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Michelle Oberman

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**“LADY MADONNA, CHILDREN AT YOUR FEET”:
TRAGEDIES AT THE INTERSECTION OF MOTHERHOOD,
MENTAL ILLNESS AND THE LAW**

MICHELLE OBERMAN**

Tragedies, great and small, occur with stunning frequency at the intersection of motherhood, madness and the law. Women suffering from postpartum mental illness encounter the legal system in a host of settings: filicide, child abuse and neglect, suicide, divorce, child custody disputes, and employment and insurance related issues. For women with postpartum mental illness, trouble with the law often begins and ends with the fact that they are mothers. Motherhood carries with it a specific set of socio-cultural norms and expectations. For a variety of reasons, some women, if not many, are ill equipped to meet these expectations. Postpartum mental illness may be viewed as simply one factor, among many, that impairs a woman's ability to meet the tasks of motherhood.

This article will describe the range of cases found at the intersection of motherhood, mental illness and the law. In so doing, it will expose the inadequacy of existing legal frameworks for understanding postpartum mental illness. Increasingly, the law is confronting and acknowledging the existence of postpartum mental health conditions. Nonetheless, the law's present approach to postpartum disorders tends to be confused by virtue of the fact that existing legal frameworks for understanding mental illness fail to capture the essence of postpartum mental illness. The law's binary approach to mental illness, in which one either is sane or insane, competent or incompetent, or able-bodied or disabled, simply fails to accommodate the vast majority of women who struggle with postpartum mental illness. The fact of the matter is that organic mental illness alone cannot account for much of what goes wrong for mothers who find themselves at the intersection of madness and the law.

For centuries, medical experts have described postpartum mental disorders and struggled to discern their origins.¹ This

* The title phrase “Lady Madonna, children at your feet” comes from the Beatles song “Lady Madonna” (1968). See ALAN ALDRIDGE, *THE BEATLES ILLUSTRATED LYRICS* 57 (1991). It is intended as a nod both to the Beatles, for their astute depiction of the struggles that are found in the mundane work of mothering, and also to my dear friend, Professor Michael L. Perlin, whose Dylan-esque wit serves as a constant source of inspiration to me. My thanks are due to him, and also to Allyson Esposito, DePaul College of Law, class of 2005, for her talented assistance in researching this article.

** Professor of Law, DePaul University College of Law.

1. Cheryl L. Meyer & Margaret G. Spinelli, *Medical and Legal Dilemmas of Postpartum*

struggle began as early as Hippocrates, who described what we now know as postpartum psychosis, and attributed it to "excessive blood flow to the brain."² In more recent times, physicians have recognized postpartum mental disorders as variations on generic mental illnesses such as psychosis and depression, but have disagreed about the exact criteria for diagnosis.³ In spite of these difficulties, experts today are in consensus regarding the fact that there is a spectrum of postpartum mental disorders, ranging from the relatively common mild and fleeting depression to the rare cases of full-blown psychosis, that are associated with the postpartum period.⁴

It is clear that postpartum mental disorders arise, in part, from a woman's physiological responses to pregnancy and childbirth.⁵

Psychiatric Disorders, in INFANTICIDE: PSYCHOSOCIAL AND LEGAL PERSPECTIVES ON MOTHERS WHO KILL 167, 168 (Margaret G. Spinelli, ed., 2003) [hereinafter *INFANTICIDE*]. See also Cheryl L. Meyer et al., *Postpartum Syndromes: Disparate Treatment in the Legal System, in IT'S A CRIME: WOMEN AND JUSTICE* 91 (Roslyn Muraskin ed., 2d ed. 2000).

2. Meyer et al., *supra* note 1, at 91.

3. *Id.* at 92-93, (summarizing classification problems in both the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)). When determining the cause of postpartum mental illness, some mental health experts focus on the hormonal shifts that occur during and around the birthing process and on a woman's predisposition for mental illness. *Id.* at 94. On the other hand, feminist researchers and practitioners believe that postpartum syndromes also may be viewed as a natural response to a society that devalues motherhood. See *Id.* at 103. This group focuses on sociological factors that may contribute to postpartum syndromes, such as single motherhood, decisions to stop working outside the home, or a lack of social support. *Id.* At 101-02. They propose a treatment of counseling, both with and without partners. See generally Scott P. Stuart, *Interpersonal Psychology for Postpartum Depression, in POSTPARTUM MOOD DISORDERS* 143-162 (Laura J. Miller, ed. 1999).

4. By far the most common form of postpartum mental health ailment is mild postpartum depression, commonly known as baby blues. This fleeting form of depression occurs so commonly that it is regarded as normal. Irvin D. Yalom et al., "*Postpartum Blues*" Syndrome: A Description and Related Variables, 18 *ARCHIVES GEN. PSYCHIATRY* 16, 16 (1968) (estimating that between five percent and eighty percent of women experience some kind of postpartum psychiatric disorder). Onset is typically somewhere between the third and fifth days after delivery, and usually only lasts a few days. Symptoms usually include irritability, dysphoria, anxiety, and inability to think clearly. See generally Laura J. Miller & Margaret Ruskstalis, *Beyond the "Blues": Hypotheses About Postpartum Reactivity, in POSTPARTUM MOOD DISORDERS, supra* note 3, at 3-16. Postpartum depression, the second category of postpartum disorders is more severe, lasting longer than 'baby blues.' Barbara L. Parry, *Postpartum Depression in Relation to Other Reproductive Cycle Mood Changes, in POSTPARTUM MOOD DISORDERS, supra* note 3, at 28. It occurs in ten percent of women and may have a delayed onset of anywhere from six weeks to three to four months after delivery, and typically lasts six months to a year. *Id.* Postpartum psychosis is much more rare and much more severe than either 'baby blues' or postpartum depression. It occurs in approximately one out of every five hundred to one thousand births, and has a rapid onset within the first few days to two to three weeks after delivery. Meir Steiner & William Y.K. Tam, *Postpartum Depression in Relation to Other Psychiatric Disorders, in POSTPARTUM MOOD DISORDERS, supra* note 3, at 48. Women with a history of psychiatric illness are most at risk for this type of postpartum disorder. *Id.*

5. See Miller & Ruskstalis, *supra* note 4, at 9-16; Victoria Hendrick & Lori L. Altshuler,

What complicates the matter, however, is the considerable evidence that physiological explanations alone do not account for the incidence of these disorders. For instance, numerous studies demonstrate that new mothers who lack sufficient social support are at greater risk for developing a postpartum mental disorder.⁶ Additional evidence that the origins of postpartum mental illness may not be strictly physiological comes from the well-established fact that postpartum syndromes occur with far less frequency in non-Western cultures.⁷ Two different studies suggest that the development of postpartum mental disorders may be inhibited by cultural structures that support new mothers.⁸ For instance, some non-Western cultures mandate a period of rest and seclusion for new mothers, offer mothers assistance in the form of social and financial support, and use rituals to structure a distinct postpartum time period, during which the mother is recognized as having attained a new social status.⁹

It remains unclear whether social support can prevent postpartum mental illness, or whether it simply protects mothers and their children against the potential threat posed by such illnesses. For instance, it seems obvious that the risks posed even by severe postpartum mental illness are inhibited in a culture in which a new mother is accompanied and assisted, on a full-time basis, by her own mother and other female relatives. Toward this end, it is critical to observe the dramatic changes in family structure that the West, and particularly the United States, experienced in the latter decades of

Biological Determinants of Postpartum Depression, in *POSTPARTUM MOOD DISORDERS*, *supra* note 3, at 66-78 (finding that biological factors influence women's vulnerability to major depression during postpartum because this period is a time of rapid and dramatic physiologic change). See also Deborah Siechel, *Neurohormonal Aspects of Postpartum Depression and Psychosis*, in *INFANTICIDE*, *supra* note 1, at 76.

6. Meyer et al., *supra* note 1, at 102. See also John J. Harding, *Postpartum Psychiatric Disorders: A Review*, 30 *COMPREHENSIVE PSYCHIATRY* 109-12 (1989); Christina Lee, *Social Context, Depression and the Transition to Motherhood*, 2 *BRIT. J. HEALTH PSYCHOL.* 93-108 (1997); Valerie Thurtle, *Post-natal Depression: The Relevance of Sociological Approaches*, 22 *J. ADVANCED NURSING* 416-424 (1995) (finding that certain sociocultural factors, such as single motherhood, lack of social support, and other stressful life events increase a woman's risk for developing a postpartum depression). See generally Bonnie Fox & Diana Worts, *Revisiting the Critique of Medicalized Childbirth: A Contribution to the Sociology of Birth*, 13 *GENDER & SOC.* 326-46(1999) (finding that of forty women giving birth for the first time, women with strong support from their partners were less likely to develop a postpartum syndrome, and that the development of 'baby blues' was related to feeling overwhelmed by the responsibilities of motherhood).

7. See M.J. Hayes et al., *Transactional Conflict Between Psychobiology and Culture in the Etiology of Postpartum Depression*, 55(3) *MED. HYPOTHESES* 266, 271 (2000).

8. *Id.* at 266-76; G. Stern & L. Kruckman, *Multi-Disciplinary Perspectives on Post-Partum Depression: An Anthropological Critique*, 17(5) *SOC. SCI. & MED.*, 1027-41 (1983).

9. Stern & Kruckman, *supra* note 9, at 1027-41.

the twentieth century.¹⁰ At the very least, it seems plausible to surmise that postpartum mental illness has become far more visible, if not more common, due to the breakdown of family structures that formerly supported new mothers.

It was inevitable that the combination of the growing medical consensus about and the increased visibility of postpartum mental illness would force the legal system to contend with issues pertaining to postpartum mental illness in a wide variety of contexts. This article will examine three such contexts: when raised as an excuse or for mitigation by a criminal defendant, when raised in the context of various family law proceedings, and as it relates to issues of employment or insurance. This article explores the challenges posed by postpartum mental illness in each of these settings, and evaluates the legal system's response to postpartum mental illness. Finally, this article concludes by considering the challenges and risks posed to the legal system by adopting this nuanced model of mental illness, and the best ways of containing those risks.

I. POSTPARTUM MENTAL ILLNESS AND THE CRIMINAL LAW: FILICIDE CASES¹¹

Every year, in the United States alone, several hundred mothers kill their children.¹² Only a fraction of these crimes are committed by mothers who are suffering from a postpartum mental illness, specifically postpartum depression or postpartum psychosis.¹³ The criminal justice system seems to struggle with these cases, achieving inconsistent results, in which it is not unusual for mothers with documented postpartum mental illnesses to receive lengthy prison sentences.¹⁴

10. By the end of the twentieth century, close to 30 percent of all households with children under the age of eighteen were headed by one parent rather than two. Single parenthood in the context of a fragmented community and in the absence of an extended family means that all the tasks of parenting must be borne more or less alone.

CHERYL L. MEYER & MICHELLE OBERMAN, *MOTHERS WHO KILL THEIR CHILDREN: UNDERSTANDING THE ACTS OF MOMS FROM SUSAN SMITH TO THE "PROM MOM,"* 13 (2001) [hereinafter MEYER & OBERMAN] (citing Zainab Chaudry, *The Myth of Misogyny*, 61 ALB. L. REV. 511, 513 (1997)).

11. Often termed infanticide, this article will use the scientific term of filicide, increasingly embraced by the international community, when referring to a mother's act of killing of her child or children.

12. See MEYER & OBERMAN, *supra* note 10, at 46 ("... estimates for annual occurrences of neonaticide range between 150 and 300.") (citation omitted).

13. Approximately eight percent of cases involving mothers who kill their children involve mothers who suffer from a diagnosed postpartum disorder. See *id.*, at 92.

14. *Id.*, at 60.

After a brief overview of the insanity defense, which is the legal lens through which the U.S. criminal justice system views postpartum mental illness, this section will examine the way in which the legal system is responding to women who assert postpartum mental illness in defense against criminal charges.

A. *Brief Overview of the Defenses of Mental Incompetence and Insanity in the U.S. Legal System*

Unlike many countries around the world, the United States does not have a specific criminal statute that governs the crime of filicide.¹⁵ As a result, American mothers who kill their children are charged with a wide variety of offenses, including murder,¹⁶ and are only able to assert the standard range of criminal defenses. To the extent that the criminal law recognizes postpartum mental illness, it recognizes it as a form of insanity as it pertains either to the woman's competence to stand trial or to her culpability for the crime.¹⁷

The issue of competence to stand trial refers to the ability of a defendant to understand the charges against her and to assist her counsel at trial. A woman with extremely severe postpartum mental illness may be incompetent to stand trial, but generally speaking, most women who were suffering from postpartum mental illness when they killed their children have recovered enough to be found competent by the time of trial.¹⁸ Moreover, there is little long-term benefit to the defendant who is found incompetent to stand trial, as she will be confined to a mental health facility indefinitely, until she is found competent.¹⁹

The more significant legal mechanism for adducing evidence of postpartum mental illness lies in the insanity defense. The exact language for determining legal insanity varies across jurisdictions, but the majority of states require some version of the M'Naghten test—a showing that at the time of her act, disease prevented the defendant from knowing either the nature and quality of her act, or that the act was wrong.²⁰

15. *See infra* note 79 (discussing the British Infanticide Act).

16. MEYER & OBERMAN, *supra* note 10, at 58.

17. Meyer et al., *supra* note 1, at 95.

18. *Id.*

19. *Id.*

20. GARY B. MELTON ET AL., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS* 190-93 (2d ed. 1997). *See* Meyer et al., *supra* note 1, at 95.

This standard, which focuses on the defendant's cognitive state of mind, is widely criticized as being obsolete and out of keeping with contemporary understandings regarding mental illness and its effect on one's ability to control one's actions.²¹ Specifically, the consensus among mental health experts today is that mental illness may significantly impair one's capacity to control one's actions or impulses, thus leading an individual to commit acts that they know to be morally wrong.²² As will be seen in the following discussion, it is this distinction that operates to the detriment of filicide defendants, among others, as the mothers virtually always understand that it is morally wrong to kill their children.

A final manner in which postpartum mental illness arises in the context of criminal cases is in the sentencing phase, when judges and juries may be moved to mitigate the severity of punishment in response to evidence that the defendant was suffering from mental illness.²³ Because judges and juries need not articulate the justifications for their sentences, it is difficult to know how often or how dramatically evidence of postpartum mental illness influences the sentences meted out to mothers who kill.

B. *Filicide and Postpartum Mental Illness*

In my past work on the topic of mothers who kill their children, my co-author Cheryl L. Meyer and I have identified five basic categories of filicide.²⁴ These include neonaticide, fatal neglect, fatal abuse, assisted or coerced filicide and purposeful filicide.²⁵ Although mental illness is found among mothers in all five categories, it is the last category—that of purposeful filicide—which encompasses the majority of mothers who kill their children while suffering from postpartum mental illness.²⁶

21. See WAYNE R. LAFAVE, CRIMINAL LAW § 7.2(c) (4th ed. 2003); Daniel M'Naghten's Case, 8 Eng. Rep. 718, 718 (1843); Maria Massucci & James A. Pitaro, Note, *Victimization as a Defense: Valid Protection for the Innocent or Escape from Criminal Responsibility?*, 8 ST. JOHN'S J. LEGAL COMMENT. 305, 327 (1992) (stating that the M'Naghten test is the model most frequently incorporated into state penal statutes for insanity defenses); Sandy Meng Shan Liu, Comment, *Postpartum Psychosis: A Legitimate Defense for Negating Criminal Responsibility*, 4 SCHOLAR 339, 366 (2002).

22. See Liu, *supra* note 21, at 366; RALPH SLOVENKO, PSYCHIATRY AND CRIMINAL CULPABILITY 24-25 (1995).

23. Meyer at al., *supra* note 3, at 96.

24. MEYER & OBERMAN, *supra* note 10, at 36-38.

25. *Id.*

26. *Id.* at 38.

The category of purposeful filicide refers to mothers who deliberately kill their children.²⁷ Some of these mothers, but not all, suffer from psychotic delusions or profound depression triggered by their bodies' hormonal response to pregnancy, labor and delivery.²⁸ An excellent example of this phenomenon is found in the case of Andrea Yates, who was suffering from postpartum psychosis when she "drowned her five children (ages six months to seven years)."²⁹

In the aftermath of the killings, a troubling view of Yates' daily life emerged. Yates was, by all accounts, a devoted and loving mother, who was working at home to raise her five children.³⁰ Indeed, more than merely being a stay-at-home mom, Yates was home-schooling the children—a monumental task given that there were five of them, all under the age of eight.³¹ In addition to caring for her children, Yates served as a primary caretaker for her father, who suffered from Alzheimer's disease for the eight years preceding his death.³²

At the time of the murders, Yates already had a long history of psychiatric illness.³³ Her first experience of postpartum mental illness occurred shortly after the birth of her first child, Noah, in 1994, "when she felt Satan's presence and 'heard Satan's voice' tell her to 'pick up the knife and stab the child.'"³⁴ Yates tried to forget this episode, not telling anyone, but it kept recurring over the years, in the form of an apparition telling her to "get a knife."³⁵

Yates was not formally diagnosed with postpartum depression until after the birth of her fourth son in February of 1999.³⁶ Her depression was extremely severe. She attempted suicide twice, and subsequently was hospitalized.³⁷ Through the use of psychotropic medicine, Yates' illness eventually improved.³⁸

Although her doctors were concerned when she became pregnant again, the birth of her fifth child in November 2000 initially

27. *Id.*

28. *Id.* at 92.

29. Margaret G. Spinelli, *Introduction to INFANTICIDE*, *supra* note 1, at xvi-xvii.

30. *Id.*

31. *Id.*

32. Evan Thomas, *Motherhood and Murder*, *NEWSWEEK*, July 2, 2001, at 20.

33. Spinelli, *supra* note 29, at xvii.

34. *Id.*

35. Bill Hewitt et al., *Life or Death: Does Andrea Yates, on Trial for Murder in Houston, Deserve Mercy for Drowning Her Five Kids? Or is She, as Prosecutors Argue, Fully Responsible for the Crimes They Say She had Contemplated for Months?*, *PEOPLE*, Mar. 4, 2002, at 82.

36. *Id.* See also Laura Parker, *Coalition Supports Houston Mom*, *USA TODAY*, Aug. 28, 2001, at 1A.

37. Hewitt et al., *supra* note 35.

38. *Id.*

did not seem to trigger any major postpartum depression.³⁹ When Yates' father died in March of 2001, however, all her symptoms returned and worsened.⁴⁰ She became profoundly withdrawn, and her family recognized that Yates appeared to be catatonic.⁴¹ She was hospitalized, but was discharged after twelve days.⁴² The medication was not as successful this time.⁴³ Consequently, two weeks before the tragedy, her psychiatrist changed her medication, discontinuing her antipsychotic medication.

In June 2001, in the throes of a full-blown psychotic episode, Yates succumbed to the voices in her head, and killed her children.⁴⁴ After her arrest, she requested a razor to shave her head and reveal the "mark of the beast—666" that she believed was on her scalp.⁴⁵

The state of Texas charged Yates with capital murder.⁴⁶ The jury reached a guilty verdict after several hours of deliberation.⁴⁷ It took them only thirty-five minutes to reject the prosecution's bid for the death penalty, opting instead for a life sentence.⁴⁸

The Yates case is atypical in the number of children killed, but in many other aspects, it is quite typical. Postpartum mental illness, even after diagnosis, is quite difficult to treat. This is in part because doctors only recently have reached consensus about the existence and etiology of these disorders.⁴⁹ But it also is due to the fact that treatment is quite difficult. This is readily apparent when one considers the problem of suicide among women suffering from postpartum mental illness.⁵⁰

39. *Id.*

40. *Id.*; Thomas, *supra* note 32.

41. Spinelli, *supra* note 29, at xvii.

42. Hewitt et al., *supra* note 35.

43. *Id.*

44. *Id.*

45. Spinelli, *supra* note 29, at xvii.

46. Hewitt et al., *supra* note 35.

47. Spinelli, *supra* note 29, at xvii.

48. *Id.*

49. *See supra* note 3, and accompanying text.

50. *See Steiner & Tam, supra* note 4, at 49. For a woman suffering from postpartum illness, suicide is at least as great a risk as harming her children. For instance, consider the case of Melanie Stokes. On June 11, 2001, Ms. Stokes, 41, jumped from a hotel window to her death, less than four months after giving birth to her daughter, Sommer Skyy. Prior to the birth of her child at forty, she led a nearly perfect life by all accounts, and was excited about the prospect of having a child even before she knew she was pregnant. After her daughter's birth, she showed signs of severe depression, and was unable to care for herself or her baby. Three hospitalizations and ten different medications later, she continued to suffer. Despite the fact that she was constantly being watched and cared for by her loving family, they could not keep her safe or prevent her from harming herself. Postpartum disorders "are often diagnosed late or not at all. Treatment, if it's available, may be a matter of guesswork. People can get sick and sicker with the speed and unpredictability of an avalanche." Louise Kiernan,

The problem of treatment is all the more complicated for a mother who has other children. Ms. Yates was hospitalized on several occasions, but on each occasion, she was released back to her home, so that she could resume caring for her five children.⁵¹ Her doctors had little reason to believe that she was "cured," or that their treatment had rendered her capable of handling the enormous emotional, physical, and psychological demands she faced at home.⁵² Indeed, in retrospect, it seemed that the structure of her home life, given the frailty of her mental status, was a prescription for disaster.

A second aspect of the Yates case that commonly is seen in filicide cases involving postpartum mental illness is that of maternal isolation.⁵³ For the most part, when Andrea Yates suffered from her suicidal delusions and her paralyzing depression, she did so alone. Her neighbors had little idea that she was troubled.⁵⁴ Her only respite was the occasional visit from her mother-in-law and the relief offered by her husband, whose beliefs about the home and family are best explained in a statement he made to the prosecutor: "Man is the breadwinner and woman is the homemaker."⁵⁵ His wife had only two hours of personal time each week.⁵⁶ Under such circumstances, it simply is inaccurate to assert that her mental illness was the sole cause of the death of her children. Had she had a solid support network consisting of family and friends, she might have been able to wait out the course of treatment needed to cure her of her psychosis. Had a community of trusted family and friends known of her illness, she would not have been left alone with her children immediately upon her release from the hospital.

C. *Filicide, Postpartum Mental Illness and the Insanity Defense*

One of the most remarkable things about the Yates case was the extent to which experts on both sides agreed about the fact that Ms. Yates was profoundly mentally ill.⁵⁷ Yates pled not guilty by reason of insanity to her charge of capital murder.⁵⁸ In order to be

Descent into Darkness, CHI. TRIB., Feb. 16, 2003, at 1.

51. Margaret G. Spinelli, *The Promise of Saved Lives: Recognition, Prevention and Rehabilitation*, in *INFANTICIDE*, *supra* note 1, at 245.

52. *Id.* at 245-46.

53. See ANN L. DUNNEWOLD, *EVALUATION AND TREATMENT OF POSTPARTUM EMOTIONAL DISORDERS* 19-20 (1997).

54. See Thomas, *supra* note 32.

55. Spinelli, *The Promise of Saved Lives*, *supra* note 51, at 245.

56. *Id.*

57. Meyer & Spinelli, *supra* note 1, at 175.

58. *Id.* at 174.

found not guilty for reasons of insanity in Texas, however, the law required that Mrs. Yates prove “failure to know the act was wrong,” one of the more restrictive legal insanity standards derived from the M’Naghten Rule.⁵⁹ The defense maintained that she did not know right from wrong at the time of the killings because she was in a psychotic state.⁶⁰ However, the prosecution asserted that she knew right from wrong at the time of the killings because she had called both her husband and 911 to confess to having killed her children.⁶¹ This evidence, the prosecutors successfully claimed, showed that she knew that her actions were wrong, and seemed to undermine her claim of insanity.⁶²

Although it likely is true that the majority of women with postpartum mental illness who plead insanity do not succeed, some experts believe that the insanity defense is somewhat more successful when raised by this particular population than it is in general. Professor Michael Perlin suggests that these mothers who kill might be considered “empathy outliers,” as they are slightly more likely to succeed in garnering a jury’s empathy in response to their desperate mental illness.⁶³ Indeed, in recent years, several women who killed family members while suffering from postpartum psychosis have successfully invoked the insanity defense.⁶⁴

59. *See id.*, at 174-77. *See also* TEX. PENAL CODE ANN. § 8.01(a) (2003) (“It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong.”); 2-53 TEX. CRIM. PRAC. GUIDE § 53.303 (Procedure for use of Insanity Defense).

60. Meyer & Spinelli, *supra* note 1, at 175.

61. *Id.*

62. *See id.* at 174-76. However, the verdict may also reflect the considerable misinformation among jurors who did not believe her postpartum syndrome defense, or perhaps did not understand the judge’s instructions regarding the “not guilty for reasons of insanity” verdict.

63. MICHAEL L. PERLIN, *THE JURISPRUDENCE OF THE INSANITY DEFENSE* 192 (1994). *See also* Henry J. Steadman et al., *The Use of the Insanity Defense*, in *REPORT TO GOV. HUGH L. CAREY ON THE INSANITY DEFENSE IN NEW YORK*, 68-69 (1978) (prepared under the direction of William A. Carnahan, Deputy Commissioner and Counsel) (finding,

that society, in its desire to preserve an illusion of “mother love,” is hesitant to carefully scrutinize the mother-child relationship and recognize realistically that the most reasonable target for a mother’s frustration and anger is her child. Instead, to preserve our illusions about “mother love,” we categorize women who murder their children as “insane”).

64. *See, e.g.*, the case of Susan Mooney, a successful Wall Street executive who was charged with the second-degree murder of her seven month old son in 2001. In November of 2002, a New York judge found her not guilty by reason of mental disease or defect, accepting the defense’s argument that she suffered from postpartum psychosis and did not know what she was doing at the time. She remains at a secure, state-operated mental facility. Chrisena Coleman, *Killer Mom Will Stay in Psych Hosp*, *DAILY NEWS* (NEW YORK), Apr. 30, 2003, Suburban at 1; Chrisena Coleman, *Mom Avoids Prison in Baby Death*, *DAILY NEWS* (NEW YORK), Nov. 15, 2002, News at 10. *See also* the case of Maria Amaya, who slit the throats of

Even when a court accepts the fact that a woman's criminal actions were the result of postpartum mental illness, and finds her not guilty for reasons of insanity (NGRI), the unique nature of these mental illnesses often defies easy resolution. Typically speaking, a defendant who is found NGRI is ordered to reside in a mental facility until such time as she or he is determined to pose no further danger to herself or others.⁶⁵ Studies demonstrate that, on average, defendants who are sentenced to mental facilities serve longer sentences in mental hospitals than do those who are found guilty and sentenced to prison.⁶⁶ Postpartum mental illness poses a challenge to the disposition of criminal cases in that it typically is not a chronic medical condition, and, when properly treated, the mothers often experience a full recovery in a relatively short period of time.⁶⁷ Thus, although they were found to have been insane at the time of their crimes, some, if not many, of these women do not require long-term institutionalization for mental illness. As a result, the criminal justice system must grapple with the underlying justifications for incarceration and punishment.

The case of Sheryl Massip illustrates this problem. Massip was a California woman who was charged with killing her six-week-old son while suffering from postpartum psychosis.⁶⁸ By the time of her trial, Massip's symptoms had disappeared and she was no

her four children as they slept in their beds, then tried to kill herself. In 1992, two years after her children's deaths, Amaya was found fit to stand trial, but the district attorney's psychiatrist found she had been so mentally ill at the time of the killings that she did not appreciate the consequences of her own actions. She was found not guilty, and was sentenced to remain at a supervised residential housing center for the mentally ill. Caren Halbfinger, *Local Slayings, Yates Cases Present a Stark Contrast*, J. NEWS, Mar. 17, 2002, at 1A; Mike Tolson, *Unequal Justice: Criminal Punishment Widely Disparate in Maternal Filicide Cases Such as Yates'*, HOUSTON CHRON., Sept. 10, 2001, § A at 1. For an example of a case in which evidence of postpartum psychosis was used to mitigate the severity of the punishment, see the case of Seema Rothstein, in June of 2002, in which a wife stabbed herself and husband, killing him. After an agreement was reached by both sides, she pled guilty to involuntary manslaughter and received a five-year suspended sentence. Maria Glod, *No Prison Term In Man's Slaying; Fairfax Wife Had Postpartum Psychosis*, WASH. POST, Jul. 26, 2002, at B7; Tom Jackson & Maria Glod, *Muhammad's Appointed Lawyer Prizes Ideal of Justice for All*, WASH. POST, Nov. 10, 2002, at A8.

65. PERLIN, *supra* note 63, at 4 (finding that not only are stays in mental facilities typically longer than the average prison sentence, they often are far more restrictive than many prisons or reformatories).

66. *Id.*

67. MEYER & OBERMAN, *supra* note 10, at 12 (citing Michael W. O'Hara, *Postpartum "Blues," Depression and Psychosis: A Review*, 7 J. PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY 205 (1987)).

68. Eric Lichtblau, *Appeal Argued in Postpartum Case*, LOS ANGELES TIMES, May 24, 1990, at B1. At Massip's 1987 murder trial, evidence showed that she threw her son into oncoming traffic, picked him up and carried him to her garage, hit him over the head with a blunt object, and the finally killed him by running him over with her car. *Id.*

longer psychotic.⁶⁹ The jury found Massip guilty of second-degree murder, based on their discomfort with the notion that she would otherwise avoid being punished for her crime.⁷⁰ Two months later, however, the judge overturned the jury verdict and acquitted Massip on temporary insanity grounds, ordering her to undergo at least one year of outpatient therapy to treat her postpartum psychosis.⁷¹ The judge believed the record clearly showed that Massip was emotionally disturbed.⁷² The appellate court affirmed on insanity grounds, saying that the defendant did not have the requisite state of mind to commit the murder because she was suffering from postpartum mental illness.⁷³

More recently, a Connecticut court refused to relinquish jurisdiction over Dawn March, who was found NGRI in October of 1991, for the drowning death of her six month old child.⁷⁴ In spite of the fact that all of the medical experts agreed that she no longer was mentally ill, and that her behavior while on conditional release was without blemish, the court asserted its right to retain jurisdiction due to severity of the offense.⁷⁵

The complexity of these cases, both in terms of the circumstances leading up to the crimes, and in terms of the perceived justifications for incarceration and punishment, is enormous. It is no wonder that so many nations around the world elect to view filicide as a *sui*

69. *Id.*

70. *People v. Massip*, 271 Cal. Rptr. 868 (Cal. App. 1990).

71. *Id.*

72. *Id.*

73. *Id.* See also Mary Lentz, *A Postmortem of the Post Partum Psychosis Defense*, 18 CAP. U. L. REV. 525, 536 (1989); Tricia L. Schroeder, Note, *Postpartum Psychosis as a Defense for Murder*, 21 W. ST. U. L. REV. 267, 279 (1993); Liu, *supra* note 21, at 15-16. See also Michelle Oberman, *Mothers Who Kill: Coming to Terms with Modern American Infanticide*, 34 AM. CRIM. L. REV. 1, 34-35 (1996) [hereinafter Oberman, *Mothers Who Kill*].

74. *State v. Dawn March*, 265 Conn. 697, 830 A.2d 212 (2003).

75. *Id.*; See also Halbfinger, *supra* note 64, at 1A (describing the case of Maria Amaya). Maria Amaya was originally found not competent to stand trial after she killed her four children. The injuries she sustained in trying to take her own life required major surgical reconstruction, and she was hospitalized and treated for nearly two years. Once she recovered from her physical injuries, Amaya was sent to a secure state hospital. After responding to treatment, she was found mentally competent to stand trial. In 1992, the prosecution and the court accepted her guilty plea. She then spent another two years in a less secure psychiatric center, as ordered by the court. By 1994, a psychiatric report described her as a model patient who was cooperative and helpful. In June of 1999, a New York judge ordered Amaya to attend an outpatient treatment program for five years. Since then, she has been living in dormitory-style housing for people recovering from mental illness. Upon her release, comments from the assistant district attorney who prosecuted the case, as well as the former police chief of the town in which Amaya lived, revealed a sense that she had not really paid for her crime. They believed she should have been criminally penalized because she took the lives of four children, whether she was insane or not. While they felt sympathy for Amaya, they did not think she should be out in public.

generis offense, and to treat the cases in a consistent, and highly medicalized fashion.⁷⁶ Some countries go even farther than the standard English 1938 Infanticide Act, which reduces the severity of the criminal act from murder to manslaughter, and generally punishes the crime with probation.⁷⁷ According to Professor Gary Slapper, “in some countries, such as Sweden, such cases are taken within the province of a panel of doctors, not the criminal justice system.”⁷⁸

The medicalized approach taken by nations with infanticide statutes, or by nations such as Sweden, has its own flaws. Although there may be sociological or cultural justifications for treating *all* filicide cases differently from other forms of homicide, the laws are predicated upon scientific explanations. That is, they allow a woman relief based upon the notion that, during the course of the first twelve months following a child’s birth, the “balance” of her mind may be upset for reasons contingent upon childbirth or lactation.⁷⁹

76. See Oberman, *Mothers Who Kill*, *supra* note 73, at 18. The following nations are among those that have criminal codes that recognize filicide as a specific, less culpable form of homicide: Austria, NEW YORK UNIV., THE AMERICAN SERIES OF FOREIGN PENAL CODES, THE AUSTRIAN PENAL ACT 66 (Norbert D. West & Samuel I. Shuman, trans., 1966) [hereinafter AUSTRIAN PENAL CODE]; Columbia, NEW YORK UNIV., THE AMERICAN SERIES OF FOREIGN PENAL CODES, THE COLOMBIAN PENAL CODE 106 (Phanor Eder, trans., 1967) [hereinafter COLOMBIAN PENAL CODE]; Finland, NEW YORK UNIV., THE AMERICAN SERIES OF FOREIGN PENAL CODES, FINNISH PENAL CODE 71 (Mattie Jousten, trans., 1987) [hereinafter FINNISH PENAL CODE]; Greece, NEW YORK UNIV., THE AMERICAN SERIES OF FOREIGN PENAL CODES, GREEK PENAL CODE 148 (Nicholas B. Lolis, trans., 1950) [hereinafter GREEK PENAL CODE]; Italy, NEW YORK UNIV., THE AMERICAN SERIES OF FOREIGN PENAL CODES, ITALIAN PENAL CODE 193 (Edward M. Wise & Allen Maitlin, trans., 1978) [hereinafter ITALIAN PENAL CODE]; Korea, NEW YORK UNIV., THE AMERICAN SERIES OF FOREIGN PENAL CODES, THE KOREAN CRIMINAL CODE 109 (Paul Ryu, trans., 1960) [hereinafter KOREAN PENAL CODE]; New Zealand, *Crime Act of 1961*, in SPENCE & GARROW’S CRIMINAL LAW 135 (W.S. Spence, ed., 1962) [hereinafter *New Zealand Crime Act of 1961*]; The Phillipines, THE REVISED PENAL CODE ANNOTATED 355 (Jose Nollado, ed., 1988) [hereinafter PHILIPPINE PENAL CODE]; Turkey, NEW YORK UNIV., THE AMERICAN SERIES OF FOREIGN PENAL CODES, THE TURKISH CRIMINAL CODE 145 (Orphan Sepici & Mustafa Ovacik, trans., 1965) [hereinafter TURKISH PENAL CODE].

77. Gary Slapper, *Mothers, Madness and Medieval Justice*, TIMES LONDON, Feb. 4, 2003 at 3, available at 2003 WL 3101596.

78. *Id.*

79. See Oberman, *Mothers Who Kill*, *supra* note 73, at 15. One example of this is the British Infanticide Act of 1922 which provided that those defendants whose minds were disturbed as the result of giving birth, if their offense would have amounted to murder, could only be convicted of manslaughter. The 1922 Act was originally limited to newly born children, but was amended in 1938 in response to a case that held that the law did not extend to a woman who killed her thirty-five-day-old child. The amended law included any child under the age of twelve months, and extended the defense of lactation-related hormonal imbalance.

The full text of the Infanticide Act reads as follows:

Where a woman by any wilful act or omission causes the death of her child being a child under the age of twelve months, but at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered

Women suffering from postpartum mental illness readily meet this standard. Indeed, most mothers who kill their infants, even those who are not diagnosed with a postpartum mental disorder, rather easily meet it.

It is clearly possible, however, that some women who commit filicide do not suffer from any sort of postpartum mental illness. It is worth noting the debate provoked by this issue among contemporary United States experts. The American Psychiatric Association, in its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), recognizes mood disorders following pregnancy using the generic category of "affective mental diagnoses with postpartum onset."⁸⁰ The DSM-IV limits these disorders to episodes within four weeks of giving birth.⁸¹ In contrast, Dr. Laura Miller, an expert in treating postpartum mental disorders, has found that these mood disorders are not solely biological in nature, but that they often arise out of a woman's response to the "sociocultural and economic" influences in her environment.⁸² Additionally, postpartum mental disorders may be triggered by factors such as maternal isolation and poverty.⁸³ As a result of such influences, symptoms may arise, and persist, long after the birth of a child.⁸⁴

In spite of their uncertain scientific foundation, infanticide acts remain popular in the nations with these laws because they successfully avoid the pitfalls of standard insanity jurisprudence and honor both the medical community's and society's sense that these cases are somehow different from standard homicide cases.⁸⁵ By comparison, the United States' approach to filicide cases seems decidedly removed from contemporary understandings of the nature and origins of postpartum mental illness.⁸⁶ Instead, the insistence in the United States on viewing these cases through the lens of

from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child, then, notwithstanding that the circumstances were such that but for this Act the offence would have amounted to murder, she shall be guilty of felony, to wit of infanticide, and may for such offence be dealt with and punished as if she had been guilty of the offence of manslaughter of the child.

Infanticide Act, 1938, 1 & 2 Geo. 6, ch. 36 (Eng.).

80. AMERICAN PSYCHIATRIC ASSN., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 386 (4th ed. 1994) [hereinafter DSM-IV]

81. *Id.*

82. See generally Joanne Wile & Maria Arechiga, *Sociocultural Aspects of Postpartum Depression*, in POSTPARTUM MOOD DISORDERS *supra* note 3, at 83.

83. See *id.* at 84-85.

84. See Oberman, *Mothers Who Kill*, *supra* note 73, at 38.

85. *Id.* at 17-19.

86. See *id.* at 20-33.

insanity law seems to be an exercise in absurdity. There seldom is any real doubt as to the mental instability of mothers who kill their children while suffering from postpartum psychosis or profound postpartum depression. More importantly, the questions we ask of filicidal mothers with postpartum mental illness are almost completely disconnected from the matter of how and why their children died. Likewise, whether they pass or fail the tests for insanity, the manner in which we punish these mothers seems void of any meaningful inquiry into their moral blameworthiness. This is not to say that mothers who commit filicide do not merit punishment, but rather, that any effort to do justice in these cases requires a careful inquiry into the circumstances that gave rise to the mother's actions, including her mental health status.

II. POSTPARTUM MENTAL ILLNESS AND ISSUES OF LEGAL COMPETENCE

Issues relating to postpartum mental illness arise with some frequency in a host of non-criminal legal contexts.⁸⁷ For the most part, postpartum mental illness-related claims grow out of claims made, either by a mother, or by her partner, that her postpartum mental illness rendered her incompetent to engage in a given activity.⁸⁸ Generally speaking, courts readily admit evidence and testimony relating to postpartum mental illness. The primary difficulty raised by these claims arises from the complex interaction between the biological and the structural, or socio-cultural forces that shape postpartum mental illness. In short, courts have little trouble understanding the debilitating effects of postpartum depression or psychosis. What is more difficult is determining the extent to which these medical conditions should excuse a mother's failure to comply with legal standards expected of the general population, or mothers in particular. I will explore this problem in three family law contexts: decisions to relinquish a child for adoption, child custody disputes, and proceedings to terminate parental rights.

87. See Meyer et al., *supra* note 1, at 96.

88. *Id.* at 97-99.

A. *Postpartum Mental Illness and the Decision to Relinquish Custody*

There are at least four appellate-level cases between 1997 and 2002 in which biological mothers who had relinquished custody of their children attempted to set aside the adoptions, claiming that they had surrendered their rights while suffering from postpartum depression.⁸⁹ Adoption contracts are highly regulated, and all states require a period of time following birth in which a mother can change her stated intention to relinquish her child, and elect instead to keep it.⁹⁰ However, adoption cases involving postpartum mental illness tend to involve mothers who became symptomatic, and relinquished their children weeks, or even months after birth — long after the waiting periods had passed.⁹¹

For instance, consider the case of *C.L.B. v. D.G.B.*⁹² This case involved a child born to a high school-aged couple that was residing with the paternal grandparents.⁹³ Within the first month after the child's birth, the mother, C.L.B., developed severe postpartum depression, attempted suicide, and required hospitalization and medication. During her hospitalization, the paternal grandparents cared for the baby.⁹⁴ While hospitalized, C.L.B. began to confront her personal history of

89. See, e.g., *Adoption of C.L.B. v. D.G.B.*, 812 So.2d 980 (Miss. 2002) (a biological mother and father had consented to give their child up for adoption. The mother later brought suit claiming that the adoption was invalid because she had been suffering from postpartum depression when she consented. The court upheld the adoption, saying the mother failed to show that she lacked the mental capacity to consent and that she failed to show the adoption was obtained through duress, fraud, or coercion); See also *In re J.A.B.*, 744 So.2d 575 (Fla. App. 1999); *In re Adoption of C.J.F.T. v. J.W.*, 1999 WL 332446660 (Utah Ct. App. 1999) (a mother brought suit asking the court to withdraw her consent to give her child up for adoption because she suffered from postpartum depression; the court upheld the adoption); *Croslin v. Croslin*, 1997 WL 44394 (Tenn. Ct. App. 1997) (concerning situation where adoptive child's mother and maternal grandmother filed to set aside the adoption of the mother's child to the maternal grandfather and his wife. Although the mother argued she had suffered from postpartum depression, the appellate court found there was insufficient evidence to find that there was undue influence asserted upon the mother to influence the adoption).

90. See generally Susan Yates Ely, Note, *Natural Parents' Right to Withdraw Consent to Adoption: How Far Should the Right Extend*, 31 U. LOUISVILLE J. OF FAM. L. 685 (1992-93) (discussing the concept of delayed revocation). See also Margaret F. Brinig, Note, *The Effect of Transactions Costs on the Market for Babies*, 18 SETON HALL LEGIS. J. 553, 558 (1994) (discussing the fact that birth mothers are not allowed to give binding consent until after children are born).

91. See, e.g., *Adoption of C.L.B.*, 812 So.2d 980; *In re Adoption of C.J.F.T.*, 1999 WL 332446660, *Croslin*, 1997 WL 44394.

92. *Adoption of C.L.B.*, 812 So.2d at 982.

93. *Id.*

94. *Id.*

childhood physical and sexual abuse at the hands of her father and grandmother.⁹⁵ Upon her release, when the baby was six weeks old, C.L.B. felt incapable of caring for the infant alone and sought legal advice in order to provide some form of legal guardianship to the paternal grandparents, and also to restrict her former abusers from having access to her baby.⁹⁶ At a meeting that was also attended by the baby's father and the paternal grandmother, the lawyer suggested having the paternal grandparents adopt the child.⁹⁷ The young couple agreed, and final adoption papers were signed when the baby was approximately eight weeks old.⁹⁸

Over the next few months, as C.L.B.'s medication began to take effect and she recovered from her postpartum depression, her relationship with the baby's father disintegrated.⁹⁹ Because the father began living with another woman, C.L.B. left his parent's property and returned to her parents' home.¹⁰⁰ CLB did not see the child once she left their home, although the record does not indicate whether this was due to the grandparents' resistance to her visiting, to CLB's discomfort with them, or some other reason.¹⁰¹

Two and a half months later, when the baby was just under six months old, C.L.B. filed a motion to set aside the adoption.¹⁰² The court rejected her motion on the grounds that she was unable to demonstrate that her decision to relinquish custody was the result of fraud, duress, or undue influence.¹⁰³ The record showed that, three days after her admission to the hospital, a social worker's evaluation found her to have "good decision-making ability," and that C.L.B. testified, at the time she surrendered custody, that she was "cured."¹⁰⁴

This result is identical to virtually every reported case involving postpartum mental illness-related challenges to maternal decisions to relinquish custody.¹⁰⁵ The courts tend to uphold the placements without any substantive analysis of the extent to which postpartum depression may have impaired the mother's capacity to enter into a binding agreement. Instead, the primary legal inquiry in some

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*, at 984.

104. *Id.*, at 985.

105. *Id.*; *In re J.A.B.*, 744 So.2d at 575; *Adoption of C.J.F.T.*, 1999 WL 33244660 at * 1; *Croslin*, 1997 WL 44394 at * 1.

states is whether the mother's decision resulted from fraud, duress, or undue influence.¹⁰⁶ Unsurprisingly, mothers whose decision capacity was impaired by virtue of postpartum mental illness typically cannot, in the absence of additional facts, meet this evidentiary burden.

This particular legal inquiry, like that of the test for insanity, misses the scope of the situation that led to the mother's action. The decision to relinquish a child is, after all, different from the decision to buy a new car. Postpartum depression is typified by the mother's feelings of incompetence with regard to parenting her child.¹⁰⁷ Untreated, these women become convinced that they are terrible mothers and that they never will be capable of providing a loving home for their child.¹⁰⁸ It is no wonder that the thought of relinquishing a child is tempting to a woman in this condition. Likewise it is little wonder that, once they receive treatment and recover from their depression, some of these women are horrified to learn that they cannot recover custody of their child.

Judicial decisions regarding adoption tend to be driven by policies favoring the best interests of the child, which are perceived

106. See Brinig, *supra* note 90, at 568-69. Because there is no federal regulation or even federal court review of child custody/adoption matters, each state has adopted its own scheme. This results in a huge variation in practice. All of the states fall into one of five statutory constructions. Twenty, the largest number of states in one category, allow revocation of consent to adoption under very narrow circumstances. In these states, there typically there can be no revocation except in cases in which consent was obtained by fraud, duress, or coercion. The twenty states that allow revocation only upon proof of fraud, duress, or coercion are as follows: Alabama, ALA. CODE § 26-10A-14 (2003) (fraud or mistake); Connecticut, CONN. GEN. STAT. § 17a-112 (2003) (fraud or coercion and in best interest); Florida, FLA. STAT. ANN. § 63.082 (West 1997) (fraud or duress); Idaho, IDAHO CODE § 16-1504 (2003) (fraud, duress, or undue influence); Illinois, ILL. ANN. STAT. CH. 750 § 50/11 (Smith-Hurd 2003) (within twelve months if fraud or duress); Maine, ME. ST. T. 18-A § 9-315 (fraud, duress, mistake and final decree not entered); Minnesota, MINN. STAT. ANN. § 259.24(6)(a) (West 2003) (fraud); Missouri, MO. REV. STAT. § 453.056 (2003) (for cause); Nebraska, NEB. REV. STAT. § 43-104 (1998) (reasonable time before accepted); Nevada, NEV. REV. STAT. ANN. § 127.080 (Michie 2002); New Jersey, N.J. STAT. ANN. § 9:2-16 (West 2002) (fraud, duress, or misrepresentation); New Mexico, N.M. STAT. ANN. § 32A-5-17 (Michie 1998) (involuntary of fraud before final decree); Rhode Island, R.I. GEN. LAWS § 15-7-6 (2000) (misrepresentation); South Carolina, S.C. CODE ANN. § 20-7-1720 (Law. Co-op. 2002); Vermont, VT. STAT. ANN. TIT. 15A, § 2-408 (2002) (fraud, duress, coercion or undue influence); Virginia, VA. CODE ANN. § 63.1-225 (Michie 2002) (before final order upon fraud or duress; after placement only upon mutual consent); Washington, WASH. REV. CODE § 26.33.160 (2003) (fraud or duress); West Virginia, W.VA. CODE § 48-4-5 (Michie 2001); Wisconsin, WIS. STAT. ANN. § 48.46 (West 2003) (involuntary consent); In re D.L.S., 332 N.W.2d 293 (Wis. 1983); Wyoming, WYO. STAT. ANN. § 1-22-109(d)(1988) (fraud or duress). See also Catherine Sakach, Notes and Comments: *Withdrawal of Consent for Adoption: Allocating the Risk*, 18 WHITTIER L. REV. 879.

107. See Teresa Jacobsen, *Effects of Postpartum Disorders on Parenting and on Offspring*, in POSTPARTUM MOOD DISORDERS, *supra* note 3, at 120-22.

108. *Id.*

to be those that favor stable placement in permanent settings.¹⁰⁹ Logic exists in this policy, as few would support the notion that adoptions should be open to challenge by birth mothers long after the child has become emotionally attached to the adoptive parents. Nonetheless, those who facilitate adoptions are the least cost avoiders in these contexts.¹¹⁰ After all, it seems that, by definition, postpartum depression will impair a mother's capacity to make long-term, binding decisions about how and whether she can parent her children.

Generally speaking, the only safeguard against the risk of a birth mother relinquishing her child due to her postpartum illness lies in statutorily imposed waiting periods.¹¹¹ Although the waiting periods guard against 'hurried' decisions by birth mothers, they do little to help those whose decisional capacity is impaired by postpartum depression or psychosis. These women typically develop symptoms weeks, and sometimes even months, after giving birth,¹¹² and they are unlikely to change their minds about a decision to relinquish until after they have either been successfully treated, or have recovered on their own.

Some states have adopted the 1994 Uniform Adoption Act, which requires that a birth mother be offered counseling and a lawyer prior to consenting to relinquish her child.¹¹³ Although this

109. Although some children enter the adoption market when their parents are found unfit, the vast majority begin the process after their parents voluntarily relinquish parental rights. This relinquishment procedure is called "voluntary consent to adoption". See Brinig, *supra* note 90, at 566.

110. A vast majority of states recognize both private placement and agency adoptions. In an agency adoption, a biological mother gives her child to a licensed agency, which places the child with a family of the agency's choosing. Usually, the child is placed in foster care until the birth mother's consent becomes irrevocable. In order for the adoption to become final, a social worker must give a satisfactory finding, which then leads to a judicial decree. Generally, people disfavor agency adoptions because of their rigidity and long wait time for a healthy infant. In an independent adoption, a biological mother places her child with a family of her choice, typically with a doctor or lawyer acting as her intermediary. The adoptive parents pay the biological mother's legal and medical fees, and usually take the baby home immediately from the hospital. Most states require adoptive parents to undergo an investigation by a social worker to determine their parental fitness. See Mindy Schulman Roman, Note, *Rethinking Revocation: Adoption from a New Perspective*, 23 HOFSTRA L. REV. 733, 738 (1995).

111. Most state adoption laws contain provisions requiring a waiting period before signing, signatures of witness, or notarization of the form contract, to protect the birth mother from making a hurried decision when the physical and emotional stresses of childbirth might impair her ability to make a rational decision. See, e.g., W. VA. CODE § 48-4-5(a)(2) (1996) (requiring seventy two hours after birth to pass before a birth parent may execute consent).

112. See, e.g., G.G.V. v. J.L.R., 39 P.3d 1066 (Wyo. 2002).

113. In 1994, the National Conference of Commissioners on Uniform Laws created a comprehensive model adoption code, called the Uniform Adoption Act (UAA). The UAA contains provisions regarding when a birth mother may consent, counseling options for birth

is admirable in spirit, such a generic nod to the importance of diagnostic counseling is unlikely to offer much protection to birth mothers suffering from postpartum mental illness. Instead, those who work with birth mothers should be required to assess the possibility that a birth mother's decision to relinquish custody is related to her postpartum mental illness, rather than the product of an informed, long-term decision not to parent her child. Forcing those who work on behalf of facilitating adoptions to evaluate the mother's capacity to relinquish her child would minimize the risks to both mother and child inherent in a making an irrevocable decision to relinquish a child while in the throes of postpartum depression.

B. *Postpartum Mental Illness and Child Custody Disputes*

Child custody disputes are notoriously vicious in nature, and it is no surprise to learn that there is a line of cases in which fathers, seeking primary or sole custody, raise the issue of their ex-wife's postpartum mental illness in support of their petitions.¹¹⁴ It is impossible to discern, from a review of reported cases, how often claims relating to postpartum mental illness are raised in the context of custody disputes, let alone how often they are successful.¹¹⁵ What is noteworthy, however, is that although some decisions mention postpartum mental illness in the list of factors relating to its decision, almost no cases stop to explore the meaning and the implications of such a diagnosis.

For example, several reported cases involving custody disputes mentioned the fact that the mother had suffered from postpartum illness following the child's birth.¹¹⁶ Yet none of these cases included a substantive discussion of what that diagnosis meant, and of the impact that it might have had on the mother's ability to parent, or on the parents' relationship.¹¹⁷ Instead, the fact that these mothers were, in most cases, diagnosed, medicated and in some cases hospitalized with postpartum mental illness, is mentioned almost

mothers prior to giving consent, and mandatory representation by counsel not affiliated with the adoption agency. For example, the proposed UAA provides that the voluntary consent by an unwed mother (those considered most vulnerable) must contain a statement that the individual executing the consent has received or been offered counseling services. The UAA has been adopted by a growing number of states. See generally Michelle Cucuzza, Note, *The Uniform Adoption Act: Strengthening New York's Protection for Unwed Mothers*, 61 BROOKLYN L. REV. 931, 934, 960 (1995) (discussing the Uniform Adoption Act).

114. See Meyer, et al., *supra* note 1, at 96-99.

115. *Id.* at 97.

116. See, e.g., *G.G.V. v. J.L.R.*, 39 P.3d 1066 (Wyo. 2002); *Davidson v. Davidson*, 576 N.W. 2d 779 (Neb. 1998).

117. *G.G.V.*, 39 P.3d 1066; *Davidson*, 576 N.W.3d 779.

in passing.¹¹⁸ To be fair, many of these cases involve tragic situations in which, for a variety of reasons, neither parent seems well suited to caring for their children.¹¹⁹ By the time the court sees the case, postpartum mental illness really is just one of the many factors to be weighed in determining the best placement for a child.¹²⁰

Sometimes, however, it is clear that the fact that the mother became ill and was unable to function as her child's (or children's) sole caretaker is the very thing that ultimately led to her loss of custody. For instance, in both *Bragg v. Horne*¹²¹ and *Marriage of Collingwood*,¹²² both mothers permitted their husbands' parents to assume roles as primary caretakers while they were hospitalized.¹²³ Their relationships with their husbands became strained during the course of their illnesses, and ultimately ended.¹²⁴ By the time the mothers fully recovered and were able to care for their children, the fathers had filed for divorce, and along with their parents, sought custody of the children.¹²⁵ In *Collingwood*, the mother was denied physical custody on the grounds that it would be disruptive to her children.¹²⁶ In *Bragg*, the severely depressed mother succumbed to pressure from her child's paternal grandmother to transfer custody to her.¹²⁷ Upon her recovery, her request to reassume custody of her child was denied.¹²⁸

By definition, postpartum mental illness hinders a mother's capacity to act as her child's primary caretaker. Recall that, in addition to physiological causes, postpartum mental illness seems to be triggered by social and cultural factors such as the lack of a supportive home environment.¹²⁹ The divorce and custody challenges that raise postpartum mental illness-related issues may be seen as a testimony to the circular nature of the environmental factors that contribute to, and are exacerbated by, a mother's postpartum mental illness. Although their primary task is to determine the child's best interests, courts evaluating custody disputes raising postpartum mental illness-related claims would do well to consider

118. *G.G.V.*, 39 P.3d 1066; *Davidson*, 576 N.W.3d 779.

119. *G.G.V.*, 39 P.3d 1066; *Davidson*, 576 N.W.3d 779.

120. *G.G.V.*, 39 P.3d 1066; *Davidson*, 576 N.W.3d 779.

121. 764 So.2d 1177 (La. App. 2 Cir. 2000).

122. 460 N.W.2d 486 (Iowa App.1990).

123. *Bragg*, 764 So.2d, at 1178; *Collingwood*, 460 N.W.2d at 487.

124. *Bragg*, 764 So.2d, at 1178; *Collingwood*, 460 N.W.2d at 487.

125. *Bragg*, 764 So.2d, at 1178; *Collingwood*, 460 N.W.2d at 487.

126. 460 N.W.2d at 488.

127. 764 So.2d at 1179.

128. *Id.* at 1182.

129. See Meyer et al., *supra* note 1, at 94.

these factors in their cases, particularly when assessing the mother's competence as a parent.

C. *Postpartum Mental Illness and Termination of Parental Rights Cases*

Like custody disputes, cases involving the termination of a mother's parental rights frequently raise the issue of postpartum mental illness. Most often, the mother raises the issue in her own defense. In some cases, mothers raise the claim of postpartum depression years after their children were born, and without any medical evidence that they suffered from such a condition, in an effort to excuse years of abusive and neglectful behavior.¹³⁰

Such cases call attention to the challenges inherent in recognizing a 'syndrome defense' based on postpartum mental illness. The phenomenon of postpartum mental illness is undeniably real, it impairs a woman's capacity to mother her child,¹³¹ and it requires medical treatment.¹³² Until recently, so little attention has been paid to postpartum mental illness that it largely went undiagnosed.¹³³ Moreover, the problem of access to care, and in particular to mental health care, remains a forceful barrier to treatment for many mothers who struggle with postpartum mental illness.¹³⁴ All this being true, to the extent that courts are receptive

130. See, e.g., *In re Alexandra C.*, 2002 Conn. Super. LEXIS 917 (Conn. Super., 2002), in which a mother with a lifelong history of severe mental illness, including 20 hospitalizations and 10 suicide attempts, blamed her failure to visit her daughter over the course of her first year of life, when the daughter resided in foster care, on the fact that she had postpartum depression. See also, *In re A.D.*, 1998 WL 418040 (Tex. App. Hous. 1 Dist 1998) (unpublished opinion) (rejecting the mother's assertion that her bad parenting was due to postpartum depression, noting that she had not sought medical treatment for this condition).

131. See Jacobsen, *supra* note 107, at 120-22.

132. Steiner & Tam, *supra* note 4, at 48.

133. *Id.*

134. In trying to limit the costs of health, accident, and disability insurance policies, the underwriters of many policies limit or exclude benefits coverage for mental illnesses or disorders. Generally, mental diseases that have physical causes typically are covered, while mental disorders that are primarily psychiatric in nature are excluded. Jay M. Zitter, Annotation, *What Constitutes Mental Illness or Disorder, Insanity, or the Like, Within Provision Limiting or Excluding Coverage Under Health or Disability Policy*, 19 A.L.R. 5th 533, 540-41 (2001). Zitter describes the Blake case, in which the extensive psychiatric treatment of a patient suffering from postpartum depression after childbirth was excluded from coverage under a group health policy because it was termed a "mental" illness. *Id.* at 547-48 (citing *Blake v. Unionmutual Stock Life Ins. Co.*, 906 F.2d 1525 (11th Cir. 1990)). See *infra* notes 155-58 and accompanying text (describing the role played by this distinction in coverage determinations).

to postpartum mental illness-based explanations for negligent or abusive parenting, it is inevitable that a far broader class of mothers will attempt to excuse their unlawful behavior toward their children by attributing it to postpartum mental illness.

In view of this problem, one might expect that cases involving the termination of parental rights would require a relatively close scrutiny of the woman's medical condition. It is important to reiterate that it is impossible to generalize about the judicial treatment of cases involving postpartum mental illness using only the information available through reported cases. But it is noteworthy that among reported cases there are virtually no reported decisions that analyze the meaning and the impact of postpartum mental illness on the mother's treatment of her infant.¹³⁵ Instead, courts generally consider the mother's claim that she suffered from postpartum mental illness by placing it into the context of her other reported activities and behavior when making their ruling.¹³⁶

This approach is completely understandable in many termination cases, in which the mother's capacity for providing a safe and loving home seems to be virtually nonexistent. Yet there are also cases whose facts suggest that the mothers temporarily lost or relinquished custody when suffering from postpartum mental illness, and that once their children became temporary wards of the state it was extremely difficult to regain custody.¹³⁷ This remained true even after the mothers had recovered from their postpartum illness, and worked to comply with reunification plans.¹³⁸

Perhaps the saddest thing that can be observed about this line of cases is that they seem to depict in stark terms precisely what mental health experts have concluded: that postpartum mental illness is related both to physiological and to social conditions.¹³⁹ Thus, these cases involve mothers who tend to be profoundly

135. See *supra* notes 109-110, and accompanying text.

136. *Id.*

137. See, e.g., *In re Smith Children*, 1990 WL 70926 (Ohio App. 12 Dist. 1990) (unpublished opinion), in which a very young mother of 5 children developed postpartum depression, referred her family to children's services, and began fighting for reunification with them 18 months later, upon her recovery and compliance with the State's reunification plan. The State opposed reunification on the grounds that the children were emotionally disturbed and would be too difficult for the mother and father to handle. In spite of the *Guardian ad Litem's* report, which found that the children's instability largely was due to the transient and restrictive nature of their foster care placements, the State opposed reunification and appealed a lower court decision granting custody to the parents. The appellate court agreed with the lower court's decision, and ultimately, the children were returned to their parents.

138. *Id.*

139. See, Margaret G. Spinelli, *Prevention of Postpartum Mood Disorders*, in *POSTPARTUM MOOD DISORDERS*, *supra* note 3, at 219-29.

mentally disturbed, and in many cases were ill before they had their children.¹⁴⁰ These women's experience of postpartum mental illness constitutes just one more destabilizing factor in their lives—one that often brings them to the attention of state agencies whose job it is to protect children.¹⁴¹ Unlike the mothers who temporarily lose custody, but are successfully reunited with their children, it seems that little can be done to help these women build the support network they need in order to parent their children.¹⁴²

From this perspective, the risk that these mothers might fabricate postpartum mental illness as a defense seems to matter quite little. Courts are unlikely to be hoodwinked by this strategy, given the multiplicity of factors that already hinder reunification in these cases. The larger problem would appear to be the reverse. Specifically, there are cases in which a mother suffers from a genuine, but time-delimited case of postpartum mental illness, and because of her limited support system, requires state involvement in order to provide care for her children.¹⁴³ In these cases, the mother's marginal economic status may prejudice a court's determination regarding reunification long after she is healthy and able to parent her children. This problem may be seen in the line of appellate court cases overturning trial court orders terminating parental custody.¹⁴⁴ Although the mothers in these specific cases ultimately prevailed and were reunited with their children, the reunification process took many months and even years. Thus, these cases must be viewed not simply as instances in which "the system" worked, but also as grave, if delimited, tragedies for the children and their parents, who were plunged into the chaos of disrupted custody and separation from one another.

140. Michelle Oberman, *A Brief History of Infanticide and the Law*, in *INFANTICIDE*, *supra* note 1, at 13.

141. Oberman, *Mothers Who Kill*, *supra* note 73, at 37-38.

142. *Id.*

143. *In re Child of B.J.C & C.J.C.*, 2001 WL 267468 (Minn. App., 2001) (unpublished opinion) (Plaintiff's mother and father challenged the district court's determination that their child was in need of child protective services, where the mother was suffering from mental illness related to postpartum depression. The appellate court reversed the district court's findings, concluding that their findings of fact were insufficient to sustain their decision that the child's best interests were served by being apart from her parents); *In re Cory M.*, 3 Cal. Rptr. 2d 627 (Cal. App. 1 Dist., 1992) (A biological mother appealed a trial court order terminating reunification services and authorizing proceedings to terminate her parental rights. The appellate court held that the trial court erred in ordering termination proceedings); *Edwards v. County of Arlington*, 361 S.E.2d 644 (Va. App., 1987) (A biological mother appealed the termination of her parental rights. The appellate court reversed, noting that the mother was diagnosed with an atypical psychosis).

144. *Id.*

III. DISABILITY BENEFITS AND POSTPARTUM MENTAL ILLNESS

If postpartum mental illness impairs a woman's ability to function as a primary caretaker for her child, it likely has a similar effect on a woman's capacity to return to employment outside of the home. The resumption of employment following the birth of a child is taxing even for a healthy woman.¹⁴⁵ Much has been written about the second-shift, and the extent to which women, rather than their husbands, are likely to absorb the bulk of new labor created when a child is added to a household.¹⁴⁶ To the extent that a new mother is struggling with postpartum depression, this transition is necessarily more difficult. There is much literature on depression, illustrating the detrimental effect that depression has on the workforce, and demonstrating that a surprisingly large percentage of the population struggles with this particular mental illness.¹⁴⁷ Until quite recently, relatively few of those affected sought treatment for depression. Medical studies indicate that a high percentage of those seeking treatment are inappropriately treated, which reflects both the failure of doctors to keep pace with new

145. For women who recently have had a child, going back to work can be very difficult. In American homes with both parents working, women do approximately two-thirds of the work at home, including childcare, cooking, and cleaning. Women tend to devote more of their time at home to housework and proportionately less of it to childcare, the household job they would prefer to do. Women more often do two or more things at once, causing them to have to juggle and balance household tasks. As a result, women tend to talk more about being emotionally sick, overtired, and emotionally drained. See generally ARLIE HOCHSCHILD, *THE SECOND SHIFT* (1989) (finding that one reason that half the lawyers, doctors, and other professionals are not women is because men do not share the raising of their children and the caring of their homes). See also RHONA MAHONY, *KIDDING OURSELVES: BREADWINNING, BABIES AND BARGAINING POWER* (Susan Rabiner ed., 1995) (arguing that who does what at home shapes the entire economy outside the home).

146. See HOCHSCHILD, *supra* note 145; MAHONY, *supra* note 145.

147. A study in the *Journal of the American Medical Association* documents the overwhelming scope of depression in the United States, as well as its huge impact on job productivity. Walter F. Stewart et al., *Cost of Lost Productive Work Time Among US Workers with Depression*, 289 *JAMA* 3135 (2003). The study of lost worker productivity estimates that the illness costs employers an extra \$31 billion a year in lost productive time. *Id.* The study found that 9.4 percent of the American workforce was suffering from some type of depressive disorder during a given two-week period. *Id.* Rather than use sick days, employees with clinical depression go to their jobs, despite feeling sad, irritable, or distracted. Such reduced performance can account for eighty percent of lost productivity. At female-dominated workplaces, the effect can be doubled because women suffer from depression almost twice as much as men. Because depression often is stigmatized, difficult to identify, and untreated, many employers do not press health insurers to provide mental health coverage in the same way they cover other medical procedures. See Marilyn Elias, *Americans with Major Depression Don't Get Adequate Treatment*, *USA TODAY*, June 18, 2003, at D4; Patricia Guthrie, *Depression Costs Firms \$31 Billion Every Year*, *ATLANTA J. & CONST.*, June 18, 2003, at A1; Karen Patterson, *Depression's Reach Profound*, *DALLAS MORNING NEWS*, June 18, 2003, at 1A.

developments in pharmaceutical interventions for treating mental illness, as well as a societal bias against mental illness in general.¹⁴⁸ Nowhere is this truer than in cases of postpartum mental illness. Women are slow to seek help for postpartum mental illness and the doctors they are most likely to see (their obstetricians and their child's pediatricians) typically do not possess special training in postpartum mental health issues.¹⁴⁹ Moreover, even the mental health experts do not necessarily agree on standard courses of intervention and treatment for postpartum mental illness.¹⁵⁰ Thus, it may take several months or more of treatment before a woman suffering from postpartum mental illness is able to perform her job at full capacity.¹⁵¹

A series of cases involving employment termination and insurance benefits highlights this problem. These cases arise because of the extent to which access to mental healthcare treatment, and to healthcare benefits in general in the United States, is tied either to one's employment or to one's spouse's employment. Thus, loss of employment triggers a loss of access to healthcare. Moreover, employment itself does not guarantee access

148. "Historically, individuals with a mental illness have been treated with contempt, fear, and cruelty [because there was no] medical explanation for [the] individual's strange behavior." See Keith Nelson, Comment, *Legislative and Judicial Solutions for Mental Health Parity: S. 543, Reasonable Accommodation, and an Individualized Remedy Under Title 1 of the ADA*, 51 AM. U.L. REV. 91, 97. Cultures therefore concluded that "mental illness stemmed from parental misdeeds, demonic possession, or simply deficient character." *Id.* Despite medical advances, society continues to harbor a deeply held suspicion both of mental illnesses and the mentally ill. *Id.* at 98-99.

Surveys show that mental disabilities are the most negatively perceived of all disabilities. Individuals with mental illness are denied jobs, refused access to apartments in public housing or entry to places in public accommodation. Behavioral myths have emerged suggesting that persons with mental disabilities are deviant, worth less than 'normal' individuals, are disproportionately dangerous and are presumptively incompetent.

Michael L. Perlin, *The Americans with Disabilities Act: "What's Good is Bad, What's Bad is Good, You'll Find Out When You Reach the Top, You're on the Bottom": Are the Americans with Disabilities Act (and Olmstead v. L.C.) Anything More Than "Idiot Wind"?*, 35 U. MICH. J. L. REFORM 235, 236 (2001) (internal citations omitted) [hereinafter Perlin, *Idiot Wind*]. In 2002, about 13 million Americans suffered from an episode of major depression, according to the Journal of the American Medical Association. It is estimated that depression affects about 34 million Americans at some point in their lives. However, the 2003 study found that only one-third to one-half of people suffering from depression seek treatment. Stigma prevents some people from getting help. People discuss mental illness less openly than they would a physical illness, and therefore do not seek treatment as readily. Moreover, access to treatment is severely restricted in rural areas, and for those who are uninsured or under-insured. See generally *supra* note 147.

149. See Meyer et al., *supra* note 1, at 101.

150. See *id.* at 91.

151. *Id.* at 101-02.

to mental health care, as most employee benefits packages severely limit coverage for mental illness.¹⁵² Consistent with well-established principles, these cases give women seeking relief the burden of establishing that their employer or insurer's policies discriminated against them on statutorily prohibited grounds, such as gender or disability.¹⁵³ As such, the central issue in these cases is the extent to which a policy treats postpartum mental illness differently from other, more generic varieties of mental illness,¹⁵⁴ and the extent to which a woman suffering from postpartum mental illness has a legally recognized disability.

Unlike other civil cases raising postpartum mental illness,¹⁵⁵ these cases contain a considerable amount of judicial analysis of postpartum mental illness. The most curious aspect of these cases is that their analysis of the problem is driven by quirks in the governing law, and is, as a result, almost absurdly disconnected from the nature and impact of postpartum mental illness. Specifically, employers and insurers, in an effort to limit the high costs of health-related employment benefits, tend to choose policies with clauses that limit their liability for insurance claims related to mental disorders.¹⁵⁶ Because so many illnesses manifest with mental as well as physical symptoms, courts have struggled over the interpretation of these clauses.¹⁵⁷ Many courts distinguish between mental disorders that can be traced to "physical" causes and those that are of "psychiatric" origin.¹⁵⁸ "Physical" ailments merit coverage, while those of "psychiatric origin" are excluded.¹⁵⁹ Other courts consider the nature of the treatment provided, and the extent to which the treatment was "psychiatric" in nature.¹⁶⁰ To the extent that treatment is "psychiatric," it is not covered.¹⁶¹ Finally, some

152. See, e.g., Roland Sturm & Rosalie Liccardo Pacula, *Mental Health Parity and Employer-Sponsored Health Insurance in 1999-2000: I. Limits*, 51 PSYCHIATRIC SERVICES 11 (Nov. 2002) available at <http://www.rand.org/health/articles/parity.datapoint1.pdf>.

153. In 1990, Congress passed the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101-12213 (1994). "The ADA was enacted to 'provide strong, consistent, [and] enforceable standards [for] ending discrimination against individuals with disabilities' and to bring such individuals into the economic and social mainstream of American life." Elizabeth A. Pendo, *Disability, Doctors and Dollars: Distinguishing the Three Face of Reasonable Accommodation*, 35 U.C. DAVIS L. REV. 1175, 1178 (2002).

154. See *supra* §§ II A and II B.

155. See generally Zitter, *supra* note 134.

156. See *id.* at 533, 540.

157. *Id.*

158. *Id.* at 540-41.

159. *Id.*

160. *Id.*

161. *Id.*

courts merely determine whether a layman's understanding of the clause would have included treatment for a given illness.¹⁶²

One might think that these tests would bode well for the coverage of postpartum mental illness. There is abundant evidence of the physiological causes of postpartum mental illness, and the standard treatment for postpartum mental illness typically includes medication in addition to talk therapy.¹⁶³ In addition, ignorance about postpartum mental illness is so pervasive that it is hard to imagine what a layman's understanding of this group of disorders would be.¹⁶⁴ While it may appear that these factors would increase the likelihood of allowing coverage of mental illness, postpartum mental illnesses have been excluded from coverage under all three of these tests.

The landmark case on this topic is *Blake v. Unionmutual Stock Life Insurance*.¹⁶⁵ A mother, Pamela Blake, incurred \$33,279.55 in unpaid medical bills following hospitalization and treatment for severe postpartum depression.¹⁶⁶ Her insurance policy limited coverage for mental illness to thirty days of inpatient care and \$1,000 of outpatient treatment.¹⁶⁷ In contrast, the policy provided much more generous coverage for "sickness," which included pregnancy-related claims.¹⁶⁸ Therefore, Ms. Blake argued that her postpartum depression was a physical or organic "sickness" caused by her pregnancy.¹⁶⁹ Her medical expert testified regarding the manner in which postpartum mental illness is brought about by hormonal shifts following pregnancy, and the time-limited nature of postpartum mental illness, which accounted for the fact that, by the time of trial, Ms. Blake was mentally well.¹⁷⁰ Nonetheless, the court rejected this testimony, finding that there was no proof that her illness had an "organic" basis because Ms. Blake's physician never tested her hormone levels.¹⁷¹ Thus, the court denied coverage for her expenses, on the grounds that her postpartum mental illness was mental, rather than physical, in origin.¹⁷²

162. *Id.*

163. See DUNNEWOLD, *supra* note 53, at 50-75.

164. See MEYER & OBERMAN, *supra* note 10, at 11.

165. 906 F.2d 1525 (11th Cir. 1990).

166. *Id.* at 1528.

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.* at 1529.

171. 906 F.2d 1530 (11th Cir. 1990).

172. *Id.*

Reported cases in which a woman claims that she was fired or otherwise discriminated against while suffering from a postpartum mental illness similarly tend to run afoul of general laws governing discrimination in the workplace. For example, consider *Nweke v. Prudential Insurance Co. of America*,¹⁷³ a complicated decision involving a former insurance agent who claimed, among other things, that her company violated prohibitions against both gender and disability-related discrimination in terminating her employment.¹⁷⁴ The plaintiff, Ms. Nweke, presented evidence of derogatory treatment by her supervisor, beginning when she announced her pregnancy, and continuing through her struggles with pregnancy-related and postpartum depression.¹⁷⁵ In addition she adduced ample evidence of her diagnosis with and treatment for acute depression. Ms. Nweke suffered from a major depressive disorder that began during pregnancy and continued during the months after delivery.¹⁷⁶

Concern about retaining her job and her disability benefits prompted her return to work. First, she returned for several days, just one week after she was diagnosed with major depression and placed on psychotropic medication, and then permanently, the day after her disability benefits expired.¹⁷⁷ Upon her return, Ms. Nweke was assigned a new, less-experienced supervisor, who had been promoted to a supervisor position instead of her, because according to Ms. Nweke's manager, the coworker in question was a woman past child-bearing age who would not leave to have children.¹⁷⁸ Several weeks after her return Ms. Nweke was placed on probation due to her "low productivity" in the preceding year (during which she worked only six months).¹⁷⁹ Her ability to meet her target performance goals during probation was hindered by the fact that many of her clients or files were reassigned while she was absent on short-term disability leave.¹⁸⁰ Ms. Nweke struggled and succeeded in meeting her probationary goals for the first two quarters of her

173. 25 F. Supp. 2d 203 (S.D.N.Y. 1998).

174. *Id.*

175. *Id.* at 209.

176. *Id.*

177. *Id.* Because it can take four weeks for the full therapeutic effect of such medications to be realized, there was little reason to expect that Ms. Nweke would have recovered sufficiently to perform her job. See, e.g., ELI LILLY & CO., FLUOXETINE [PROZAC] PACKAGE INSERT (2003), available at <http://pi.lilly.com/prozac.pdf> at 23 (last accessed Oct. 15, 2003) (finding that similar to "other drugs effective in the treatment of major depressive disorder, the full effect [of Prozac] may be delayed until 4 weeks of treatment or longer.")

178. *Nweke*, 25 F. Supp.2d, at 209.

179. *Id.* at 211.

180. *Id.*

probation.¹⁸¹ She failed, however, to meet the target for the third period, and one year after she returned to work, she was dismissed from her job.¹⁸²

In dismissing Newke's complaints on summary judgment, the court held that:

Nweke bears the burden "of presenting evidence that [Prudential] perceived her to be incapable of working a broad range of jobs suitable for a person of her age, experience, and training because of her disability." . . . She has presented no such evidence. Granted, Nweke was terminated because she failed to satisfy the LPP requirements [her probationary productivity quota]. However, there is no indication that Prudential believed that she could not "keep up" because of her depression.¹⁸³

To the extent that Ms. Nweke's testimony is believed, it is not surprising that she ultimately failed to make the adjustment back into a competitive and somewhat hostile workplace. Her depression and the considerable efforts required in parenting a child, particularly in the first year of life, all weighed against the odds that she could overcome the probationary quota requirement. Perhaps the saddest aspect is the fact that it was her effort to succeed that, in the end, doomed her case. Ultimately, it was her struggle to perform as a good employee that undermined her ability to show that she was disabled by her condition.¹⁸⁴ Once again, the lens through which the law views postpartum mental illness misses the full scope of the nature and impact of this set of disorders.¹⁸⁵

181. *Id.*

182. *Id.* at 212.

183. *Id.* at 229. (quoting *Ryan v. Grae & Rybicki, P.C.*, 135 F.3d 867, 872).

184. *Id.* at 228, in which the court found that, because the plaintiff was able to function well enough to return to work, she did not carry her burden in proving that she was "substantially limited in her ability to perform a major life activity."

185. The same is true for the treatment of many other mental illnesses under the ADA or ERISA. See generally Michael L. Perlin, "Make Promises by the Hour": *Sex, Drugs, the ADA, and Psychiatric Hospitalization*, 46 DEPAUL L. REV. 947, 950 (1997) (discussing application of the ADA to individuals in inpatient psychiatric hospitals); Nelson, *supra* note 148 (finding that despite the rise in litigation since the enactment of the ADA on equal coverage of mental illnesses, the overarching conclusion has been that unequal coverage does not constitute illegal discrimination under the ADA); Perlin, *Idiot Wind*, *supra* note 148 (finding that the ADA did not prove to be a panacea for citizens with mental disabilities).

IV. POSTPARTUM MENTAL ILLNESS AND THE STRUCTURE OF MOTHERHOOD

As we have seen, generally speaking, the law governing mental illness does not prescribe long inquiries into a person's circumstances, or the social or cultural factors that might give rise to or exacerbate a particular mental disorder. Instead, the law confines itself to narrow, binary inquiries regarding a person's mental state.¹⁸⁶ Is she sane? Was she competent? Is she disabled? For the most part, these inquiries bring little legal relief to women whose postpartum mental illness got them into legal difficulties. More likely than not, women suffering from postpartum mental illness will not be sick enough to have their crimes or mistakes excused, nor will they be able to demand accommodation on the basis of their disability. Yet a close examination of the facts that underlie these cases demonstrates that the legal inquiry often misses the most compelling evidence. In many cases, the fact of the woman's mental illness, in conjunction with her social, economic, and cultural circumstances, argues in support of mitigating her culpability for her criminal acts, or of diminishing her responsibility for her civil wrongs.¹⁸⁷

There is no readily apparent solution to this problem. A move by the courts to embrace a postpartum syndrome defense, in the criminal context, might help a small percentage of the women who commit criminal acts while suffering from postpartum mental illness.¹⁸⁸ There are women whose postpartum psychosis renders them legally insane at the time they commit a crime, and they should have the benefit of this defense. Yet experience with other "syndromes" (e.g. battered women's syndrome, rape trauma syndrome) teaches us that these syndrome-defenses are far from a panacea.¹⁸⁹

186. See MEYER & OBERMAN, *supra* note 10, at 70-71.

187. See, e.g., Meyer & Spinelli, *supra* note 1, at 95 (discussing exculpation of criminal defendants; *Id.* at 97-101 (discussing women's mental illness in civil cases).

188. See Meyer & Spinelli, *supra* note 1, at 180-81 (providing discussion of effects of judicial recognition of a postpartum syndrome defense in criminal cases).

189. Women's defenses such as battered women's syndrome or rape trauma syndrome recognize women's unique biology and socialization within the legal system. Some feminists are critical of the use of women's legal defenses because they invoke traditional notions that women are in need of protection, and create a notion of an "ideal" abused woman. They are concerned that such defenses might be seen as evidencing women's biological inferiority to men. Arguments against using the battered women's syndrome as a defense include the "tendency for the experiences of the abused women to be overshadowed by expert testimony; the negative ramifications of syndromization; and the boundaries imposed by creating the 'ideal' abused woman." See Meyer et al., *supra* note 1, at 97 (citing Lori G. Beaman, *Women's Defenses: Contextualizing Dilemmas of Difference and Power*, in *WOMEN AND CRIMINAL*

They likely will be interpreted narrowly, thus excluding from coverage those women whose symptoms are in some manner atypical. Moreover, the vast majority of women who get ensnared with the law when suffering from postpartum mental illness will not be deemed sick enough, and thus, will not be helped by a court's willingness to recognize postpartum psychosis as a variety of the insanity defense.¹⁹⁰

An alternative model for broadening the legal lens through which the law views women with postpartum mental illness is found in criminal law, under the contemporary partial defense of extreme emotional disturbance.¹⁹¹ This standard, found in the Model Penal Code, reflects a modernization of the old "heat of passion" defense to homicide charges.

Today, the heat of passion defense uses an "objective standard" that requires juries to determine whether the reasonable person would have been sufficiently impassioned by the provocation to kill.¹⁹² The Model Penal Code goes one step further and adds a subjective component.¹⁹³ Under the Model Penal Code, juries look at whether there was a reasonable explanation for the extreme emotional disturbance.¹⁹⁴ But the Code also requires the jurors to determine the reasonableness of the defendant's response to her circumstances, from her viewpoint.¹⁹⁵ Its underlying premise is that people

JUSTICE, 9(3), 87-88 (1998)). See also Hope Toffel, Note, *Crazy Women, Unharmed Men, and Evil Children: Confronting the Myths about Battered People Who Kill Their Abusers, and the Argument for Extending Battering Syndrome Self-Defenses to All Victims of Domestic Violence*, 70 S. CAL. L. REV. 337 (1996); David L. Faigmen & Amy J. Wright, *The Battered Woman Syndrome in the Age of Science*, 39 ARIZ. L. REV. 67, 101, n.235 (1997). Other critics argue that the application of rape trauma syndrome and the battered women's syndrome favor women, a politically potent group who are easily viewed as victims, while disfavoring the bulk of criminal defendants. For example, young African-American males living in a world of violence are often not allowed to introduce social science evidence in their defense. See Janet C. Hoffel, *Essay: The Gender Gap: Revealing Inequities in Admission of Social Science Evidence in Criminal Cases*, 24 U. ARK. LITTLE ROCK L. REV. 41 (2001).

190. See MEYER & OBERMAN, *supra* note 10, at 70-73.

191. The manslaughter provision of the Model Penal Code states that criminal homicide constitutes manslaughter when it is "committed under the influence of extreme mental or emotional disturbance for which there is reasonable explanation or excuse. The reasonableness of such explanation or excuse shall [sic] be determined from the viewpoint of a person in the actor's situation under the circumstances as he believes them to be." MODEL PENAL CODE § 210.3(1)(b). The Model Penal Code, which has been adopted by a substantial minority of jurisdictions, thus introduces a subjective component into the extreme emotional disturbance defense. Oberman, *Mothers Who Kill*, *supra* note 73, at 86-88.

192. See Oberman, *Mothers Who Kill*, *supra* note 73, at 86-87.

193. *Id.* at 86.

194. MODEL PENAL CODE § 210.3(1)(b).

195. Joshua Dressler, *Rethinking Heat of Passion: A Defense in Search of a Rationale*, 73 J. CRIM. L. & CRIMINOLOGY 421, 443 (1982) (noting that "[t]he defense is theoretically applicable even if the victim was not a provoker").

sometimes intentionally act in a criminal manner (i.e. killing), but extenuating circumstances exist that mitigate their culpability.¹⁹⁶

Interestingly, this is the same sentiment that underlies the Infanticide Acts, which are predicated upon a scientifically improbable belief that “the balance of her [a woman’s] mind” may be disturbed for a period of twelve months following childbirth for reasons deriving from labor and delivery or lactation.¹⁹⁷ In effect, however, the Infanticide Acts recognize as unique the circumstances that might lead a mother to harm her child in the first year of its life. As a result, they limit the severity of the legal charge to manslaughter, and they implicitly endorse non-incarceration, and sentences involving probation and counseling.¹⁹⁸

I have no delusions that the extreme emotional disturbance defense, adopted only by a handful of jurisdictions in the homicide context, and never used in defending a filicide case, will be widely adopted as a partial defense in postpartum mental illness cases. Nor do I offer this partial defense as an alternative to using postpartum syndromes as full excuses in those cases in which medical diagnosis and expert testimony demonstrate that a woman was rendered insane and/or legally incompetent by virtue of her postpartum mental illness.

Instead, the extreme emotional disturbance approach to understanding postpartum mental illness is interesting, in large part, as a thought-experiment. In examining the extent to which the woman’s actions were responsive to her environment, we are asked to consider the circumstances that contributed to the terrible thing that occurred. Rather than confining us to a scientific model, and to irrelevant questions such as the extent to which her postpartum mental illness is of physical or psychiatric origin, the extreme emotional disturbance approach lets us ask why this woman failed to behave as the law would have her behave.

There are obvious problems with such an approach. First, the observation that criminal or other aberrant behavior may result from failings in an individual’s social, economic or cultural background applies far beyond the scope of postpartum mental illness. Thus, allowing such factors to mitigate legal responsibility could destabilize the entire legal system. Moreover, such an approach is ripe for abuse, in that women will invoke postpartum mental illness as an excuse for a host of criminal and otherwise problematic acts

196. *Id.* at 442-43.

197. See *supra* note 10, at 11 (regarding the debate on this issue among U.S. experts).

198. See MEYER & OBERMAN, *supra* note 10, at 11.

that, in reality, had little to do with their having had a child, let alone a postpartum mental illness. Finally, to the extent that the legal system comes to embrace the notion that a woman may be destabilized during the first year following the birth of a child, there is a credible threat that all women will be treated as less than fully competent legal citizens.¹⁹⁹

My response to the first of these concerns is that indeed, it may be the case that our entire jurisprudence of criminal responsibility needs to be reworked in view of contemporary understandings of the interplay between mental illness and human behavior. Such a task is well beyond the scope of this article. Nevertheless, women suffering from postpartum mental illness should not be held hostage by such a fear. To the extent that one understands postpartum mental disorders as legitimate manifestations of mental illness, responsive to either or both the physiological and the socio-cultural realities affecting a particular mother, it is unjust and illegitimate to ignore available information regarding the nature and scope of these illnesses.

Next, there is the fear that recognizing the impact of external factors in shaping the legal system's response to a woman suffering from postpartum mental illness will lead to the widespread abuse of such 'excuses.' The reply to this concern is that the abuse of postpartum mental illness as an 'excuse' already is happening. There have been cases in which women have sought to blame their role in an armed robbery or drug deal on the fact that they were suffering from postpartum mental illness at the time that they committed the crime.²⁰⁰ To date, judges have been quite astute in reviewing the medical information offered in support of such defenses. There is little reason to believe that they would be unable to discern the legitimacy of postpartum mental illness-related

199. Exceptionalizing women threatens to deny them the "same capacity for self-governance that is attributed to men." Anne M. Coughlin, *Excusing Women*, 82 CAL L. REV. 1, 6 (1994). Professor Coughlin elaborates on this point, noting that:

If women achieve leniency by exploiting, rather than challenging and revising, the existing categories of excuse, they not only leave the theory of criminal responsibility intact, they also leave intact the competing life stories that the theory constructs and makes available for excused actors and responsible human beings to experience. The experience of the responsible actor is one that resonates powerfully in our culture and, by securing excuse, women assure that it is one that will continue to be denied to them.

Id. at 25 (internal citations omitted).

200. See *Paul v. State*, 2002 WL 1902199 (Ga. App. 2002) (Affirming conviction of armed robbery defendant despite assertion that Defendant was suffering from postpartum depression); *People v. Batcher*, 736 N.Y.S.2d 920 (N.Y. App. Div. 2002) (affirming conviction of drug-dealing defendant despite assertion of postpartum depression).

claims, even in the event that a greater number of women elected to invoke such claims in their legal actions.

Finally, there is the concern that all women would be pathologized in the event that the legal system came to embrace the notion that mental illness may be due, in part, to the conditions under which a mother attempts to raise her child. I believe that, should this unlikely event come to pass, it actually may be salutary for society as a whole, and in particular for mothers. Indeed, if there is one lesson to be gleaned, it is that so very much of what goes wrong at the intersection of motherhood, madness and the law is foreseeable and often preventable. To the extent that the legal system considers the circumstances that shape the fabric of the daily life of its litigants who raise postpartum mental illness-related claims, it likely will bring into focus the very factors that led to her legal troubles. In so doing, the law might be able to nudge society in the direction of change, by forcing us to focus on what we can do to alter the circumstances that give rise to the tragedies associated with postpartum mental illness.