William Mitchell Law Review

Volume 32 | Issue 1 Article 9

2005

The Conflicted Treatment of Postpartum Psychosis under Criminal Law

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THE CONFLICTED TREATMENT OF POSTPARTUM PSYCHOSIS UNDER CRIMINAL LAW

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I. INTRODUCTION

A. *The Question of Postpartum Psychosis*

In 1987, Sheryl Massip killed her six-week-old son. She first threw him into oncoming traffic, then hit him on the head, and finally ran him over with her own car.[1] Prior to these actions, Massip had suffered from hallucinations, severe depression, and thoughts about suicide.[2] She initially claimed that the child had been kidnapped, but later admitted to killing him.[3] Although a California jury found her guilty of second-degree murder,[4] the judge presiding over the case overturned the verdict two months later and entered an acquittal on insanity grounds.[5] He required Massip to undergo at least one year of outpatient therapy to treat the postpartum psychosis,[6] even though her symptoms had disappeared given the span of time between the death of her son and the trial.[7] On the prosecution's appeal, the appellate court upheld the judge's finding of insanity on the basis of postpartum psychosis.[8]

In 2001, Andrea Yates drowned her five children six months after the birth of her youngest child.[9] Yates had suffered from a history of postpartum illness,[10] beginning with voices she heard soon after the birth of her first child telling her to stab her newborn child.[11] Her severe postpartum depression after the birth of her fourth child in 1999 led to two suicide attempts and subsequent hospitalization.[12] After the birth of her fifth child, she

1. Eric Lichtblau, *Appeal Argued in Postpartum Psychosis Case*, L.A. TIMES, May 24, 1990, at B1.
2. People v. Massip, 271 Cal. Rptr. 868, 869 (Ct. App. 1990).
3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.*
7. CHERYL L. MEYER & MICHELLE OBERMAN, MOTHERS WHO KILL THEIR CHILDREN: UNDERSTANDING THE ACTS OF MOMS FROM SUSAN SMITH TO THE "PROM MOM" 12 (2001). See Section II.B below for a discussion of the defining characteristics of postpartum psychosis.
8. *Massip*, 271 Cal. Rptr. at 869.
9. Margaret G. Spinelli, *Introduction* to INFANTICIDE: PSYCHOSOCIAL AND LEGAL PERSPECTIVES ON MOTHERS WHO KILL xvi-xvii (Margaret G. Spinelli, ed., 2003).
10. *Id.* at xvii.
11. *Id.*
12. Anne Belli Gesalman, *Signs of a Family Feud*, NEWSWEEK, Jan. 21, 2002, at 41.

became almost catatonic and was hospitalized again but discharged.[13] Her physician discontinued her antipsychotic doses.[14] Two weeks later, Yates committed the drownings and then called both her husband and the police.[15] Although Yates raised an insanity defense based on a postpartum psychosis diagnosis, a Texas jury found her guilty of five counts of murder, ultimately rejecting the death penalty in favor of a life sentence.[16]

B. The Questions Postpartum Psychosis Raises

The women in these cases, the mental illness afflicting them, and the differing court and jury treatments they received raise a number of questions concerning how society and the law approach postpartum illness, particularly postpartum psychosis. One question is how to identify the causes of, define, and delimit the boundaries of postpartum illnesses and postpartum psychosis.[17] Another question is how the biological basis of postpartum psychosis implicates ideas of feminism, motherhood, and gender equity.[18] The nature of postpartum psychosis also raises significant questions about the present standards of the cognitive test applied to the insanity defense in most states, and whether those existing legal frameworks adequately capture postpartum psychosis or whether they create a gap through which women suffering from postpartum illness fall.[19]

C. Potential Solutions to the Criminal Treatment of Postpartum Psychosis

This article will address these questions and explore a variety of solutions to the problem of addressing postpartum psychosis. One solution is to maintain the status quo system.[20] This "solution" determines that defendants suffering from postpartum psychosis who meet the high bar of the cognitive test for successfully raising an insanity defense are properly excluded from punishment, but

13. Spinelli, *supra* note 9, at xvii.
14. *Id.*
15. Cheryl L. Meyer & Margaret G. Spinelli, *Medical and Legal Dilemmas of PostPartum Psychiatric Disorders*, *in* INFANTICIDE: PSYCHOSOCIAL AND LEGAL PERSPECTIVES ON MOTHERS WHO KILL, *supra* note 9, at 176.
16. Spinelli, *supra* note 9, at xvii.
17. *See infra* Part II.
18. *See infra* Part III.
19. *See infra* Part IV.
20. *See infra* Part V.A.

those who do not meet the test are properly located within the existing criminal justice system. An alternative approach is to implement statutory provisions such as those enacted in the United Kingdom and many European countries, which provide for lesser charges or sentencing for crimes committed by women within a certain time period after the birth of a child.[21] Another option is to implement a different version of the insanity test for postpartum psychosis based on the unique characteristics of the illness and the limited pool of individuals who can have this mental illness.[22] The last option this article discusses is to keep postpartum psychosis cases within the criminal system, but to either reduce the criminal sentence or remove the sentencing phase to the mental health treatment system rather than working within the present system of incarceration.[23]

II. IDENTIFYING AND DEFINING POSTPARTUM PSYCHOSIS

A. A Brief History of Postpartum Illness

Diagnoses of postpartum illness stem from as far back as Hippocrates in the fourth century, B.C., who noted in one woman recently delivered of twins a "severe case of insomnia and restlessness that began on the sixth day" after the birth.[24] Postpartum illness falls along a spectrum researchers have divided into three different categories: postpartum blues, postpartum depression, and postpartum psychosis.[25]

B. Types of Postpartum Illness

Postpartum blues, otherwise known as "baby blues"[26] or "maternity blues,"[27] affects between an estimated twenty-five to

21. *See infra* Part V.B.
22. *See infra* Part V.C.
23. *See infra* Part V.D.
24. *See* SHARON L. ROAN, POSTPARTUM DEPRESSION: EVERY WOMAN'S GUIDE TO DIAGNOSIS, TREATMENT & PREVENTION 24 (1997).
25. Velma Dobson & Bruce Sales, *The Science of Infanticide and Mental Illness*, 6 PSYCHOL. PUB. POL'Y & L. 1098, 1104 (2000).
26. Michael O'Hara, *Post-partum "Blues," Depression, and Psychosis: A Review*, 7 J. PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY 205, 206 (1987).
27. Michael L. Perlin, *"She Breaks Just Like a Little Girl": Neonaticide, the Insanity Defense, and the Irrelevance of "Ordinary Common Sense,"* 10 WM. & MARY J. WOMEN & L. 1, 14-15 (2003).

eighty-five percent of women during the first six to eight weeks after they deliver a child.[28] Because this condition occurs so commonly, physicians, psychiatrists, and laypeople alike consider it a "normal" part of the childbirth process.[29] Its impact is largely "trivial" and "fleeting,"[30] involving a range of minor presentations of irritability, diminished appetite, mood swings, crying jags, anxiety, disorientation, and fatigue,[31] usually beginning the first few days after childbirth and rarely continuing past two weeks.[32] Postpartum blues do not impair a woman's sense of judgment, and, as mentioned, are considered a normal element of the childbirth process and not a mental disorder or a disease.[33]

Postpartum depression affects between an estimated five to twenty percent of new mothers.[34] Postpartum depression is considered to be a "clinical depression occurring during the weeks and months following childbirth."[35] It usually appears within the first six months following childbirth.[36] It presents symptoms including disinterest, sleep problems, fatigue, decision-making difficulties, guilt, thoughts of suicide, feelings of inadequacy and hopelessness, and lack of love for the new child.[37]

Postpartum psychosis occurs much more rarely—one or two of every thousand new mothers,[38] or approximately 0.2% of new mothers, will have episodes of psychosis in which they experience delusions or hallucinations, severe depression, disordered thought

28. Dobson & Sales, *supra* note 25, at 1104. The range of women postpartum blues affects varies widely from study to study. One study places the range at fifty to eighty percent. Anne Damante Brusca, *Postpartum Psychosis: A Way Out for Murderous Moms?*, 18 HOFSTRA L. REV. 1133, 1133 (1990). Another lists the range at fifty percent. Brice Pitt, *Maternity Blues*, 122 BRIT. J. PSYCHIATRY 431, 433 (1973).

29. Brusca, *supra* note 28, at 1141.

30. *Id.*

31. Dobson & Sales, *supra* note 25, at 1104; Jessie Manchester, *Beyond Accommodation: Reconstructing the Insanity Defense to Provide an Adequate Remedy for Postpartum Psychotic Women*, 93 J. CRIM. L. & CRIMINOLOGY 713, 719 (2003).

32. Dobson & Sales, *supra* note 25, at 1104; Manchester, *supra* note 31, at 719.

33. O'Hara, *supra* note 26, at 207-09.

34. Some sources estimate ten to fifteen percent of new mothers develop postpartum depression. Brusca, *supra* note 28, at 1143; O'Hara, *supra* note 26, at 210. Another study estimates between five and twenty percent. Dobson & Sales, *supra* note 25, at 1105.

35. Dobson & Sales, *supra* note 25, at 1105.

36. MEYER & OBERMAN, *supra* note 7, at 77.

37. Brusca, *supra* note 28, at 1143; Dobson & Sales, *supra* note 25, at 1105; O'Hara, *supra* note 26, at 217.

38. MEYER & OBERMAN, supra note 7, at 12.

processes, and deviant behavior.[39] Some disordered thought processes expressed by mothers suffering from postpartum psychosis include seeing a room upside down, fearing conspiracies to kill her child, and obsessive thoughts about ways in which to harm the child herself.[40] Postpartum psychosis typically arises within the first two weeks after childbirth, and it generally requires hospitalization and aggressive medical treatment.[41]

C. Postpartum Psychosis as a Mental Disorder

Postpartum psychosis is not categorized in the Diagnostic and Statistical Manual of Mental Disorders–Fourth Edition (DSM-IV) as its own diagnosis.[42] Instead, it is included within the general "mood disorders" category,[43] and is not considered, within the DSM-IV, to be distinguishable from non-postpartum psychoses,[44] although the DSM-IV does refer to a "postpartum onset specifier."[45] The DSM-IV states that the symptoms of postpartum depression do "not differ from the symptomatology in nonpostpartum mood episodes and may include psychotic features."[46] As an affective disorder, postpartum psychosis is cyclical and can reoccur with subsequent pregnancies.[47] An estimated one in seven to one in four subsequent pregnancies can spark another postpartum psychotic episode.[48] The fact that postpartum psychosis does not appear in the DSM-IV as a separate condition is problematic because it does not separate the psychosis from other psychotic disorders.[49]

39. KATHARINA DALTON, DEPRESSION AFTER CHILDBIRTH 84-90 (3rd ed. 1996); MEYER & OBERMAN, *supra* note 7, at 12; Dobson & Sales, *supra* note 25, at 1106.

40. Michele Connell, *The Postpartum Psychosis Defense and Feminism: More or Less Justice for Women?*, 53 CASE W. RES. L. REV. 143, 146 (2002) (summarizing patient stories in DALTON, *supra* note 39).

41. DALTON, *supra* note 39, at 85; Dobson & Sales, *supra* note 25, at 1106-22.

42. Connell, *supra* note 40, at 146.

43. Manchester, *supra* note 31, at 722.

44. O'Hara, *supra* note 26, at 217.

45. Manchester, *supra* note 31, at 722.

46. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 386 (4th ed. 1998).

47. Brusca, *supra* note 28, at 1145.

48. *Id.* at 1146.

49. One commentator suggests that this failure to categorize postpartum psychosis as a separate disorder reflects how "male-centered models" of medicine, law, and language marginalize women suffering from postpartum disorders and fail to recognize the medical attention they require. Laura E. Reece, Comment, *Mothers Who Kill: Postpartum Disorders and Criminal Infanticide*, 38 UCLA L. REV. 699, 710-11 (1991).

D. The Uncertain Cause(s) of Postpartum Psychosis

One problem is that the exact cause of postpartum illness, including postpartum psychosis, has not yet been determined, and medical experts do not agree on its possible causes.[50] Hippocrates attributed it to an "excessive blood flow to the brain."[51] At the time of the Infanticide Act of 1938 in the United Kingdom, physicians explained the disorder as the effect of lactation[52]creating hormonal aftereffects to the labor and delivery process.[53] Other studies have pointed to the endocrinal changes in the body following pregnancy and childbirth,[54] the levels of progesterone, estradiol, and estrogen in the body,[55] or the changes in tryptophan metabolism,[56] but these results have been inconclusive.[57]

An additional complication for postpartum psychosis is the role external aggravating factors can have. Some studies have shown that, for instance, "the level of support that the mother receives from the father and family" during the months following the birth of a child is "more determinative" of postpartum depression than other demographic or biological factors.[58] One study has noted that mothers suffering from postpartum psychosis generally fit the mold of "devoted mothers,"[59] but an obsession with being a "good mother" causes insecurity about "who they are and their parenting ability" that becomes a severe delusion and slips into a psychosis.[60] Another study has found that "prepregnancy stressors such as unplanned pregnancy, marital discord, poor identity with the mother, prenatal anxiety, and emotional problems" may be contributing factors, but "do not by themselves

50. Connell, *supra* note 40, at 148.
51. Meyer & Spinelli, *supra* note 15, at 168.
52. Katherine O'Donovan, *The Medicalisation of Infanticide*, 1984 CRIM. L. REV. 259, 261 (1984).
53. *Id.* at 262.
54. DALTON, *supra* note 39, at 68.
55. J.B. Murray & L. Gallahue, *Postpartum Depression*, 113 GENETIC SOC. & GEN. PSYCHOL. MONOGRAPHS 193, 203 (1987).
56. Reece, *supra* note 49, at 713.
57. Steven Lee, *Postpartum Emotional Disorders*, 1984 MED. TRIAL TECH. 286, 291 (1984).
58. O'Hara, *supra* note 26, at 214.
59. Susan Ayres, *"[N]ot a Story to Pass On": Constructing Mothers Who Kill*, 15 HASTINGS WOMEN'S L.J. 39, 107 (2004) (quoting interview with Cheryl Meyer from *60 Minutes* (CBS television broadcast Dec. 9, 2001)).
60. *Id.*

account for the etiology of postpartum mental disorders."[61] It remains unclear, however, whether social support structures can actually prevent postpartum mental illness, or whether such structures "simply protect[] mothers and their children against the potential threat posed by such illnesses."[62] Postpartum psychosis is also "quite difficult to treat."[63]

III. SITUATING POSTPARTUM PSYCHOSIS IN THE CONTEXT OF CONCEPTS OF MOTHERHOOD AND FEMINIST THEORY

A. Perceptions of Motherhood—Good, Bad, and Mad

Historically, women, at least in European and American society, have been defined along one of two binaries—either as the "temptress" figure, or as a pure mother figure[64]—the Eve and the Madonna. The mother figure encompasses a certain set of attributes—namely self-sacrifice, compassion, and caring[65]—that define her as a "good mother" and, synonymously, a "good woman."[66]

Such treatment of women suffering from postpartum psychosis—or even women who commit infanticide for other reasons—continues today. Often, the media—and the jury—judge a woman who has killed her child or children while suffering from postpartum psychosis along preconceived ideas of "good" or "bad" womanhood. One commentator has posited that the killing of one's child is an extreme social transgression because an "infanticidal mother directly challenges male authority, and the male-dominant family structure."[67] Such a challenge requires a

61. Brusca, *supra* note 28, at 1146-47. *See also* John J. Harding, *Postpartum Psychiatric Disorders: A Review*, 30 COMPREHENSIVE PSYCHOL. 109, 109-12 (1989); Valerie Thurtle, *Post-natal Depression: The Relevance of Sociological Approaches*, 22 J. ADVANCED NURSING 416, 416-24 (1995).

62. Michelle Oberman, *"Lady Madonna, Children at Your Feet": Tragedies at the Intersection of Motherhood, Mental Illness and the Law*, 10 WM. & MARY J. WOMEN & L. 33, 35 (2003).

63. *Id.* at 40.

64. LITA LINZER SCHWARTZ & NATALIE K. ISSER, ENDANGERED CHILDREN: NEONATICIDE, INFANTICIDE, AND FILICIDE 3 (2000); Sandy Meng Shan Liu, *Postpartum Psychosis: A Legitimate Defense for Negating Criminal Responsibility?*, 4 SCHOLAR 339, 377 (2002).

65. SCHWARTZ & ISSER, *supra* note 64, at 3; Liu, *supra* note 64, at 377.

66. SCHWARTZ & ISSER, *supra* note 64, at 3; Liu, *supra* note 64, at 377.

67. Karen Lewicki, *Can You Forgive Her?: Legal Ambivalence Toward Infanticide*, 8

mother to be defined in a binary way—either mad or bad.[68] Women who generally conform to stereotypical gender norms but who commit the crime of killing their children are seen as "mad," whereas women who do not conform to such norms and kill their children are seen as "bad."[69] A mother society views (or the press depicts) as bad generally receives a more severe sentence than does a mother society views as mad in this context.[70]

During the Yates trial, for instance, the press focused heavily on how Yates had been an "ideal" wife and mother prior to the murders. She was a housewife who was caring for and home-schooling her five children. She was also caring for her father, who was afflicted with Alzheimer's. In a *60 Minutes* interview, her husband noted that "she's a terrific mother that loved the children," and commentator Ed Bradley noted that the Yateses looked "like a normal, happy family."[71] Susan Ayres sees such comments and such an opinion of Yates as a superb mother as "specularizing" her in a projection of the male ego,[72] as an ideal mother figure. She comments that the media circuses surrounding postpartum psychosis infanticides tend to focus on those mothers who were "unlikely candidates to kill their children"[73] because they are not "bad," not underprivileged, and not "mad" other than the manifestation of postpartum psychosis.[74] The effect such stereotypes and preconceptions about womanhood and motherhood have on how women suffering from postpartum psychosis are perceived add to the complexity of how postpartum psychosis should be treated within the legal system.

B. Feminist Theory Positions on Assimilation and Difference

Some commentators have argued that accommodating postpartum psychosis as a legitimate defense that should merit "special treatment" recognizes the difference between men and

S. CAL. INTERDISC. L.J. 683, 685 (1999).

68. Ayres, *supra* note 59, at 58-59.

69. Perlin, *supra* note 27, at 11. *See also* SCHWARTZ & ISSER, *supra* note 58, at 3.

70. Ayres, *supra* note 59, at 72 (citing Michelle Oberman, *Understanding Infanticide in Context: Mothers Who Kill, 1870-1930 and Today*, 92 J. CRIM. L. & CRIMINOLOGY 707, 714 (2002)).

71. *Id.* at 105.

72. *Id.*

73. *Id.* at 106.

74. *Id.* at 106-07.

women in far-reaching and detrimental ways. Focusing on these differences allows the legal resolution of "matters of great importance and complexity by the simplistic, reflexive assertion that women and men are 'simply not similarly situated.'"[75] Patricia Pearson suggests that focusing on special treatment for women ultimately will result in diminished rights for women.[76] She notes that postpartum psychosis was used as a nineteenth-century rationale for denying women the vote.[77]

Other commentators have suggested that such an approach would threaten to treat women in general as "less than fully competent legal citizens."[78] Commentator Anne Coughlin, for instance, argues that creating a difference in treatment of men and women can deny women the "same capacity for self-governance that is attributed to men."[79] "The experience of the responsible actor is one that resonates powerfully in our culture and, by securing an excuse, women assure that it is one that will continue to be denied to them," she claims.[80] Dorothy Roberts argues that a defense based on a mental disorder experienced only by women "risk[s] misdiagnosing the causes of some women's crimes."[81] Further, Deborah Denno points out that using a "gender-based standard for punishment or defenses would most likely incorporate gender difference[s] in the prevalence or prediction of crime,"[82] creating a system of profiling that would work to the detriment of women by "perpetuat[ing] sexism and negative stereotypes of women."[83]

In part, these arguments reflect concerns about medicalizing women's negative experiences within an oppressive social system.

75. Connell, *supra* note 40, at 166 (quoting Wendy W. Williams, *The Equality Crisis: Some Reflections on Culture, Courts, and Feminism*, 14 WOMEN'S RTS. L. REP. 151, 164 (1992)).

76. *Id.* at 167 (citing PATRICIA PEARSON, WHEN SHE WAS BAD: VIOLENT WOMEN AND THE MYTH OF INNOCENCE 91 (Viking Penguin 1997)).

77. *Id.*

78. Oberman, *supra* note 62, at 66.

79. Anne M. Coughlin, *Excusing Women*, 82 CAL. L. REV. 1, 6 (1994), *cited in* Oberman, *supra* note 62, at 66 n.199.

80. *Id.* at 25, *cited in* Oberman, *supra* note 62, at 66 n.199.

81. Dorothy E. Roberts, *The Meaning of Gender Equality in Criminal Law*, 85 J. CRIM. L. & CRIMINOLOGY 1, 10 (1994).

82. Manchester, *supra* note 31, at 748-49 (quoting Deborah W. Denno, *Gender, Crime, and the Criminal Law Defenses*, 85 J. CRIM. L. & CRIMINOLOGY 80, 123 (1994)).

83. *Id.* at 749; Roberts, *supra* note 81, at 2.

Roberts argues that women should not need to claim insanity simply because "the law does not recognize the stifling social conditions that contributed to their criminal acts."[84] Within this "stifling" legal system, a postpartum psychosis defense claim "reflects society's reluctance to address women's problems unless they are explained as illnesses."[85]

These arguments for an assimilative approach would not permit a different treatment of women suffering from postpartum psychosis than that of any other defendant suffering from a psychotic disorder. They argue an assimilative approach is necessary, in order to avoid implicating gender difference as a rationale for creating other legally recognized differences to the detriment of women, to avoid a presumption of insanity or mental instability among women who recently have gone through childbirth, and to avoid characterizing social problems and inequities as mental or medical problems and thereby evading the need to improve social structures for women.

The problem with such an approach is that it assumes a level playing field between the genders when, in fact, the present system is not level at all. "If the current standard by which women are being judged is resulting in injustice," one commentator argues, "then correcting that standard does not mean that women are treated more leniently than men. It means that they are treated equally."[86] The purpose of gender sameness assumes an element of absurdity when the center of controversy is a mental disorder that someone can experience only when she has given birth—something out of the realm of possibility for men. So when the media covering the Yates case talked of her psychosis as "transcend[ing] gender,"[87] one commentator notes, "to argue that the Yates case 'transcends gender' is to miss the basic point that Andrea Yates' defense depends upon a female-specific psychiatric condition."[88]

In addition, one area in which the law specifically acknowledges a difference between men and women is precisely in the pregnancy arena. Women who are pregnant or who have

84. Roberts, *supra* note 81, at 11.
85. *Id.*
86. Connell, *supra* note 40, at 167.
87. *Id.* at 153 (quoting Sally Satel, *The Newest Feminine Icon—A Killer Mom*, WALL ST. J., Sept. 11, 2001, at A26).
88. *Id.*

recently given birth are given "special treatment" that, in actuality, levels the playing field by placing their employment situation on a par with that of men through the Pregnancy Discrimination Act of 1978, for instance.[89] The Act states that "women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes."[90] It is the recognition and specific treatment of the difference between the genders that allows for the sameness of the result. From this perspective, recognizing a related difference in postpartum psychosis—also affecting women who recently have experienced the childbirth process—is not a significant carve-out in gender difference. In addition, there is no "slippery slope" because the women who could come within this legal carve-out constitute a very small pool bounded by very specific criteria.

IV. POSTPARTUM PSYCHOSIS AND ITS PRESENT RELATIONSHIP TO THE INSANITY DEFENSE

Societal and legal treatment of infanticide in general changes like "a roller coaster—moving from a lenient-to-moderate period to a severe period, then changing to a very lenient period . . . ."[91] In recent years, however, juries have shown less leniency than earlier in the century.[92]

The majority of states employ a cognitive test for determining whether or not someone is legally insane as a defense against a criminal charge. About half of the states employ the M'Naghten test, which requires a showing that, at the time of the criminal offense, the mental disease or disorder in question prevented the defendant from knowing the nature or quality of her act, or knowing the wrongfulness of her act.[93] About half of the states use the American Law Institute (ALI) test, by which the defendant is considered insane if, at the time of the offense, as a result of mental disease or defect he lacked substantial capacity either to appreciate the criminality/wrongfulness of his conduct or to

89. 42 U.S.C. § 2000e (2000).

90. *Id.* § 2000e(k).

91. Norman J. Finkel et. al., *Commonsense Judgments of Infanticide: Murder, Manslaughter, Madness, or Miscellaneous?*, 6 PSYCHOL. PUB. POL'Y & L. 1113, 1115 (2000).

92. Ayres, *supra* note 59, at 72.

93. RICHARD MORAN, KNOWING RIGHT FROM WRONG: THE INSANITY DEFENSE OF DANIEL MCNAUGHTAN 2 (1981).

conform his conduct to the requirements of the law.[94] Although the use of "appreciate" as opposed to "know" appears to lower the bar somewhat from an "all or nothing" approach to cognition, it still creates a gap between the manifestation of postpartum psychosis and the requirements of the cognitive test.

A key problem is that postpartum psychosis may significantly impair a woman's mental stability while still not rising to the level of an irresistible impulse—thereby not meeting a volitional test, should it apply—and still not meeting the cognitive test required under most states to qualify as an insanity defense. Nearly all postpartum psychosis sufferers understand the moral wrongness of killing their child(ren).[95] At the same time, "[t]here 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."[96]

John Hinckley Jr.'s attempted assassination of President Ronald Reagan and his subsequent acquittal by reason of insanity led many states to adopt a narrow understanding of the insanity defense. For instance, Idaho, which previously followed the ALI rule, eliminated the insanity defense altogether after Hinckley's acquittal.[97] As a result of such narrow interpretations of the insanity defense, "[m]ore likely than not, women suffering from postpartum mental illness will not be sick enough to have their crimes or mistakes excused . . . ."[98]

Texas law, for instance, recognizes only a narrow definition of the insanity defense.[99] The prosecutor needs to establish only that the defendant knew the difference between right and wrong.[100] This became easy for the prosecutor to establish in the Yates case because she herself called the police after drowning her children to report the act.[101] Four of the jurors in the case who were later interviewed noted that Yates' confession indicated that she was

94. *Id.*
95. Oberman, *supra* note 62, at 38.
96. *Id.* at 47.
97. Jessie Manchester, Comment, *Beyond Accommodation: Reconstructing the Insanity Defense to Provide an Adequate Remedy for Postpartum Psychotic Women*, 93 J. Crim. L. & Criminology 713, 746 (2003); *see also* IDAHO CODE ANN. § 18-207 (2005).
98. Oberman, *supra* note 62, at 63.
99. Reanta Salecl, *The Real of Crime: Psychoanalysis and Infanticide*, 24 CARDOZO L. REV. 2467, 2467 (2003).
100. *Id.*
101. Spinelli, *supra* note 9, at 174-75.

"thinking pretty clearly" and "didn't sound psychotic,"[102] that she planned to kill the children the night before,[103] and that her call to police after she had drowned them showed "she knew exactly what she was doing . . . [a]nd she knew it was wrong, or she would not have called the police."[104] The fact that psychiatrists called as expert witnesses for both the defense and the prosecution agreed that she suffered from severe psychosis was inconsequential under Texas law.[105]

The overarching problem is that the law offers a relatively binary approach to insanity and its role within criminal law. One is either "sane or insane, competent or incompetent, or able-bodied or disabled" under the present legal system, one commentator notes.[106] As a result, the system "simply fails to accommodate the vast majority of women who struggle with postpartum mental illness."[107]

V. POSSIBLE SOLUTIONS TO THE PROBLEM OF SITUATING POSTPARTUM PSYCHOSIS WITHIN CRIMINAL LAW

A. Maintaining the Existing System

One solution is to say that no "solution" at all is necessary because there is no real "problem." Postpartum psychosis is simply one of a variety of psychotic disorders and should not be treated in a way that differs from other disorders that could allow a defendant to raise an insanity defense. Such an approach would also fall in line with the assimilation feminist view by not highlighting gender difference.[108] The problem with this approach is that it does not recognize the unique nature of postpartum psychosis as a disorder that affects only women, and only women who have just had a child.

102. Lisa Teachey, *Jurors Say they Believed Yates Knew Right from Wrong*, HOUS. CHRON., Mar. 18, 2002, at 1A.
103. *Id.*
104. *Id.*
105. Salecl, *supra* note 99, at 2467.
106. Oberman, *supra* note 62, at 33.
107. *Id.*
108. *Id.* at 63 n.189.

B. Statutory Resolution—Automatic Presumption of Insanity

England, Canada, Australia, and some other European countries have statutes that acknowledge the potential effects of postpartum depression and psychosis on new mothers. The Australian Infanticide Act of 1938, for instance, addresses the killing of children under one year of age.[109] The English Infanticide Act of 1938 allows the jury to reduce the sentence of a woman who kills her child under a year old from murder to manslaughter,[110] and generally results in probation.[111] The statute states:

> 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 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.[112]

In Sweden, these sorts of cases go before a panel of medical doctors rather than enter the criminal justice system at all.[113]

Such an approach recognizes that postpartum psychosis afflicts only women and that these women, while not "insane" in the traditional sense of the term, have a severe mental condition that, at the very least, reduces their culpability in the criminal act of killing their infant children. Yet some commentators have noted that because the English statute requires no causality between the mental disorder and the killing of the child, "it practically constitutes a per se defense to any killing that occurs within one

109. Bernadette McSherry, *The Return of the Raging Hormones Theory: Premenstrual Syndrome, Postpartum Disorders and Criminal Responsibility*, 15 SYDNEY L. REV. 292, 304 (1993).

110. Kimberly Waldron, *Postpartum Psychosis as an Insanity Defense*, 21 RUTGERS L.J. 669, 679 (1990). For a relatively complete list of countries that recognize the killing of a child soon after birth as a less culpable category of homicide, see Oberman, *supra* note 62, at 45 n.76.

111. Oberman, *supra* note 62, at 45.

112. Infanticide Act, 1938, 1 & 2 Geo. 6, c. 36, § 1 (Eng.).

113. Oberman, *supra* note 62, at 45.

year of birth."[114] This disconnect between the disorder and the crime is problematic because postpartum psychosis is only one of a number of different reasons researchers have found for why new mothers kill their infant children.[115] Another problem with such an approach is that it assumes that all women after childbirth are, to some extent, insane[116] and not fully culpable for their actions. Such a perspective could open doors to extending this perspective to other arenas, as per Pearson's argument,[117] or to impacting perceptions about the mental inferiority or fragility of women as compared to that of men.

C. Creating a New Test for Postpartum Psychosis

Some commentators have suggested creating a new insanity test to apply exclusively to postpartum psychosis. One commentator has proposed the following standard, which is a modified version of the Irresistible Impulse Test:[118]

> 1. Affirmative defense: The defendant can raise the affirmative defense of insanity based on postpartum psychosis if:
>
> a.) the killing of the defendant's child occurred within one year of the mother giving birth to that child or another child, and
>
> b.) an expert psychiatrist appointed by the court determines that there is a reasonable doubt as to the defendant's sanity.
>
> 2. Elements: The defendant must prove, to the extent determined by state law, that:
>
> a.) she was suffering from postpartum psychosis, and
>
> b.) there was a causal connection between the psychosis and the killing, and
>
> c.) she did not know right from wrong, or, if she did

114. Connell, *supra* note 40, at 164; *see also* Waldron, *supra* note 110, at 679 (explaining that the Infanticide Act allowed a woman to be guilty of infanticide rather than first degree murder without establishing that the disorder was severe enough to affect her self-control or responsibility).

115. MEYER & OBERMAN, *supra* note 7, at 36-38; Oberman, *supra* note 62, at 36.

116. Debora K. Dimino, *Postpartum Depression: A Defense for Mothers Who Kill Their Infants,* 30 SANTA CLARA L. REV. 231, 257 (1990).

117. *See supra* Part III.B.

118. Connell, *supra* note 40, at 162-63.

> know right from wrong, then she must prove that because of the psychosis, she had lost the ability to choose between right and wrong.[119]

This test has a few advantages over the present system and over the statutes such as England's Infanticide Act.[120] Like the Infanticide Act, it has a temporal requirement that fits the parameters of the onset of postpartum psychosis–no more than one year after the birth of a child.[121] It also applies only to the killing of the defendant's child. Unlike the Infanticide Act, however, the proposed test requires a causal connection between postpartum psychosis and the killing of the child. This addresses much of the objection to those statutes.

Such a test would have the advantage of recognizing (i) the effects postpartum psychosis have on women and their actions, and (ii) the failure of the cognitive test to capture the disorder. It would not offer a per se assumption of insanity, as statutes like England's Infanticide Act do, but it would bridge the gap between the present requirements of the cognitive test and the effects of postpartum psychosis.

One issue is that having this test emphasizes the differences between women and men and the treatment of psychiatric disorders affecting them. This treatment elicits the arguments some feminist scholars have made against emphasizing differences and thereby raises the possibility of other disparate gender treatment.

Another issue with this sort of new test for postpartum psychosis is that it opens the door for creating disorder-by-disorder tests rather than an "insanity defense" test. Such an approach may not, in fact, be a "problem" per se. Such an approach would bring the legal treatment of mental illnesses and disorders more in line with the mental health system's treatment and presumably would eliminate the binary legal system in place now. The problem with such an approach is that it creates a case-by-case basis for determining criminal culpability instead of a bright-line rule that would generate more conformity across cases. In addition, given the public's suspicion of the insanity defense in general and the worry that each disorder would receive individualized treatment

119. *Id.*
120. *See supra* Part V.B.
121. Connell, *supra* note 40, at 163.

that likely would not create uniformity across cases, it is unlikely that such an approach would be feasible.

D. Offering Alternative Sentencing Options

1. Containment Within the Criminal System, but Lighter Sentencing

Some courts and prosecutors have not accepted postpartum psychosis or depression as a complete insanity defense to murder, but they have used it as a key mitigating factor in the sentencing phase to acknowledge the unique and temporary nature of the mental disorder.[122] In 2002, for instance, a Virginia woman pled guilty to involuntary manslaughter as a result of her postpartum psychosis, and her five-year sentence was suspended in recognition of the unique and temporary nature of her condition.[123]

By and large, this sort of approach requires an acknowledgment of postpartum psychosis as creating diminished capacity, rather than as a fully exonerating defense. It reduces the level of criminal responsibility, recognizing that recidivism is not likely to be a problem, but it still accomplishes the goal of retributivism. It can result in a lesser prison sentence rather than a longer commitment in a mental institution should an insanity defense be successful.[124] In effect, it is what Stephen Morse sees as a punishment meted out in proportion to what is deserved, rather than a fixed and absolute punishment for a specific criminal act.[125]

2. Mental Treatment Instead of Serving Time in Prison

Another solution is to shift postpartum psychosis to treatment within the mental health system rather than incarceration within the criminal system. This is what a "guilty but mentally ill" (GBMI) verdict functionally prescribes. At the time of sentencing, the court would determine whether or not the defendant needs mental treatment. It could recommend probation with mandatory treatment, or it could eschew probation in favor of

122. Dimino, *supra* note 116, at 244.

123. Oberman, *supra* note 62, at 42 n.64 (citing Maria Glod, *No Prison Term in Man's Slaying; Fairfax Wife Had Postpartum Psychosis*, WASH. POST, July 26, 2002, at B7).

124. Liu, *supra* note 64, at 375.

125. Stephen J. Morse, *Justice, Mercy and Craziness*, 36 STAN. L. REV. 1485, 1493-94 (1984) (book review).

institutionalization at a mental treatment facility.[126] The defendant would serve the time of the sentence either in the treatment facility or, when treatment becomes unnecessary, in prison.

Such an approach might better serve postpartum psychosis defendants because it emphasizes the treatment of the disorder rather than incarceration. The problem is that postpartum psychosis affects new mothers for only a relatively brief period of time after the birth of a child.[127] Generally, by the time a defendant has come to trial and been sentenced, the psychotic flare-up has passed and the defendant is no longer even in a treatment phase.[128] As a result, should such a defendant receive a GBMI verdict that carries a treatment phase followed by the rest of the sentence spent incarcerated, she would be shuttled directly to incarceration, making the end result not much different than simply being found guilty without a mental illness assessment.

Placement in a treatment facility in general poses some challenges in the postpartum psychosis context. On average, defendants "sentenced to mental facilities serve longer sentences in mental hospitals than do those who are found guilty and sentenced to prison."[129] These longer terms pose an interesting problem for defendants with postpartum psychosis. On the one hand, women who suffer from postpartum psychosis invariably are charged with either killing or attempting to kill their child. As a result, they are subject to longer prison terms, if not the death penalty, should they be convicted. These consequences are greater than for many of the felony or misdemeanor charges and associated penalties that other defendants who raise the insanity defense face. As a result, a longer period in a mental hospital might be preferable as opposed to the serious prison sentence should a murder charge stick.

On the other hand, these women "pose a challenge" because postpartum psychosis is a relatively short-term disorder that is not a chronic condition.[130] Women suffer from it only after the birth of a child, and when treated they experience a complete recovery after a short period of time.[131] The psychosis does not recur until and unless they give birth to another child. In this aspect, it is very

126. Liu, *supra* note 64, at 394.
127. Oberman, *supra* note 62, at 43.
128. Reece, *supra* note 49, at 751.
129. Oberman, *supra* note 62, at 43.
130. *Id.*
131. *Id.*

unlike most other psychoses because an additional episode is entirely predictable and linked to a specific physiological event, and the psychosis is "timed-out" in a sense. Although the Yates case points to the dangers of not recognizing and treating the disorder, proper treatment at the first onset of the mental disorder effectively prevents future dangerousness and eliminates recidivism. Also, society at large is not placed at risk by a woman with postpartum psychosis, because it generally affects only the woman involved and her child or children, and only after she has recently given birth.[132] As a result, the dangerousness that justifies long-term incarceration in a mental hospital or in a prison is absent.

3. A Hybrid Approach

The special conditions that surround postpartum psychosis suggest a combination of requiring lighter sentencing provisions and a treatment program might best accomplish the goals of rehabilitation and retributivism without allowing postpartum defendants to fall through gaps in the system. Lighter sentencing upon a showing that the defendant was suffering from postpartum psychosis, that the disorder caused her to kill her child(ren), but that she cannot make out a full insanity defense to meet the cognitive test, provides social retribution for wrongdoing but recognizes that control over that wrongdoing was not entirely in the hands of the defendant due to the disorder.

The key difference between such a sentencing provision and statutes such as England's Infanticide Act is requiring a causal link between the disorder and the offense. In addition, putting such a defendant in a treatment facility rather than incarcerating her in prison during the time of her sentence recognizes her disorder rather than punishing her for events that, but for the disorder, would not have occurred. The causal link requirement also helps counter the assimilative argument against different standards for men and women in the criminal law context because it does not presume that women should be treated differently, but that defendants who have postpartum psychosis should be treated differently.

This combination of lighter sentencing and treatment facility

132. Reece, *supra* note 49, at 751.

institutionalization is not a perfect solution. The fact that women who have suffered from postpartum psychosis generally are improved, if not fully restored, by the time their case reaches a sentencing phase makes the treatment facility institutionalization seem a bit superfluous. Yet, if such guidelines were followed, then the entire process would move more quickly, women could plead into this system, and they could receive the treatment needed for an appropriate time period.

VI. CONCLUSION

Given the complex web of issues surrounding postpartum psychosis, including the basis for the disorder, the gender implications it carries, the problems that exist in conforming it to legal standards for insanity, and people's suspicions about temporarily morbid psychotic disorders, it is unlikely that a perfect solution exists for the legal treatment of the disorder. But the system as it exists now has failed for women such as Andrea Yates, who everyone—jurists, the prosecutor, and the public alike—agreed was suffering from a mental instability due to postpartum psychosis at the time she killed her children. A new system that creates some sort of carve-out for women suffering from postpartum psychosis creates no slippery slope of retributionist exclusion that would extend to a wide pool of criminal offenders. An acceptable solution is one that recognizes the unique nature of postpartum psychosis and resolves, at least in part, the problem of balancing treatment and punishment. A hybrid of reduced sentencing and treatment over incarceration moves in this direction.