereafter, she confessed to her husband.\footnote{Sullivan, supra note 181, at 30, col. 5.} After being found not guilty by reason of insanity, Green was ordered to undergo a psychiatric evaluation in a state mental hospital as an outpatient.\footnote{Id. at 29, col. 3. Green also underwent voluntary sterilization prior to her arrest in 1986. Zeldis, supra note 181, at 2, col. 3.}

5. \textit{Angela Thompson.}—In another California case, Angela Thompson pleaded guilty to drowning her nine-month-old son in 1983, and submitted the question of postpartum psychosis to the judge.\footnote{Berg, supra note 176, at 5, col. 1.} Thompson drowned her son in the bathtub “after hearing the voice of God tell her the child was the devil.”\footnote{Toufexis, supra note 2, at 81.} She said she thought if she killed the baby that her husband “would raise him to life again in three days and that the world would know that [her] husband was Jesus Christ.”\footnote{Id.} Thompson, diagnosed as suffering from the psychosis and hospitalized after the birth of her first child, experienced periods of hallucinations, panic, religious obsession, and then attempted suicide.\footnote{Id. at 29, col. 3.} Yet when she became pregnant with her second child, doctors told her to forget about her previous psychosis, that it would not happen again.\footnote{Id.}

After pleading guilty to killing her second child, Thompson spent several months in a mental hospital, gave birth to another son, and has since sought to publicize the problem of postpartum psychosis.\footnote{Berg, supra note 176, at 5, col. 1; Jordan, supra note 18, at 2, col. 1; Toufexis, supra note 2, at 83.}

6. \textit{Lucrezia Gentile.}—In April of 1988, Lucrezia Gentile, a Brooklyn housewife, first reported that her two-month-old son had been kidnapped, then she broke down and admitted she had drowned

\footnote{Another positive step being taken to foster knowledge and awareness of postpartum disorders is the creation of a task force under the direction of California Senator Robert Presley. Jordan, \textit{Assembly Approves Postpartum Psychosis Bill,} \textit{L.A. Daily J.}, July 21, 1989, at 3, col. 2. The task force will instruct peace officers on “recognizing and handling” women who may be suffering from postpartum disorders. \textit{Id.}}
him in his bath because she could not stand his incessant crying.\textsuperscript{194} Gentile, indicted for second degree murder, is awaiting trial in which postpartum psychosis is expected to be raised as the defense.\textsuperscript{195}

7. Kathleen Householder.—In another celebrated case, a West Virginia woman, Kathleen Householder, used the postpartum psychosis defense to plead guilty to a reduced charge of involuntary manslaughter in the killing of her two week old daughter.\textsuperscript{196} Householder, like Comitz, Massip and Gentile, first told police her baby had been kidnapped, and even went so far as to appear on television and plead for the child's return.\textsuperscript{197} Three weeks later, she confessed that she had accidentally hit the baby with a rock, during a moment of frustration, then put the baby in a plastic trash bag, and threw the baby into the Shenandoah River.\textsuperscript{198} An autopsy revealed the infant died of head trauma and suffocation.\textsuperscript{199} Householder then pleaded guilty to manslaughter by reason of insanity and spent twenty-two months in prison.\textsuperscript{200}

The litany of these chilling stories will continue,\textsuperscript{201} as more

\begin{itemize}
\item \textsuperscript{194} Moss, \textit{New Defensive Measure, supra} note 172, at 22; Toufexis, \textit{supra} note 2, at 81.
\item On April 20, 1988, Mrs. Gentile said that she had a “daydream” in which she thought of hurting her child. Buder, \textit{Judge Accepts Insanity Plea In ’88 Drowning of Infant, N.Y. Times}, Nov. 10, 1989, at B3, col. 5. In her account of the crime, Mrs. Gentile described that after listening to the baby crying, she filled up the tub and held her son under the water. \textit{Id.} at col. 6. After dressing him in a snowsuit and hat, she put him in a garbage bag, wrapped him up in a blanket and walked him in the stroller. \textit{Id.} She then put him in a garbage can in front of another house in the neighborhood. \textit{Id.}
\item \textsuperscript{195} Moss, \textit{New Defensive Measure, supra} note 172, at 22; Zeldis, \textit{supra} note 181, at 2, col. 3.
\item \textsuperscript{196} Trigoboff, \textit{supra} note 17, at 26, col. 2.
\item \textsuperscript{197} \textit{Id.}
\item \textsuperscript{198} \textit{Id.} at 26, cols. 1-2.
\item \textsuperscript{199} \textit{Id.} at 26, col. 1.
\item \textsuperscript{200} Russell, \textit{supra} note 137, at 10, col. 1; Trigoboff, \textit{supra} note 17, at 26, col. 1. This case has been questioned by both medical and legal experts. Some experts doubt Householder was mentally ill at the time of the crime. See, e.g., Trigoboff, \textit{supra} note 17, at 26 col. 1.
\item \textsuperscript{201} Tanya Dacri, another Pennsylvania mother, is infamous for the alleged drowning death and mutilation of her son Zacharry. See Russell, \textit{supra} note 137, at 12, col. 1. She also claims to have been suffering from postpartum psychosis. If she is acquitted, it will be the first time in Pennsylvania that a defendant won a homicide case by arguing temporary insanity due to postpartum psychosis. \textit{Id.} at 12, col. 2.
\item In 1987, Michelle Remington, a Vermont factory worker, fatally shot her infant son Joshua with a .22 caliber handgun and then unsuccessfully attempted suicide. All charges were dropped in the case when the judge declared she was not guilty by reason of insanity. \textit{Id.} at 10, col. 1; Toufexis, \textit{supra} note 2, at 81.
\item In Bucks County, Pennsylvania, Sharon Weisendale drowned her two month old daughter Melissa in the bathtub. She pleaded guilty but mentally ill to third degree murder, received a five year suspended sentence and was ordered to undergo psychiatric treatment at a state hos-
pending cases which plan to use the postpartum psychosis defense come up for trial, and previous cases continue to be appealed. Therefore, the evolving case law is an important factor to watch and consider in the development and assessment of the postpartum psychosis defense.

B. Reactions to the Defense

In the cases which have been reported in the last six to seven years in which the postpartum psychosis defense was raised, there has been a disparity in the outcomes. Commentators suggest that about one-half of the women were found not guilty by reason of insanity, one-fourth received light sentences, and one-fourth received long prison sentences. Reactions to a postpartum psychosis defense tend to be at one extreme or another. Some commentators believe people are becoming more receptive to the postpartum psychosis defense, due in part to the efforts to publicize the disease being made by families of the afflicted mothers, and by women's self-help groups and networks. However, others argue that juries may be skeptical because the psychosis is temporary and the mother may fabricate stories to cover up her actions. Some argue that the problem with
the defense is overcoming “the natural feelings of a jury that a mother who kills her child must be a terrible, rotten person.” An- other factor to consider in evaluating the jury’s reaction will be their natural sympathy for the child. If the jury is not “bowled over by evidence that the mother didn’t know what she was doing” then the “image of the helpless baby will overwhelm everything.”

Another obstacle faced by defendants who plead the postpartum psychosis defense is that the illness lacks the full acceptance of the medical and psychiatric communities. Postpartum psychosis is not accepted as a distinct and separate form of mental illness, and therefore is not listed in the psychiatric community’s bible of disorders, the DSM-III. This problem of the lack of medical acceptance will arise when defense attorneys try to establish proof of insanity, for which they must bring in a psychiatrist. Most psychiatrists are either not familiar with the illness, or are split down the middle on its diagnosis. Prosecutors are, therefore, likely “to impeach any psychiatrist offering a postpartum psychosis diagnosis on the grounds that the psychiatrist is going against the weight of the psychiatric community.”

murder because the “evidence of planning, weighing of options, and covering her own tracks trended to negate [her] claim that she was unable to appreciate her situation or the nature of her conduct.” Id. at 696-97, 365 S.E.2d at 630. However, the trial judge did consider a diagnosis of postpartum depression as a mitigating factor when determining the sentence. Id. at 693-94, 365 S.E.2d at 628. Some psychiatrists attribute such stories to the mother’s attempt to dissociate herself from the crime. Russell, supra note 137, at 10, col. 5.

Others say that such reports are consistent with the denial aspect of postpartum psychosis, when the mother separates her thoughts from her feelings and details are forgotten. Moss, New Defensive Measure, supra note 172, at 22; Trigoboff, supra note 17, at 26, col. 1. One researcher argues that these stories are not necessarily indicative of sanity because “[t]he reality is that crazy people also make plans, but they make crazy plans.” Toufexis, supra note 2, at 83; see Moss, New Defensive Measure, supra note 172, at 22.

207. Russell, supra note 137, at 10, col. 2. However, these feelings can be a “two-edged sword.” Id. at 10, col. 3. A jury may believe the mother is an evil person, but down deep some people want to believe that the mother could not be in her right mind and kill her own child. Id.

208. Berg, supra note 176, at 5, col. 1. When presented with a postpartum psychosis defense, jurors will be “overwhelmed with sympathy for the mother or overwhelmed with horror. There’s very little in between.” Trigoboff, supra note 17, at 26, col. 2; see Cox, supra note 173, at 3, col. 4. One commentator suggested that public sympathy is against insanity defenses, as a result of the successful defense to the shooting of President Reagan by John Hinckley. Trigoboff, supra note 17, at 26, col. 1.

209. See supra notes 16-24 and accompanying text.
210. See supra notes 20-24 and accompanying text.
211. See Russell, supra note 137, at 10, col. 2.
212. Trigoboff, supra note 17, at 1, col. 4.
V. CONCERNS ABOUT USING A POSTPARTUM PSYCHOSIS DEFENSE

American courts will undoubtedly see more and more of a postpartum psychosis defense, especially if publicity of the illness, though sensational in nature, continues. However, there are certain factors which may impede a total recognition of this defense. First, before a postpartum psychosis defense can be accepted by the legal system and treated in a consistent manner, the medical and psychiatric professions must accept and understand this illness. The differences in opinion as to the exact cause of the illness, the lack of knowledge generally about the illness, and the psychiatric profession's inability and unwillingness to properly classify the illness and list it as a bona fide disorder, all will impede a successful use of the defense in American jurisprudence.

Another problem which must be overcome is the fear that criminal defendants will abuse the postpartum psychosis defense. The fact that the epidemiology of the disorder is unclear could lead to abuse of the defense, since there is no typical profile of the woman likely to develop postpartum psychosis. As with any other novel defense, it will take time and a careful study of cases to overcome this fear. However, as with other insanity defenses, the level of proof required to establish a successful postpartum psychosis defense and the corroboration of expert testimony, should weed out most defendants trying to exploit the defense for their own purposes.

Yet another concern this defense raises, as with the PMS defense, is that recognition of an exclusively female defense will promote sexism. Feminists argue that these exclusively female defenses would minimize the advancements women have made over the last two decades. "Feminists fear a stereotyping of women as un-
controllable, unpredictable, and undependable."

VI. CONCLUSION

At issue is whether postpartum psychosis should be recognized as a separate statutory defense, or whether it should remain under the general insanity tests like other mental diseases. At present, it appears doubtful that postpartum psychosis will become a substantive defense. First, it must achieve acceptance in the medical community and second, there must be enough evidence to establish, with a high degree of certainty, that the defendant's conduct was proximately caused by the disorder. However, presently there is not enough conclusive evidence in the medical community to consider postpartum psychosis as an illness in need of special recognition. Therefore, the criminal justice system should rely on the insanity statutes that are already in place. The facts of each case and the applicable jurisdictional test for insanity must be taken into account.

Should the facts of a case fail to meet the applicable insanity test, the defense of diminished capacity, where accepted, may be an alternative. The diminished capacity defense will allow evidence of an abnormal mental condition, evidence which was insufficient to satisfy any of the insanity tests, and the defendant will be convicted of a lesser-included offense. Until the awareness and acceptance of postpartum psychosis increase it should be used as a mitigating factor in sentencing, including cases where an insanity defense fails. By recognizing postpartum psychosis in mitigation, instead of as a substantive defense, a court could retain more control over the defendant if she continued to pose a threat to society or to herself. The court could require psychiatric testing of the defendant at the time of sentencing, tailor her sentence to the degree of her affliction and

219. DiLiberto, supra note 7, at 355. Many feminists feel that these strictly female biological defenses would oppress, not help women. Id.; see also Edwards, Mad, Bad or Pre-Menstrual, 138 New L.J. 456, 458 (1988) (stating that the PMS defense would be used to further stigmatize women); Holtzman, supra note 7, at 715 (stating that PMS “must be viewed as much a sword to be used against women as a shield to protect them.”); Osborne, Perspectives on Premenstrual Syndrome: Women, Law & Medicine, 8 Can. J. Fam. L. 165, 180 (1989) (stating that the PMS defense would reinforce a “conception of women as inherently irresponsible and unstable.”).

220. See supra notes 16-88 and accompanying text.

221. For a discussion calling for a separate substantive defense for postpartum psychosis, see Note, Postpartum Psychosis as a Defense to Infant Murder, 5 Touro L. Rev. 287, 305 (1988) (stating that postpartum psychosis should be made a statutory affirmative defense to infant murder, wherein a proved case of postpartum psychosis would result in acquittal) (authored by Barbara E. Rosenberg).
supervise the necessary treatment. The sentence imposed therefore, should reflect the need for treatment, yet at the same time satisfy society's need for retribution so the defendant will not be completely exonerated of the crime by using a medically uncertain defense.

"In general, biological deficiency defenses that have no place under the insanity defense have an uncertain place in the criminal law." When knowledge and acceptance of this disorder rise to the level required by the criminal justice system, the system must then weigh the importance of the mounting evidence and recommend a policy for its use.

Anne Damante Brusca

222. Comment, supra note 9, at 666.
223. This knowledge and acceptance can be gained through better education of medical personnel as to postpartum disorders and through increased research in this area to find definite causes for this disorder and also better treatment measures. There should be more task forces to educate the public and law enforcement agencies and personnel. There should also be more support groups to help not only the postpartum disorder sufferers, but also their families, to cope with and understand what has happened to them, and to spread the word to others.