Feminine Hormonal Defenses: Premenstrual Syndrome and Postpartum Psychosis

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Introduction

Women now represent approximately fourteen percent of the active duty military[1] and their presence in the military force structure is expected to increase as more positions are opened to them.[2] Because of military age restrictions, most women serving in the armed forces are at the prime child bearing age. Medical experts warn that, throughout their entire lives, women will be at greatest risk for psychiatric illness during the period following a birth.[3] Additionally, women are susceptible to the physical, mood and behavioral changes associated with the menstrual period. Negative premenstrual symptoms may occur after a woman's first menstruation, and these recurring symptoms, which generally appear in the last week of the menstrual cycle and disappear after the onset of menses (menstrual period),[4] are collectively known as Premenstrual Syndrome (PMS)[5] and most commonly strike women in this same age group.[6]

In their severest states, the psychological illnesses associated with birth and a woman's menstrual cycle may serve as the basis for a complete or partial defense to criminal charges and even milder versions of these maladies may be used in sentence mitigation. Although there are no reported military cases raising these defenses, both psychological illnesses have been used successfully in civilian courts and both are now recognized in their severest forms as mental disorders by the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM).[7]

Because of the rise in the number of women in the armed forces and the recognition of PMS and postpartum-related illnesses as bona fide mental maladies, judge advocates should be aware of these two mental illnesses and their potential as criminal defenses. Accordingly, this article reviews the development of PMS and postpartum illnesses as recognized mental disorders, discusses their use as criminal defenses and in sentence mitigation in various criminal jurisdictions, and examines their potential as defenses within the military justice system.

Premenstrual Syndrome

References to symptoms characteristic of PMS date back to the sixth century B.C. and began to appear in American medical literature as early as 1931.[8] Premenstrual Syndrome itself was first recognized by the medical profession as a psycho-physio-

1. Paul Richter, *Loss of Women Recruits a Warning Sign for Military*, L.A. TIMES, Nov. 29, 1999, at 1.

2. Rowan Scarborough, *Women Get More Army Jobs*, WASH. TIMES, Dec. 3, 1999, at 1 (reporting that the Army plans to open more jobs to women and is "[R]ecruiting a higher percentage of women. The goal today is 20 percent of 80,000 annual inductees, up from 12 percent in 1986."); *cf.* David Wood, *Today's Military Personnel Putting New Face On Image*, CLEV. PLAIN DEALER, Dec. 12, 1999, at 4K ("About 90 percent of all military career fields are open to women . . . .").

3. SHARON L. ROAN, POSTPARTUM DEPRESSION: EVERY WOMAN'S GUIDE TO DIAGNOSIS, TREATMENT & PREVENTION ix (1997) ("[N]ot enough women of childbearing age realize it is during the postpartum period that they are at highest risk for mental illness . . . ."); DAVID G. INWOOD, *Introduction* to RECENT ADVANCES IN POSTPARTUM PSYCHIATRIC DISORDERS ix (1985) ("[W]omen are at the highest risk of their entire life for psychiatric hospitalization during the immediate postpartum period."). The postpartum period is approximately the first year after birth. ROAN, *supra* at 2.

4. "Many people refer to the days of discharge as their 'period.' Technically the discharge is referred to as menses." Howard Seiden, *Why PMS Is So Difficult To Define*, TORONTO STAR (Canada), Mar. 25, 1993, at D2.

5. Sally K. Severino & Eva Rado, *Legal Implications of Premenstrual Syndrome*, 9 AM. J. FORENSIC PSYCH. 19 (1988). Premenstrual Syndrome "symptoms appear at midcycle, just after ovulation, peak the week before the monthly period begins and end just as bleeding starts." Sally Squires, *Prozac Joins Weapons Battling Premenstrual Syndrome*, ARIZ. REPUBLIC, June 13, 1995, at C2.

6. Squires, *supra* note 5, at C2 ("Women in their 20s and 30s are the most common sufferers . . . ."); *see* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 716 (4th ed. 1994) ("Premenstrual symptoms can begin at any age after menarche, with the onset most commonly occurring during the teens to late 20s. Those who seek treatment are usually in their 30s.") [hereinafter DSM-IV]; KAREN J. CARLSON ET AL., THE HARVARD GUIDE TO WOMEN'S HEALTH 508 (1996) (stating that the most serious cases of PMS affect women between 26 and 35); KATHARINA DALTON, ONCE A MONTH: UNDERSTANDING AND TREATING PMS 14 (6th ed. 1999) (stating that PMS "affects only women of childbearing age"); NIELS H. LAURENSEN & EILEEN STUKANE, PMS, PREMENSTRUAL SYNDROME AND YOU: NEXT MONTH CAN BE DIFFERENT 60 (1983) (stating that PMS is "rare among teenagers, more noticeable during the twenties, and not only common but severe in the thirties."). Most women have their first period between the ages of 11 and 16 and their last period between the ages of 45 and 55. Seiden, *supra* note 4, at D2.

7. The DSM is used regularly by courts in criminal cases when the defendant's mental state is at issue. *See infra* note 119; Lee Solomon, *Premenstrual Syndrome: The Debate Surrounding Criminal Defense*, 54 MD. L. REV. 571, 576 (1995) ("The DSM is considered 'the bible of mental illness' and is utilized not only by therapists but also by . . . judges to identify and define the mentally ill.").

logical disorder in 1953.[9] In 1983, diagnostic guidelines for PMS were established in the United States.[10]

In 1986 PMS was proposed for inclusion in the APA revised third edition of the DSM (DSM-III-R), but the APA instead used the term late luteal phase dysphoric disorder (LLPDD), which "differed from PMS by 'a clear emphasis on mood and behavioral as opposed to physical symptoms.'"[11] The DSM-III-R included LLPDD in its appendix as a "proposed clinical diagnosis" and treated the PMS-like illness as a psychological disease.[12] Late luteal phase dysphoric disorder was the first time the DSM contained a diagnostic term linked to a menstrual cycle-related mental disorder.[13] Significantly, the most current version of the manual recognizes severe PMS to some extent as a mental disorder. Despite opposition from women's groups,[14] DSM-IV now includes premenstrual dysphoric disorder (PMDD)–a form of severe PMS–as a type of depressive disorder.[15] The DSM-IV distinguishes PMDD "from the far more common 'premenstrual syndrome'" in terms of the "characteristic pattern of symptoms, their severity, and the resulting impairment."[16] Although recognizing PMDD as a mental disorder, DSM-IV notes that insufficient information exists to include PMDD as an "official" category in the manual and instead includes PMDD as a proposal for a new category in DSM-IV's appendix.[17]

The DSM-IV lists the essential features of PMDD as symptoms that occurred regularly during the week before the onset of menses "in most menstrual cycles during the past year," "remit within a few days of the onset of menses (the follicular phase) and are always absent in the week following menses."[18] Further, a PMDD diagnosis requires that the symptoms "must cause an obvious and marked impairment in the ability to function socially or occupationally in the week prior to menses."[19] Finally, a diagnosis of PMDD requires that at least five of the following symptoms appear under the above circumstances, to include at least one from the first four:

> (1) markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts
> (2) marked anxiety, tension, feelings of being "keyed up," or "on edge"
> (3) marked affective liability (such as, feeling suddenly sad or tearful or increased sensitivity to rejection)
> (4) persistent and marked anger or irritability or increased interpersonal conflicts
> (5) decreased interest in usual activities (such as, work, school, friends, hobbies)
> (6) subjective sense of difficulty in concentrating
> (7) lethargy, easy fatigability, or marked lack of energy
> (8) marked change in appetite, overeating, or specific food cravings
> (9) hypersomnia or insomnia
> (10) a subjective sense of being overwhelmed or out of control

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8. Recent Decisions, *Criminal Law–Premenstrual Syndrome: A Criminal Defense*, 59 NOTRE DAME L. REV. 253, 254-55 (1983).

9. *In re* Irvin, 31 B.R. 251, 260 (Bankr. D. Colo. 1983). In 1953, Dr. Katharina Dalton and Dr. Raymond Green published the first paper on premenstrual syndrome in medical literature, in the *British Medical Journal*. DALTON, *supra* note 6, at 2-3.

10. DALTON, *supra* note 6, at 96 ("The first conference convened in 1983 by the National Institute of Mental Health established diagnostic guidelines for PMS . . . ").

11. Solomon, *supra* note 7, at 577 & n.48 (citation omitted); *cf.* DALTON, *supra* note 6, at 96 (defining PMS as LLPDD).

12. DALTON, *supra* note 6, at 96 (stating that PMS was defined as LLPDD and "considered a psychological rather than hormonal disease").

13. Severino & Rado, *supra* note 5, at 24 ("Only in 1987 has [the APA's DSM] included a specific diagnostic term in its research appendix to connote a disorder related to the menstrual cycle.").

14. Sally Squires, *New Guide To Mental Illness*, WASH. POST (HEALTH), Apr. 12, 1994, at 10 ("Women's groups have complained because of the stigma associated with classifying premenstrual symptoms as a mental disorder."); *Severe PMS Called 'Depressive Disorder,'* WASH. POST, May 29, 1993 (stating that the National Organization of Women opposed "efforts to link women's hormonal cycles with mental disorders" because such a connection has not been proven, PMS diagnoses may be based on "a 'cultural myth,'" and such a diagnosis "[c]ould be used against women in child custody battles, job discrimination sits and other court battles"); *see* Recent Decisions, *supra* note 8, at 268 (relating to the "concerns of many feminists that acceptance of PMS as a legal defense could lead to an erosion of the advances women have made toward social equality").

15. Solomon, *supra* note 7, at 571; *see* DSM-IV, *supra* note 6, at 716 (describing PMDD as a severe form of PMS); Squires, *supra* note 14, at 10 ("[D]ecision to classify a severe form of premenstrual syndrome called premenstrual dysphoric disorder (PMDD) as a mental illness in the appendix."). *But cf.* CARLSON ET AL., *supra* note 6, at 509 (stating that PMDD "may or may not be the same as PMS").

16. DSM-IV, *supra* note 6, at 716.

17. *Id*. at 703.

18. *Id*. at 715. Menses refers to the time of discharge. Seiden, *supra* note 4, at D2.

19. DSM-IV, *supra* note 6, at 715.

> (11) other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of "bloating" (weight gain).[20]

Similarly. Dr. Katharina Dalton, one of the world's leading authorities on PMS,[21] defines it as "recurrence of symptoms before menstruation with complete absence of symptoms after menstruation."[22] These symptoms are varied and far too numerous to list in their entirety.[23] However, the symptoms themselves do not dictate a PMS diagnosis, rather it is the timing of the symptoms in relation to the menstrual cycle.[24]

Significantly for purposes of criminal law, in its severest form the symptoms of PMS may include psychosis and hallucinations.[25] However, Dalton opines that such symptoms are short-lived, lasting only one to two days and occurring just before menstruation."[26] Further, severe PMS is considered relatively rare.[27] The DSM-IV notes that PMDD strikes only three to five percent of premenopausal women.[28] Dalton cautions that "genuine cases [of PMS that should excuse criminal misconduct] are few and far between, and it is important to ensure that PMS is not made a universal defense."[29]

Although there is no complete agreement on the cause of PMS,[30] many experts—including Dr. Dalton—believe that PMS is hormonally based.[31] Other nonhormonal causal theories include "the rapid decline in a metabolite of a neurotransmitter; yeast overgrowth in the intestines; allergies; psychological stress";[32] "a separate mood disorder that somehow becomes synchronized with the [menstrual] cycle,"[33] and "a deficiency of the brain chemical serotonin . . . ."[34] The DSM-IV fails to positively identify the cause of this mental illness. However, mental disorders may have a number of possible causes,[35] but for purposes of criminal law it is the impact of

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20. *Id*. at 717.

21. Solomon, *supra* note 7, at 573 n.20 (stating Dr. Dalton has studied PMS for over 30 years, "has studied approximately 30,000 cases and written many books and articles regarding this disorder"); Recent Decisions, *supra* note 8, at 255 (listing Dr. Dalton as "a pioneer in the study and treatment of PMS").

22. DALTON, *supra* note 6, at 7 (emphasis deleted).

23. *Id*. at 29 (stating that "150 different symptoms have already been recorded"); CARLSON ET AL., *supra* note 6, at 509 (stating that it is comprised of "variety of symptoms").

24. DALTON, *supra* note 6, at 14, 29; *see* Severino & Rado, *supra* note 5, at 19 ("[T]he symptoms themselves have been considered less important than the timing of their appearance.").

25. DALTON, *supra* note 6, at 10; *see* DSM-IV, *supra* note 6, at 716 ("Delusions and hallucinations have been described in the late luteal phase of the menstrual cycle but are very rare.").

26. *Id.* ("Symptoms of migrane, psychosis, hallucinations, and alcoholic bouts tend to last only a day or two and come immediately before menstruation.").

27. CARLSON ET. AL., *supra* note 6, at 508 ("The most serious cases of PMS [affect] 1 to 5 percent of all women . . . .").

28. DSM-IV, *supra* note 6, at 716; *see also* Sally Squires, *Study Supports Use of Antidepressant for PMS*, WASH. POST (HEALTH), Sept. 30, 1997, at 8 (stating that "[a]ffects 3 to 5 percent of women of reproductive age"). Premenstrual symptoms "usually remit with menopause." DSM-IV, *supra* note 6, at 716.

29. DALTON, *supra* note 6, at 177.

30. Solomon, *supra* note 7, at 574 ("Nor do medical experts agree on the cause . . . ."). One legal commentator noted that medical experts did not agree on the case, treatment, or diagnosis of PMS, but did seem to agree that it "causes marked psychological anomalies." Recent Decisions, *supra* note 8, at 257-8.

31. Stacey Schultz, *Sparking PMS Pains: Calcium Deficiency Triggers Symptoms*, U.S. NEWS & WORLD REP., Sept. 7, 1998 (reporting that researchers from St. Luke's-Roosevelt Hospital Center in New York report that "[f]luctuations in the hormones that regulate calcium levels over the course of a menstrual cycle may set off a host of PMS symptoms"); *see* DALTON, *supra* note 6, at 1-2, 67-80; LAUERSEN & STUKANE, *supra* note 6, at 48 ("PMS is triggered by hormonal irregularities . . . ."); Dr. Peter H. Gott, *Supplemental Hormones Ease PMS Symptoms*, ARIZ. REPUBLIC, Oct. 5, 1995, at E4 ("PMS is probably due to a hormone imbalance . . . ."); *cf.* CARLSON ET AL., *supra* note 6, at 508 (noting the "enormous hormonal changes associated with the menstrual cycle").

32. Solomon, *supra* note 7, at 574.

33. Susan Okie, *New Study Challenges PMS Case*, WASH. POST, Apr. 25, 1991, at A1 (noting that the "prevailing view" is that PMS is caused by "hormone changes that occur during a woman's menstrual cycle"). Although positing that their study "shows PMS is not triggered by hormonal changes late in the menstrual cycle," the researchers conceded that PMS "still could be tied to hormonal events in the first half of the cycle." *Id.* at A24.

34. Laura Bell, *PMS: Still a Mystery to Doctors, Sufferers: For All Its Infamy, Premenstrual Syndrome Remains Entangled in Misconceptions*, THE ORLANDO SENTINEL, Aug. 20, 1993, at E1.

35. Ralph Slovenko, *The Meaning of Mental Illness in Criminal Responsibility*, 5 J. LEGAL MED. 1, 5 (1984) ("Mental disorders now include those which not only have an organic or physical cause, but also the purely functional disorders."); *cf.* DSM-IV, *supra* note 6, at xxi-xxii ("[W]hatever its original cause, [to meet the DSM definition of a mental disorder, the illness] must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual.").

the mental illness on the accused's cognitive abilities that is of legal significance and not the root cause of the mental malady.[36]

The PMS defense has been no stranger to the European court system. European courts have seen menstruation-based defenses since at least 1845, when an English woman, Amy Shepherd, was found not guilty of shoplifting at Carlisle Quarter Sessions.[37] In 1851 and 1865 respectively, two women were acquitted of murder as a result of "temporary insanity from suppression of the menses."[38] Premenstrual Syndrome is reported to have been used as a temporary insanity defense in France.[39] Closer to home, in Canada the defense has been used successfully since the early 1980s. Early PMS defenses in Canadian courts resulted in dismissal of shoplifting charges and sentence leniency for a defendant convicted of assault.[40]

The modern resurgence of the PMS defense can be traced to three English cases tried in the early 1980s. The first case was *Regina v. Craddock.*[41] Charged with murdering a fellow barmaid, Sandie Craddock was a twenty-nine year-old woman with a record of thirty convictions and twenty-five prior suicide attempts.[42] Using Craddock's diaries and prison records, Craddock's attorney and Dr. Dalton were able to establish all of Craddock's criminal activity occurred at "cycles of 29.04 plus or minus 1.47 days" and her suicide attempts "occurred at intervals of 29.55 plus or minus 1.45 days."[43] Because of this evidence of diminished capacity, the Crown reduced Craddock's charge to manslaughter, of which she was convicted.[44] However, in light of Dr. Dalton's PMS diagnosis and successful treatment of Craddock with progesterone, the court only sentenced the defendant to probation, conditioned upon continued treatment.[45]

Craddock changed her name to Smith and generally stayed out of trouble until her progesterone dosage was reduced to its lowest level since treatment began. During her next paramenstrum, Smith threatened to kill a police officer on two separate occasions and was apprehended while lying in wait for the officer while armed with a knife.[46] Although Smith was convicted of all charges, the court again sentenced the defendant to probation, relying on Smith's PMS in mitigation.[47] On appeal, the court upheld the conviction and sentence, recognized PMS as a legitimate mitigating factor at sentencing, but found "it contrary to the purpose of criminal law to allow a defendant to commit a violent act and then be acquitted and discharged while still a threat to society."[48]

In a highly publicized murder case decided the day after *Smith*, Dr. Dalton again testified that the defendant, Christine English, who had killed her lover by pinning him to a utility pole with her car, committed the crime while under the influence of PMS.[49] In *Regina v. English*, the Crown reduced the charge to manslaughter due to the defendant's "diminished capacity," to which English pled guilty.[50] At sentencing, the

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36. *Cf.* Slovenko, *supra* note 35, at 1 (noting that the impact of the predicate mental disease or defect determines criminal responsibility).

37. Thomas L. Riley, *Premenstrual Syndrome as a Legal Defense*, 9 HAMLINE L. REV. 193, 194, n.5 (1986) (citing d'Orlan, *Medicolegal Aspects of the Premenstrual Syndrome*, 30 BRIT. J. HOSP. MED. 404, 406 (1983)).

38. *Id.*

39. Judith DiGennaro, *Sex-Specific Characteristics as Defenses to Criminal Behavior*, 6 CRIM. JUST. J. 187, 190 (1982); *see* Solomon, *supra* note 7, at 581; JO ANN C. FRIEDRICH, THE PRE-MENSTRUAL SOLUTION: HOW TO TAME THE SHREW IN YOU 85 (1987) ("In France, PMS is officially recognized as a cause of temporary insanity . . . ."). *But cf.* Recent Decisions, *supra* note 8, at 253 n.3 ("[S]everal commentators have noted that the French legal system recognizes PMS as a form of temporary insanity. None, however, has cited a French authority to support the proposition.").

40. DiGennaro, *supra* note 39, at 187. The assault conviction resulted in a sentence of probation "on the basis that the assault was in large part caused by PMS." *Id. See Solomon*, *supra* note 7, at 582 (noting that an Alberta, Canada, woman acquitted of shoplifting after presenting a PMS defense); *see* Severino & Rado, *supra* note 5, at 28 (noting that shoplifting charges were dropped in an Ottawa court in 1980 and a Toronto court in 1981 after evidence was presented that the defendants suffered from PMS).

41. 1 C.L. 49 (1981).

42. Recent Decisions, *supra* note 8, at 258. She had also been committed to mental hospitals on several occasions. *Id.*

43. DALTON, *supra* note 6, at 174; *see* Recent Decisions, *supra* note 8, at 259.

44. Recent Decisions, *supra* note 8, at 259.

45. *Id.*

46. *Id.* at 259-60. Smith threatened the police officer because of a three-year-old insult. *Id.* at 260.

47. *Id.*

48. *Id.* at 261.

49. *Id.* Dalton "testified that English suffered from PMS which caused her to become irritable and aggressive, and to lose self-control." *Id.* Further, the defense established that the defendant had probably suffered from PMS for the previous 15 years. *Id.* The case was highly publicized in the British press. *Id.* at 261 n.68.

court received evidence of PMS in mitigation, concluded "that English had acted under 'wholly exceptional circumstances,'" and "granted English a twelve-month conditional discharge and banned her from driving for one year."[51] Since this trilogy of cases, the British family and criminal courts have accepted PMS as a mitigating circumstance for most offenses.[52]

Although PMS was raised in earlier civil cases,[53] the first reported use of PMS in an American criminal case occurred in *People v. Santos*.[54] In Santos, a woman charged with child battering raised PMS as a defense, but the case was ultimately resolved through a plea bargain.[55] At a pre-trial hearing, Santos admitted beating her child, but claimed that she suffered a black out as a result of PMS. Significantly, in response to the defense argument that evidence of Santos' PMS was relevant on the issue of criminal intent, the judge ruled that such evidence would be admissible at trial.[56]

The PMS defense has been used successfully as a complete defense at least once in the United States, and the acquittal was met with heavy criticism.[57] After being pulled over by a Virginia state trooper, Geraldine Richter was verbally hostile and attempted to kick the officer in the groin.[58] She refused field sobriety tests, cursed at the troopers who attempted to handcuff her, and kicked the breathalyzer table once at the Fairfax County jail.[59] Although Richter's breathalyzer test indicated that she was legally intoxicated, the judge found her not guilty after receiving expert testimony from two witnesses concerning the affects of PMS and attacking the accuracy of the Breathalyzer, respectively.[60] The defense presented evidence that "women absorb alcohol more quickly during their premenstrual cycle" and that her perceived threat to the welfare of her children, who were also in the car, aggravated her situation.[61] A gynecologist who testified for the defense stated that Richter had PMS "but she could have controlled it if she [were] not being threatened with the welfare of her children . . . ."[62]

Postpartum Psychosis

Postpartum psychosis has been recognized by members of the medical profession since at least the fourth century B.C.[63] However, the first comprehensive study of postpartum medical maladies did not occur until 1858.[64] Recognition that women were psychologically affected by birth found its way into the Infanticide Acts of England in 1922 and 1938. This legislation

50. *Id.* at 261.

51. *Id.*

52. DALTON, *supra* note 6, at 172-73.

53. Recent Decisions, *supra* note 8, at 253 n.4 (noting various decisions beginning in 1966 concerning distribution of drugs designed to treat PMS, disability benefits for a PMS sufferer, a successful defense to revocation of a real estate broker's license, a wrongful death action using a PMS defense, and a child custody dispute in which evidence of PMS was introduced to attack the mother's competency) (citations omitted).

54. *Id.* ("*Santos* was the first attempt to use the PMS defense in a criminal case in the United States . . . .") (discussing People v. Santos, No. 1KO46229 (N.Y. Crim. Ct. Nov. 3, 1982)).

55. *Id.* at 253 (noting that charged with a felony, Santos pled guilty to a misdemeanor).

56. *Id.* at 262. Although convicted of the misdemeanor offense of harassment, Santos suffered no punishment. *Id.* (no incarceration, probation, or fine).

57. ALAN M. DERSHOWITZ, THE ABUSE EXCUSE AND OTHER COP-OUTS, SOB STORIES, AND EVASIONS OF RESPONSIBILITY 54-55 (1994) (criticizing the acquittal, calling the result wrong and "a setback for feminism"); DeNeen L. Brown, *PMS Defense Successful in Va. Drunken Driving Case*, WASH. POST, June 7, 1991, at A16 ("Assistant Commonwealth's Attorney . . . called the PMS argument 'ridiculous' . . . ."); *see* Solomon, *supra* note 7, at 587 (noting that the "case was controversial").

58. Brown, *supra* note 57, at A1.

59. *Id.*

60. *Id.* at A16 ("[O]ne of whom testified about how PMS affects some women's behavior and another who testified that the Breathalyzer reading was skewed because Richter held her breath . . . .").

61. *Id.*

62. *Id.*; *see* DALTON, *supra* note 6, at 27 ("Tolerance to alcohol also varies during the cycle in PMS sufferers. Although most days they can usually enjoy their favorite drink with no ill effects, during the premenstruum even a small amount cases intoxication.").

63. ROAN, *supra* note 3, at 24 ("Postpartum psychosis was described by Hippocrates in the fourth century B.C. as a severe case of insomnia and restlessness that began on the sixth day in a woman who bore twins."); *see* DAVID G. INWOOD, *The Spectrum of Postpartum Psychiatric Disorders*, *in* RECENT ADVANCES IN POSTPARTUM PSYCHIATRIC DISORDERS 2 (Dr. David G. Inwood ed., 1985) ("Physicians since antiquity have retrospectively recognized the association between childbirth and subsequent development of a spectrum of postpartum psychiatric disorders.").

64. ROAN, *supra* note 3, at 24. The study was conducted by French doctor Louis Victor Marce, whose list of symptoms included "melancholy, anemia, weight loss, constipation . . . menstrual abnormalities . . . confusion, faulty memory, and fogginess . . . ." *Id.*

reduced the maximum charge a mother could face for killing her baby from murder to manslaughter-like infanticide if the child was less than one year old and "if 'at the time of the act or omission casing death, the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth.'"[65]

In 1952, the APA published its first edition of the DSM which failed to link childbearing with psychological illness.[66] The DSM's failure to adequately address postpartum psychiatric disorders continued until the APA's most recent edition of the manual. Indeed, DSM-III, published in 1980, noted that "there is no compelling evidence that postpartum psychosis is a distinct entity."[67] Although it failed to discuss the cause of postpartum illness and it "excludes postpartum depression, psychosis, anxiety, or any of the other observed variations as separate and distinct illnesses."[68] The DSM-IV did recognize postpartum illness as a separate mental disorder and recognized the risk of infanticide from severe postpartum depression (PPD) and psychosis.[69] However, onset of the condition must begin within four weeks of birth.[70]

The mental illness that follows the birth of a child can be broken down into three general categories. First, the majority of new mothers suffer from a period of sadness[71] within days of birth. Known as postpartum blues, maternity blues or baby blues, this form of postpartum illness usually begins three to five days after birth and lasts approximately ten to fourteen days.[72] Most medical experts believe that the blues are caused by the rapid drop in hormonal levels following birth.[73] During the third trimester, a woman's estrogen and progesterone (hormone) levels rise to their highest point and then plunge to nearly zero within twenty-four hours after the placenta is removed.[74] Common symptoms associated with the blues include uncontrolled and spontaneous crying, mood swings, insomnia, fatigue, confusion, difficulty concentrating, irritability, and feelings of loneliness.[75] Approximately seventy to eighty percent of all new mothers suffer to some extent from this condition.[76]

The second severest category of postpartum illness is PPD. This psychiatric disorder strikes approximately ten percent of all new mothers, which equates to over 300,000 women annually in the United States.[77] It may begin suddenly or start as maternity blues and gradually develop into a mild to severe form of depression.[78] Postpartum depression is characterized by abrupt mood swings in which the mother may rapidly shift from feeling miserable to feeling happy and then miserable again.[79] Postpartum depression usually develops between the second and fourth week after birth, and commonly lasts for

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65. C.L. Gaylord, *Sunday Morning*, CASE & COMMENT 29, 30 (Nov.-Dec.1988); *see* Clark Brooks, *'Baby Blues' Gone Berserk*, SAN DIEGO UNION-TRIB., Nov. 13, 1994, at A1, A22 ("At most, the mother may be convicted of infanticide, which carries the same penalty as manslaughter."). The Infanticide Act, and its presumption of a postpartum psychological illness when a mother kills her child of less than twelve months, remains the law of England. Brenda Barton, *Comment: When Murdering Hands Rock the Cradle: An Overview of America's Incoherent Treatment of Infanticidal Mothers*, 51 SMU L. REV. 591, 596 (1998).

66. ROAN, *supra* note 3, at 24 (stating that the DSM is "without any mention of childbearing and its relationship to psychiatric illness"). The DSM is "a kind of 'bible' for doctors that describes all known psychiatric disorders and how to treat them . . . ." *Id.*

67. *Id.* at 25. DSM-III-R, published in 1987, was a slight improvement, "[b]ut its only mention of postpartum illness [was] to practically dismiss it because of its complexity." *Id.*

68. *Id.* ("[M]any health professionals and women consider this omission disappointing . . . ."). *Id.*

69. DSM-IV, *supra* note 6, at 386-7 (Postpartum Onset Specifier); *see* Barton, *supra* note 65, at 603 ("[F]or the first time in history, the American Psychiatric Association recognized postpartum onset specified as a mental condition.").

70. DSM-IV, *supra* note 6, at 386.

71. ROAN, *supra* note 3, at 9 (stating that it was "a period of sadness"); *see* Susan H. Greenberg & Joan Westreich, *Beyond The Blues*, NEWSWEEK (SPECIAL ISSUE), SPRING/SUMMER 1999, at 75 (stating that it was a "short-lived period of tearfulness and mood swings").

72. ROAN, *supra* note 3, at 8-9; DSM-IV, *supra* note 6, at 386 (lasting from three to seven days).

73. ROAN, *supra* note 3, at 10 ("The likelihood that blues will peak on the third to fifth day suggests a biological case, such as the rapid decline of hormones that occurs as a woman's body adjusts from a pregnant to a nonpregnant state."); Michael W. O'Hara, *Psychological Factors in the Development of Postpartum Depression*, *supra* note 3, at 43 ("[T]here seems to be widespread agreement that the blues are rather specific to the early postpartum period and are probably related to decreases in levels of hormones that rise significantly during pregnancy.").

74. ROAN, *supra* note 3, at 110. The placenta is usually removed within thirty minutes of the baby's delivery. *Id.*

75. *Id.* at 9; *see* ANN DUNNEWOLD & DIANE G. SANFORD, POSTPARTUM SURVIVAL GUIDE 12 (1994) (describing "tearfulness, fatigue, insomnia, exhaustion, and irritability"); *accord* INWOOD, *supra* note 63, at 11.

76. ROAN, *supra* note 3, at 9; *see* DUNNEWOLD & SANFORD, *supra* note 75, at 12 (50-80%); *see* INWOOD, *supra* note 63, at 11 (stating that it occurs "in at least 50 percent of all women").

77. ROAN, *supra* note 3, at 11-12; *see* INWOOD, *supra* note 63, at 13 (stating that it "develop[s] in more than 10 percent of postpartum women").

months if not treated.[80] Some women become suicidal and think about hurting their babies, although the vast majority of women suffering from PPD do not harm their infants.[81]

The severest form of postpartum illness is the postpartum psychosis. Such a psychosis is considered "a true medical-psychiatric emergency" because the psychological disorder may be characterized by delirium, mania, hallucinations, delusions and a substantial risk that the mother may attempt to kill herself or her baby.[82] Women with a postpartum psychosis report having hallucinations or hearing voices and sounds that do not exist.[83] The DSM-IV specifically recognizes the threat to the baby that a psychosis presents, stating: "Infanticide is most often associated with postpartum psychotic episodes that are characterized by command hallucinations to kill the infant or delusions that the infant is possessed . . . ."[84] The psychosis usually begins to develop by the third to fourteenth day after birth.[85] The psychosis is difficult to predict; approximately seventy percent of postpartum women who develop a psychosis have no prior history of psychiatric problems.[86]

Fortunately postpartum psychosis is rare, occurring in only one to three of every thousand births.[87] However, women who suffer from PPD or a postpartum psychosis are likely to experience the illness again. The likelihood of recurrence of a psychosis following a subsequent birth is reported to be as high as seventy-five to ninety percent.[88] If treated properly, the mother may recover from the psychosis quickly.[89] Most women recover fully within a year of birth.[90] However, if not treated properly, the symptoms associated with a psychosis may last for two or three years.[91]

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78. ROAN, *supra* note 3, at 12. Sometimes medical professions fail to notice that a patient has progressed from maternity blues to PPD. CARL S. BURAK & MICHELE G. REMINGTON, THE CRADLE WILL FALL 120 (1994) ("The more serious depressions get lumped in with the baby blues and are not always appreciated.").

79. DUNNEWOLD & SANFORD, *supra* note 75, at 23 ("A women will feel great, then miserable, then good, then crummy, switching from high to low with surprising speed."); *see* ROAN, *supra* note 3, at 12 (specifying "rapid mood swings"). The rapid mood swings distinguishes PPD from maternity blues. DUNNEWOLD & SANFORD, *supra* note 75, at 23.

80. ROAN, *supra* note 3, at 12.

81. *Id.* at 12-13, 167-68; *see* DUNNEWOLD & SANFORD, *supra* note 75, at 24 ("Suicidal feelings, or thoughts about harming the baby, can haunt a woman . . . ."); Greenberg & Westreich, s*upra* note 71, at 75 ("Though most mothers with PPD would never act on those fantasies [of hurting their babies], they can't stop thinking them.").

82. INWOOD, *supra* note 63, at 6-7; ROAN, *supra* note 3, at 16-17; Greenberg & Westreich, *supra* note 71, at 75 ("Since it can lead to infanticide, it is considered a 'psychiatric emergency' . . ."); *see e.g.* BURAK & REMINGTON, *supra* note 78, at 97 (stating that mother while suffering from postpartum psychosis shot and killed her baby and then shot herself, but survived).

83. DUNNEWOLD & SANFORD, *supra* note 75, at 13 (stating that it was possible to "see or hear things that are not there"); Joel Stashenko, *Hospitals Join Fight Against "Baby Blues,"* TIMES UNION (Albany N.Y.), Sept. 29, 1997, at B2 (stating that sufferers are "beset by hallucinations and delusions"); *see e.g.* People v. Molina, 249 Cal. Rptr. 273 (Cal. App. 2d 1988) (stating that the defendant who stabbed her infant experienced delusions and "auditory hallucinations which gave her commands"); Brooks, *supra* note 65, at A-1, A-22 (reporting that voices told the mother to smother baby); Patricia Davis, *Immigrant Is Ruled Insane in Slaying of Son, Daughter*, WASH. POST., Sept. 5, 1991, at D1, D5 (stating that the mother experienced hallucinations and heard voices). Beverly Bartek, who was found not guilty by reason of insanity in Nebraska after killing her daughter in 1986, reported hearing voices that told her to kill the infant. Marianne Yen, *Women Who Kill Their Infants: A Bad Case of "Baby Blues"?*, WASH. POST, May 10, 1988, at A3.

84. DSM-IV, *supra* note 6, at 386. The manual also notes that infanticide "can also occur in severe postpartum mood episodes without such specific delusions or hallucinations." *Id.*

85. ROAN, *supra* note 3, at 16; INWOOD, *supra* note 63, at 7.

86. INWOOD, *supra* note 63, at 7.

87. ROAN, *supra* note 3, at 16 (stating that it is "occurring in just one or two among one thousand births"); *see* DSM-IV, *supra* note 6, at 386 ("Postpartum mood . . . episodes with psychotic features appear to occur in from 1 in 500 to 1 in 1000 deliveries . . . ."); INWOOD, *supra* note 63, at 7 (stating that it occurs in "one to three per 1,000 births").

88. ROAN, *supra* note 3, at 200; *see* DSM-IV, *supra* note 6, at 387 ("Once a woman has had a postpartum episode with psychotic features, the risk of recurrence with each subsequent delivery is between 30% and 50%."); Brooks, *supra* note 63, at A22 ("[I]t's 50-50 the psychosis will recur."); *see*, *e.g.*, BURAK & REMINGTON, *supra* note 78, at 196 (reporting that Angela Thompson, who killed her second baby suffered from severe postpartum depression following the birth of her first child); Ronald Sullivan, *Jury, Citing Mother's Condition, Clears Her in Death of 2 Babies*, N.Y. TIMES, Oct. 1, 1988, at 29-30 (reporting that a New York woman experienced three successive psychotic episodes, killing two of her babies and attempting to kill the third). In comparison, the likelihood of PPD recurring is approximately 50%. ROAN, *supra* note 3, at 200; *see* Yen, *supra* note 83, at A3 ("Medical literature also suggests that the incidence of severe postpartum depression increases with the second child.").

89. ROAN, *supra* note 3, at 124 ("[I]f the symptoms of psychosis are treated early, they may be resolved within a single week.").

90. INWOOD, *supra* note 63, at 10 ("[M]ore than 80 percent recover fully within one year postpartum.").

91. ROAN, *supra* note 3, at 124 ("Without aggressive management and early detection, the symptoms may extend into the second and third year postpartum.").

There exists no uniformity of opinion as to the cause of postpartum depression and psychosis.[92] Many experts believe they are caused, at least in part, by hormonal changes.[93]

Another theory is that "postpartum mental illness is actually a latent illness triggered by birth."[94] Additionally, many other factors appear to increase the likelihood that a woman will experience PPD or a psychosis. Such contributing factors may include a history of depression,[95] a family history of postpartum reactions,[96] stressful life events,[97] a problematic baby,[98] fatigue,[99] and a history of victimization.[100]

Although the evidence is inconclusive, a link appears to exist between PMS and postpartum disorders. Many women who experience postpartum depression also suffered from bouts of PMS,[101] and PMS sufferers are considered to be at a greater risk of developing postpartum related psychological disorders.[102] Additionally, the risk of PMS increases when a woman has suffered an adverse postpartum reaction to birth.[103] In England, Dr. Katharina Dalton has used progesterone to successfully treat both types of illnesses.[104] However, other studies have failed to substantiate any positive affects associated with the use of that hormone[105] and not all women who experience postpartum psychosis have a history of PMS.[106]

As a criminal defense, postpartum psychosis has enjoyed mixed results.[107] Juries are considered skeptical of the defense because the victims are infants.[108] Even if they prove the existence of postpartum psychosis, defense counsel must meet the difficult task of persuading a jury that their client had "it bad enough to kill their child."[109]

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92. GREENBERG & WESTREICH, *supra* note 71, at 75 ("No one knows what causes PPD.")

93. Stashenko, *supra* note 83, at B2 (stating that the cause is unclear but several "factors are probably at play, including the dramatic hormonal changes that occur in woman after they give birth"); Brooks, *supra* note 65, at A-22 (stating that some researchers believe it is "cased by the hormonal upheaval of giving birth"); DUNNEWOLD & SANFORD, *supra* note 75, at 24 ("hormone-related"), at 63 ("many symptoms can be attributed to hormones"); GREENBERG & WESTREICH, *supra* note 71, at 75 ("It may be partly hormonal; after delivery, all women experience fluctuations in their levels of progesterone, estrogen, cortisol and prolactin."); Debra Cassens Moss, *Postpartum Psychosis Defense*, A.B.A. J., Aug. 1, 1988, at 22 (stating that some scientists believe "hormonal changes caused the illness")

94. Moss, *supra* note 93, at 22; *see* O'Hara, *supra* note 73, at 43 (stating that postpartum depression is not unique; it merely is the byproduct of a stressor (childbearing) impacting on a psychologically or biologically vulnerable woman); Dr. James A. Hamilton, *Guidelines For Therapeutic Management of Postpartum Disorders*, in *supra* note 3, at 89 (reporting that the minority position is merely "a trigger . . . that mobilizes the previously latent illness and makes its symptoms overt").

95. GREENBERG & WESTREICH, *supra* note 71, at 75; *see* O'Hara, *supra* note 73, at 51 (linking it to personal or family history of depression).

96. DUNNEWOLD & SANFORD, *supra* note 75, at 46.

97. ROAN, *supra* note 3, at 89 ("Studies have repeatedly shown that stressful life events often contribute to postpartum disorders."). Examples include moving, losing a job, death of a loved one, and financial problems. *Id.* Marital discord is also a significant risk factor. *Id.* at 97 ("The strength of the marriage is another important factor in whether a woman at risk for postpartum depression becomes ill and/or how easily she recovers."). Poverty and being a single mother also increase the risk of postpartum illness. *Id.* at 99; *accord* DUNNEWOLD & SANFORD, *supra* note 75, at 47.

98. ROAN, *supra* note 3, at 92 ("Having an infant who is premature, sick, colicky, a poor sleeper, or frequently fussy constitutes an important risk factor for depression.").

99. *Id.* at 96 ("Fatigue is an important risk factor in postpartum illness.").

100. *Id.* at 100 (listing past emotional, physical or sexual abuse as a factor).

101. *Id.* at 117 ("It is common for women with postpartum mood disorders to report having suffered from PMS."); *see* CARLSON ET AL., *supra* note 6, at 508 ("About a third of women with PMS who also have children have a history of mild to severe postpartum depression, which is twice the rate in the normal population."); *see* Burak & Remington, *supra* note 78, at 137 (stating that the author suffered from postpartum psychosis previously had severe episodes of PMS).

102. ROAN, *supra* note 3, at 6 ("[W]omen who experience premenstrual syndrome (PMS) are at increased risk of developing postpartum depression."); *see* DUNNEWOLD & SANFORD, *supra* note 75, at 46 (listing PMS as a risk factor).

103. DUNNEWOLD & SANford, *supra* note 75, at 63 ("For reasons that are not fully understood, clinical accounts suggest that once a woman experiences a postpartum reaction, her chance of experiencing PMS also rises, even if she never had any prior premenstrual symptoms."); DSM-IV, *supra* note 6, at 716 ("Females who have had severe postpartum Major Depressive, Manic, or psychotic episodes may also be at greater risk for severe premenstrual dysphoric mood changes.").

104. ROAN, *supra* note 3, at 117 ("Her studies–both in the premenstrual period and in the postpartum period–claim to show mood improvement in women who receive progesterone.").

105. *Id.* Further, blood tests on women with severe cases of PMS have not shown any progesterone deficiencies. *Id*

106. *See, e.g.*, Burak & Remington, *supra* note 78, at 196-97 (stating that Angela Thompson who drowned her baby had no prior history of PMS).

107. *See id.* at 185 (stating that a Penn State University professor located 18 infanticide cases in a five year period that relied on an "altered postpartum mental state" as a defense; nine resulted in acquittals).

Nonetheless, several defendants relying on a postpartum psychosis defense have achieved acquittals in various state courts.[110] A California judge overturned a jury verdict finding Sheryl Massip guilty of second degree murder and acquitted the defendant on temporary insanity grounds.[111] Massip alleged that she suffered from a postpartum psychosis when she ran over her six-week-old son with the family Volvo.[112] In New York, a jury acquitted Ann Green of two murder charges and an attempted murder charge after hearing evidence that she suffered from postpartum psychosis at the time of the misconduct.[113] Green had admitted suffocating her first baby in 1980 and her second in 1982, and further admitted to attempting to smother her third baby in 1985.[114]

Other defendants have relied on evidence of severe postpartum illness to obtain lenient sentences.[115] In response to expert evidence that the defendant, Latrena Pixley, suffered from postpartum depression at the time she suffocated her six-week-old daughter, a District of Columbia judge only sentenced Pixley to serve weekends in jail for three years.[116] Pixley, who pled guilty to second-degree murder, could have received a sentence of imprisonment between fifteen years and life.[117]

To the extent a trend exists in unsuccessful postpartum psychosis defenses where compelling psychiatric evidence exists, it is when the mothers (defendants) initially concoct kidnapping stories to mask the death.[118] Under such circumstances prosecutors point to the kidnapping story as proof of premeditation and rational acts.[119]

Hormonal Defenses Under Military Law

Mental Responsibility

The military's insanity standard is contained at Article 50a of the Uniform Code of Military Justice. That provision of military law provides:

> It is an affirmative defense in a trial by court-martial that, at the time of the commission of the acts constituting the offense, the accused, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of the acts. Mental disease or defect does not otherwise constitute a defense.[120]

To establish the defense of lack of mental responsibility, the accused has the burden of proof by clear and convincing evidence,[121] which has been defined as "lying somewhere between 'preponderance of the evidence' and 'beyond a reasonable

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108. Brooks, *supra* note 65, at A-22 ("Jurors are particularly skeptical of postpartum psychosis defenses . . . because the victims are babies."); *see* Moss, *supra* note 93, at 22 (stating that a defense counsel in Sheryl Massip case was "apprehensive about how the jurors will view the case, since they could be moved by 'passion and sympathy' for the child").

109. Brooks, *supra* note 65, at A-22 (citing San Diego defense counsel Jesse Gilbert).

110. Sabrina v. Collins, C.A. No. 17235, 1995 Ohio App. LEXIS 5149, *5 (Ohio Ct. App. Nov. 22, 1995) (stating that in 1981, an Ohio defendant who had killed her infant son was found not guilty by reason of insanity after being diagnosed as suffering from postpartum depression with psychotic features); Davis, *supra* note 83, at D1 (reporting that a Virginia judge found a Cambodian immigrant mother, who suffered from postpartum psychosis, not guilty by reason of insanity in the strangulation death of her 11-month-old daughter and four-year-old son); Yen, *supra* note 83, at A3 (reporting a Nebraska woman found not guilty by reason of insanity after killing her daughter).

111. Debra Cassens Moss, *Postpartum Psychosis Defense Succeeds,* A.B.A. J., Feb. 1989, at 40.

112. *Id.*

113. Sullivan, *supra* note 88, at 86.

114. *Id.* at 29-30.

115. *See, e.g.*, Brooks, *supra* note 65, at A22 (reporting that a San Diego woman who attempted to smother baby while suffering from postpartum psychosis sentenced to six years probation).

116. Paul Duggan, *Leniency in a Baby's Death,* WASH. POST, June 5, 1993, at A1.

117. *Id.*

118. Yen, *supra* note 83, at A3 ("In infanticide cases accompanied by a kidnapping story . . . the defense has been less effective . . . ."); *see* Moss, *supra* note 93, at 22 ("When women charged with such killings originally tell police the children were kidnapped, prosecutors and judges may cite it as evidence that the crime was premeditated.").

119. Yen *supra* note 83, at A3. However some mental health professionals argue that the kidnapping stories are a way of coping with the death. *Id.* (reporting that Dr. Eva Ebin, a psychiatry professor, opines that "the elaborate [kidnapping] stories may be 'a trick of the mind. It's a dissociative reaction. It's wishful thinking that they hadn't done it. They need to believe it in order to go on'").

120. UCMJ art. 50a(a) (1998).

doubt . . . .'"[122] However, the government "must still sustain its initial burden of establishing, beyond a reasonable doubt, every element of the offense—including *mens rea* [and] [t]he burden of disproving elements of the offense never shifts to the defense."[123] The military's insanity test is virtually identical to its federal counterpart[124] and is similar to the M'Naghten standard.[125]

Both the military and federal insanity tests require that the accused suffered from a mental disease or defect at the time of the crime and that such mental disease or defect be "severe." The initial inquiry in a mental responsibility defense then is whether a mental disease or defect exists. Unfortunately, there appears to be no definitive definition of these terms.[126] However, although not dispositive,[127] the reference source most widely relied upon within the criminal justice system to make this initial determination is the APA's DSM.[128] Further, for purposes of the military's mental responsibility standard, no substantive distinction exists between the terms mental disorder and mental illness and the statutory term mental disease or defect. "[I]t is the quality of the malady, not whether law and medicine attach the same label to it, that is significant."[129]

A "severe" mental disease or defect is a legal term of art,[130] but is not defined and is described almost exclusively in terms

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121. *Id.* art. 50a(b); MANUAL FOR COURTS-MARTIAL, UNITED STATES, R.C.M. 916(b) (1998) [hereinafter MCM]; *see* United States v. Martin, 48 M.J. 820, 825 (Army Ct. Crim. App. 1998). The defense must establish *both* that the defendant suffered from a severe mental disease or defect *and* that such mental condition caused him "unable at the time of the crime to appreciate the nature and quality or the wrongfulness of his acts." United States v. Reed, 997 F.2d 332, 334 (7th Cir. 1993) (sustaining conviction, the court noted that the defendant admitted "that he knew [his] voices were telling him to do something wrong"). Merely establishing that the defendant was suffering from a severe mental disease or defect at the time of the crime is not enough. *Id.*

122. United States v. Dubose, 47 M.J. 386, 388 (1998) (citation omitted); *see* United States v. Jones, NMCM 94 00485, 1999 CCA LEXIS 137, at *12 (N.M. Ct. Crim. App. May 7, 1999) (citations omitted).

123. United States v. Berri, 33 M.J. 337, 342-43 (C.M.A. 1991).

124. *Martin*, 48 M.J. at 822 ("substantively identical"); United States v. Lewis, 34 M.J. 745, 750 (N-M.C.M.R. 1991) ("virtually identical"); *see generally* 10 U.S.C.A. § 17 (West 2000). Indeed, Article 50a and 10 U.S.C. § 17 are both products of the Insanity Defense Reform Act of 1984. *Berri*, 33 M.J. at 343 n.12; *Lewis*, 34 M.J. at 749.

125. Lieutenant Colonel Donna M. Wright, *"Though This Be Madness, Yet There Is Method In It": A Practitioner's Guide to Mental Responsibility and Competency to Stand Trial*, ARMY LAW., Sept. 1997, at 20; *cf.* United States v. Bennett, 29 F. Supp. 2d 236, 238 (E.D. Pa. 1997) ("Where the M'Naghten standard prevails, as in the Insanity Defense Reform Act . . . ."). The original M'Naghten standard required that the defendant be "'laboring under such a defect or reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.'" 10 CLARK & FINNEY 200, 8 ENG. REP. 718 (1843) *cited in* Ralph Slovenko, *The Meaning of Mental Illness in Criminal Responsibility*, 5 J. LEGAL MED. 1 n.1 (1984). The military and federal requirement for a "severe" mental disease or defect is the only substantive difference between it and the M'Naghten standard.

126. DSM-IV, *supra* note 6, at xxi ("[N]o definition adequately specifies precise boundaries for the concept of 'mental disorder.'"). Recently, the Surgeon General defined "mental disorders as diagnosable conditions that impair thinking, feeling and behavior and interfere with a person's capacity to be productive and enjoy fulfilling relationships." Jeff Nesmith, *Mental Illness Often Ignored*, ATLANTA J. CONST., Dec. 14, 1999, at A1, A21. However, this definition includes within its ambit mental illnesses of "varying severity." *Id.* at A21.

127. United States v. DiDomenico, 985 F.2d 1159, 1168 n.5 (2d Cir. 1993) (Ward, J., dissenting) ("[T]hat a defendant is suffering from a disorder included in DSM-III-R is not dispositive of the legal matter."). Indeed, DSM-IV warns that "[t]he clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency." DSM-IV, *supra* note 6, at xxvii.

128. Slovenko, *supra* note 35, at 5; *see, e.g.*, United States v. Young, 43 M.J. 196, 198 (1995) (stating that government appellate counsel and court referred to DSM-IV, finding that Post-traumatic Stress Disorder was a mental disorder); *Lewis*, 34 M.J. at 745 (reviewing DSM-III-R as part of court's analysis); United States v. Jones, NMCM 94 00485, 1999 CCA LEXIS 137 (N.M. Ct. Crim. App. May 7, 1999) at *4-*14 (stating that the accused was diagnosed with bipolar disorder under criteria in DSM-III-R), *14 (reporting that appellate court rejects diagnosis of trial expert, in part, because it was "not in accord with appropriate reference to the DSM-III-R"); United States v. Scholl, 166 F.3d 964, 970 (9th Cir.), *cert. denied*, 120 S. Ct. 176 (1999) (reporting that district court relied on DSM-IV to permit limited expert testimony on compulsive gambling); Commonwealth v. Comitz, 530 A.2d 473, 477-8 (Pa. Super. Ct. 1987) (stating that the DSM-III was reviewed in case relying on postpartum depression as a defense).

129. United States v. Van Tassel, 38 M.J. 91, 92 n.1 (C.M.A. 1993). The critical inquiry in this area "is whether the *medical diagnosis* of an accused constitutes a malady that the *law labels* 'a severe mental disease or defect.'" *Id.* (emphasis in original).

130. Wright, *supra* note 125, at 21 ("['I]t is a legal term and not a medical term."). Military courts have recognized a bipolar disorder as a severe mental disease or defect. *Jones*, 1999 CCA LEXIS at *13; *cf.* United States v. Martin, 48 M.J. 820, 825 (Army Ct. Crim. App. 1998) (accepting "[a]s a matter of judicial economy" the government's concession that the accused's bipolar disorder was a severe mental disease or defect). At least one federal court has found paranoid schizophrenia to be severe mental disease or defect. United States v. Jain, 174 F.3d 892 (7th Cir. 1999). Another federal court found a serious case of post traumatic stress disorder to satisfy the federal insanity standard. United States v. Rezaq, 918 F. Supp. 463, 467 (D.D.C. 1996). In contrast, an "intermittent explosive disorder" has been rejected by a military court as a severe mental disease or disorder. United States v. Lewis, 34 M.J. 745, 751 (N-M.C.M.R. 1991). Similarly, an Antisocial Personality Disorder has failed to satisfy this requirement. United States v. Ogren, 52 M.J. 528, 536 (N.M. Ct. Crim. App. 1999) ("Such a diagnosis falls short of establishing a lack of mental capacity . . . ."); *see* United States v. Hurn, 52 M.J. 629, 634 (N.M. Ct. Crim. App. 1999) ("[T]he term 'severe mental disease or defect' does not include nonpsychotic personality disorders.").

of what is excluded from its definitional ambit. Congressional intent in using the term was "'to emphasize that non-psychotic behavior disorders or neuroses . . . do not constitute the [insanity] defense.'"[131] Rule for Courts-Martial (RCM) 706 provides further elaboration stating that "[t]he term 'severe mental disease or defect' does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, or minor disorders such as nonpsychotic behavior disorders and personality defects."[132] Although the statement of congressional intent and RCM 706 indicate that a psychosis meets this threshold requirement, in United States v. Benedict,[133] the Court of Military Appeals (COMA)[134] held that a mental illness need not rise to the level of a psychosis in order to form the basis for a defense of lack of mental responsibility.[135]

The defense must then prove that the severe mental disease or defect so impaired the accused's cognitive abilities at the time of the misconduct that the accused was unable to appreciate the nature and quality of her misconduct or appreciate that what the accused was doing was wrong. This may be established through the testimony of both lay witnesses and mental health professionals.[136] Indeed, expert testimony should be admissible to the effect that PMS or postpartum psychosis is a "severe" mental disease or defect and that it rendered the accused unable to appreciate the nature and quality or wrongfulness of her acts.[137] All relevant evidence, both objective and subjective, should be considered in making this determination.[138]

Prior to admitting expert testimony, however, the military judge must satisfy his or her "gatekeeping responsibility" of ensuring that the expert testimony or evidence "is not only relevant, but reliable."[139] This responsibility extends to all expert testimony regardless of how characterized.[140] At courts-martial, "[t]he primary locus of this obligation" is found in Military Rule of Evidence (MRE) 702.[141] This evidentiary standard contains three related requirements that: (1) the witness be "qualified as an expert by knowledge, training, or education . . .."; (2) the testimony involves "scientific, technical, or other specialized knowledge . . ."; and (3) such testimony serves to "assist the trier of fact to understand the evidence or to determine a fact in issue . . . ."[142]

The first prong is satisfied by establishing that the witness has, by virtue of education, experience or some combination thereof, "knowledge or skill [that the panel members] lack."[143] The rule is permissive allowing "'[a]nyone who has substantive knowledge in a field beyond the ken of the average court member' to be qualified as an expert witness."[144] The proffered witness "need not be an outstanding practitioner, but only someone who can help the jury."[145] In the PMS and post-partum mental

131. United States v. Whitehead, 896 F.2d 432, 436 (9th Cir. 1990) (citing S. Rep. No. 98-225 (1984), *reprinted in* 1984 U.S.C.C.A.N. 3182, 3411)).

132. MCM, *supra* note 121, R.C.M. 706(c)(2)(A).

133. 27 M.J. 253 (C.M.A. 1988).

134. On 5 October 1994, the National Defense Authorization Act for Fiscal Year 1995, Pub. L. No. 103-337, 108 Stat. 2663 (1994), changed the name of the Court of Military Appeals. The new name is the United States Court of Appeals for the Armed Forces.

135. *Id.* at 259; Wright, *supra* note 125, at 21 & n.36.

136. United States v. Dubose, 47 M.J. 386, 388-89 (1998); Wright, *supra* note 125, at 27.

137. *See generally* MCM, *supra* note 121, Mil. R. Evid. 704 (ultimate issue opinion permissible). However, the defense expert cannot express an opinion as to the accused's guilt or innocence. *Id.* app. at 22-48. In *United States v. Dixon*, the United States Court of Appeals for the Fifth Circuit held that expert testimony under the more restrictive federal rule, which would preclude testimony on the ultimate issue of a defendant's legal insanity, did not preclude an expert witness from testifying that "the defendant was suffering from a severe mental illness at the time of the criminal conduct; he is prohibited, however, from testifying that this severe mental illness does or does not prevent the defendant from appreciating the wrongfulness of his actions." United States v. Dixon, 185 F.3d 393, 400 (5th Cir. 1999).

138. *Dubose*, 47 M.J. at 389.

139. Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579, 589 & n.7 (1993); *see* United States v. Griffin, 50 M.J. 278, 283-84 (1999); *see generally* Major Victor Hansen, *Rule of Evidence 702: The Supreme Court Provides a Framework for Reliability Determinations*, 162 MIL. L. REV. 1 (1999).

140. Kumho Tire Co. v. Carmichael, 526 U.S. 137, 147 (1999); *see Griffin*, 50 M.J. at 284.

141. *See Daubert*, 509 U.S. at 589 (addressing the identical federal counterpart to MRE 702).

142. MCM, *supra* note 121, MIL. R. EVID. 702; United States v. Shay, 57 F.3d 126, 132 (1st Cir. 1995) (discussing the identical Fed. R. Evid 702).

143. EDWARD J. IMWINKELREID, EVIDENTIARY FOUNDATIONS 284 (4th ed. 1998).

144. *See* United States v. Stinson, 34 M.J. 233, 238 (C.M.A. 1992); *see also* STEPHEN SALTZBURG ET AL., MILITARY RULES OF EVIDENCE MANUAL 726 (3d ed. 1991 and 1996 Supp.) ("In other words, anything that makes someone more knowledgeable, skillful or experienced than the average person might qualify one as an expert.").

145. *Stinson*, 34 M.J. at 238; *see* United States v. Stark, 30 M.J. 328, 330 (C.M.A. 1990); SALTZBURG ET AL., *supra* note 144, at 726.

illness context, most mental health practitioners should satisfy this initial threshold requirement.

For mental health professionals testifying based on specialized knowledge of PMS or postpartum-related disorders, the Supreme Court's opinion in *Daubert* requires the demonstration of a reliable theory, technique or symptomatology for these particular mental illnesses, usually through evidence that "there has been adequate empirical verification of the validity of the theory or technique."[146] The Court in *Daubert* suggested a non-exclusive list of factors that a trial judge may consider when determining whether the proffered testimony "has a reliable basis in the knowledge and experience of [the relevant] discipline."[147] These factors include whether the theory or technique (1) has or can be tested, (2) has been the object of peer review and publication, (3) has a measurable error rate, and (4) enjoys general acceptance within the relevant professional community.[148] However, the Supreme Court noted "that the gatekeeping inquiry must be 'tied to the facts' of the particular case" and all four factors "may not be pertinent in assessing reliability" in every case.[149] Significantly, error rates for "soft" sciences such as psychiatry may not always be available.[150]

Evidence of PMS and postpartum related mental illness should survive a trial judge's reliability determination. The methodology used to study these mental maladies includes case studies and clinical interviews which is commonly relied on by mental health professionals.[151] Additionally, numerous published studies of PMS and postpartum mental illness exist and have been subject to peer review.[152] Further, the fact that a severe form of PMS and postpartum depression are recognized in DSM-IV is evidence that these mental illnesses are recognized and generally accepted within the mental health community.[153] However, because general acceptance is no longer a prerequisite for admissibility,[154] testimony concerning less severe forms of these two mental illness that are not contained in DSM-IV may still serve as the basis for expert testimony.

The third evidentiary prong, that the testimony assist the trier of fact, sets a relatively low threshold for admissibility. It does not require that such testimony be "absolutely necessary or that the subject matter of expert testimony be totally beyond the ken of court members . . . ."; rather, MRE 702 merely requires that the testimony be "helpful."[155] However, there must still exist "a valid connection between the expert's testimony and a disputed issue."[156] Absent such a connection, the testimony would be irrelevant and concomitantly not helpful.[157] For example, expert testimony describing an accused's mental impairment at the time of the charged miscon-

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146. INWINKELREID, *supra* note 143, at 286-87. By doing so the court "rule[s] out 'subjective belief and speculation.'" United States v. Hall, 165 F.3d 1095, 1102 (7th Cir. 1999).

147. Kumho Tire v. Carmichael, 526 U.S. 137, 149 (1999); *see* United States v. Kline, 99 F.3d 870, 883 (8th Cir. 1996) ("Daubert sets forth four factors which the district court should consider in determining whether the proffered expert testimony qualifies as 'scientific knowledge.'").

148. *Kumho Tire*, 526 U.S. at 149; *see* INWINKELREID, *supra* note 143, at 116; Hansen, *supra* note 139, at 18. The Peer review and publication factor allows the relevant community to identify flaws. Note, *Throwing the Bath Water Out with the Baby: Wrongful Exclusion of Expert Testimony on Neonaticide Syndrome*, 78 B.U. L. REV. 1185, 1200 n.113 (1998).

149. *Kumho Tire*, 526 U.S. at 149.

150. Note, *supra* note 148, at 1202. A "soft" science is one that does not rely on a "machine or other nonhuman indicators." State v. Burton, 590 N.Y.S.2d 972, 973 n.2 (N.Y. App. Div. 1992); *cf.* DOROTHY O. LEWIS, GUILTY BY REASON OF INSANITY 123 (1998) (stating that psychiatry is a "'soft' discipline" that relies on subjective determinations developed during sensitive interviews).

151. Note, *supra* note 148, at 1200 ("Similar case studies form the foundation for other accepted syndromes such as Battered Women's Syndrome (BWS) and Rape Trauma Syndrome (RTS)."). This methodology is commonly accepted as valid. *Id.* at 1201; *cf. Burton*, 590 N.Y.S.2d at 974 (noting that clinical interviews are a recognized methodology in psychiatry).

152. *See* ROAN, *supra* note 3, at 221-230 (listing multiple professional journal articles discussing postpartum-related mental illnesses and abnormalities); DALTON, *supra* note 6, at 275-284 (listing professional publications by Dalton addressing PMS); FRIEDRICH, *supra* note 39, at 147-153 (listing numerous articles published in various professional journals discussing PMS); LAURENSEN & STUKANE, *supra* note 6, at 197 (stating that PMS "has been the subject of more than three hundred scientific articles"). In 1931, Dr. Robert T. Frank published the first professional paper on PMS (then called premenstrual tension). The article "*The Hormonal Causes of Premenstrual Tension*" appeared in the *Archives of Neurology and Psychiatry.* LAURENSEN & STUKANE, *supra* note 6, at 34.

153. United States v. DiDomenico, 985 F.2d 1159, 1167 (2d Cir. 1993) (Ward, J., dissenting) (stating that DSM "disorders have gained general acceptance in the academic and clinical psychiatric communities"); *see* IMWINKELREID, *supra* note 142, at 289.

154. Daubert v. Merrell Dow Pharmaceuticals Inc., 509 U.S. 579, 588 (1993).

155. SALTZBURG ET AL., *supra* note 144, at 725. One federal appellate court articulated the inquiry as follows: would "the untrained layman . . . be qualified to determine intelligently and to the best degree, the particular issue without the enlightment from those having a specialized understanding of the subject matter involved." United States v. Shay, 57 F.3d 126, 113 (1st Cir. 1995) (citation omitted); *see* United States v. Houser, 36 M.J. 392, 398 (C.M.A. 1993). Testimony that invades the exclusive providence of the jury, such as witness credibility determinations, is not considered helpful. United States v. Kime, 99 F.3d 870, 884 (8th Cir. 1996).

156. *Shay*, 57 F.3d at 113 n.5 (*citing Daubert*, 509 U.S. at 591).

duct and how the impairment impacted on the accused's ability to form the requisite mental state of mind, or on the voluntariness of the accused's conduct would be admissible because such testimony would connect the accused's mental malady and its manifestations with the disputed issue of mens rea or actus reus, respectively.[158]

In their most aggravated forms, both PMS and postpartum mental illness should satisfy the military's mental responsibility standard. As discussed earlier, DSM-IV recognizes the most severe forms of both PMS and postpartum mental illness as mental disorders, and these disorders are both characterized by psychosis and hallucinations.[159] In such aggravated states, both mental illnesses may preclude the accused from appreciating the nature and quality or wrongfulness of her acts.[160]

Even when PMS or a postpartum mental illness does not arise to the level of a severe mental disease or defect, evidence of the mental condition may still be used to rebut the *mens rea* element of a charge. In *Ellis v. Jacob*,[161] the COMA recognized a partial mental responsibility defense, holding that Article 50a(a) does not preclude defense evidence that the accused lacked the specific intent necessary to sustain a conviction.[162] Currently, military courts will permit evidence of mental illness to rebut *mens rea* elements such as "premeditation, specific intent, knowledge, or willfulness."[163] However, evidence of mental illness may not be offered when the charged offense is only a general intent crime.[164]

Finally, evidence that the accused was suffering from the effects of PMS or postpartum illness, even in mild form, is admissible at sentencing. Rule for Courts-Martial 1001 permits the defense to present evidence to both explain the circumstances of the crime (extenuation) and to lessen the punishment (mitigation), regardless of whether the accused had presented such matters during the case in chief.[165]

Automatism

In addition to a complete or partial mental responsibility defense, PMS and postpartum mental illness may provide the basis for an automatism defense.[166] Automatism refers to "[b]ehavior performed in a state of mental unconsciousness or dissociation without full awareness . . ." and is associated with "actions or conduct of an individual apparently occurring without will, purpose, or reasoned intention . . . ."[167] Automatic behavior may be the result of numerous causes, including

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157. *Daubert*, 509 U.S. at 591; *see* United States v. Bennett, 29 F. Supp. 2d 236, 238-39 (E.D. Pa. 1997) (stating that the testimony of a mental health expert would be relevant and helpful if it "would 'support a legally acceptable theory of mens rea'") (citation omitted).

158. *Bennett*, 29 F. Supp. 2d at 239. Testimony that would address misconceptions about a woman's behavior following a birth or while under the influence of PMS would be helpful to the trier of fact. *See Houser*, 36 M.J. 398.

159. *See supra* notes 25-26 & 83.

160. *Cf.* DALTON, *supra* note 6, at 42 (stating that severe PMS may represent a form of temporary insanity). Of note, the postpartum psychosis defense has proven successful in at least one state court using the M'Naghten insanity standard. BURAK & REMINGTON, *supra* note 78, at 188-92 (stating that in a pretrial decision, the trial judge found author not guilty by reason of insanity–without objection from the prosecution–under Vermont's version of the M'Naghten insanity standard). *But cf.* Barton, *supra* note 65, at 598 (reporting that a woman who abandoned baby in desert convicted under Nevada's M'Naghten test despite expert testimony that she suffered from severe PPD).

161. 26 M.J. 90 (C.M.A. 1988).

162. *Id.* at 93 ("Article 50a(a), like its [federal] model, does not bar appellant from presenting evidence in support of his claim that he lacked specific intent . . . .").

163. U.S. DEP'T OF ARMY, PAM. 27-9, MILITARY JUDGES' BENCHBOOK, para. 6-5, at 780 (C2, 15 Oct. 1999); *see* Wright, *supra* note 125, at 27 ("knowledge, premeditation, or intent"); Major Eugene R. Milhizer, *Murder Without Intent: Depraved-Heart Murder Under Military Law*, 133 MIL. L. REV. 205, 237 (1991) ("[T]he defense of partial mental responsibility . . . can negate special mens rea requirements including actual knowledge . . . ."); *see also* United States v. Schap, 49 M.J. 317, 322 (1998) ("relevant to attack *mens rea* elements"); United States v. Morgan, 37 M.J. 407, 409 n.2 (C.M.A. 1993) ("[M]ay be used to attack the *mens rea* element of the offense . . . . "); United States v. Tarver, 29 M.J. 605, 608-09 (A.C.M.R. 1989) (holding that evidence of mental illness relevant to attack required *mens rea* elements).

164. United States v. Ogren, 52 M.J. 528, 536 (N.M. Ct. Crim. App. 1999) (stating that because the accused was charged with a general intent crime a mental diagnosis of Antisocial Personality Disorder "in no way relieves him of culpability"); United States v. Willis, No. 97-4091, 1999 U.S. App. LEXIS 18,298 (6th Cir. Jul. 29, 1999) (affirming district court's ruling excluding psychological testimony where defendant was only charged with a general intent crime); United States v. Gonyea, 140 F.3d 649, 654 (6th Cir. 1998) ("[D]iminished capacity is not a defense to general intent crimes . . . ."); United States v. Frisbee, 623 F. Supp. 1217, 1224 (N.D. Cal. 1985) ("The Court will not allow the jury to consider the testimony in connection with the issue of whether the defendant may have possessed the necessary intent to commit lesser offenses requiring only general intent.").

165. MCM, *supra* note 121, R.C.M. 1001(c)(1)(A) & (B); *see* Wright, *supra* note 125, at 29. Evidence of PMS or postpartum illness may serve as the basis for a downward departure under the federal sentencing guidelines for nonviolent crimes. United States Sentencing Commission Federal Sentencing Guidelines Manual, § 5K2.13, Diminished Capacity and Application Note (1988) (stating that if the defendant suffered from "a significantly impaired ability to (A) understand the wrongfulness of the behavior comprising the offense or to exercise the power of reason; or (B) control behavior that the defendant knows is wrongful").

166. *See* Recent Decisions, *supra* note 8, at 264-65 (holding that "the physiological anomalies of PMS cause behavior in women which American courts might classify as automatistic").

sleepwalking, concussion, gunshot wounds, epilepsy, convulsions, reflexive action, delirium, and diabetic shock.[168] The majority of jurisdictions view automatism as conceptually distinct from an insanity or mental responsibility defense.[169] Military court decisions have recognized the automatism defense, but have failed to define its parameters.[170]

Unlike the mental responsibility defenses described above, which focus on *mens rea*, the automatism defense asserts that there existed no *actus reas* at the time of the criminal misconduct.[171] In other words, no voluntary act exists.[172] The absence of *actus reus* serves as a complete defense to any criminal charge because absent a criminal act no criminal liability may attach.[173] Significantly for military practitioners, automatism has been used successfully in at least one reported military case[174] and its continued viability as a military defense was confirmed by COMA in *United States v. Berri.*[175]

Automatism may also serve as a defense when a complete or partial mental responsibility defense would fail because (1) the automatism defense does not require proof of any mental disease or defect[176] and (2) it may be used as a defense to both general and specific intent crimes.[177] Automatism also offers a procedural advantage to the accused, which a mental responsibility defense lacks. Significantly, because the automatism defense is distinct from a mental responsibility defense, the government continues to retain the ultimate burden of proof.[178] Further, defense counsel need not satisfy the disclosure requirements for an insanity defense, unless the defense intends to

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167. BLACK'S LAW DICTIONARY 134 (6th ed. 1990); *cf.* Reed v. State, 693 N.E.2d 988, 992 (Ind. Ct. App. 1998) ("[A]utomatism is a state a person enters, where, although he may be capable of action, he is not conscious of what he is doing.").

168. State v. Hinkle, 200 W. Va. 280, 285 (W.Va. 1996); Reed v. State, 693 N.E.2d 988, 992 (Ind. Ct. App. 1998); Recent Decisions, *supra* note 8, at 264 n.93.

169. Major Michael J. Davidson & Captain Steve Walters, *United States v. Berri: The Automatism Defense Rears Its Ugly Little Head*, ARMY LAW., Oct. 1993, at 17, 18-19:

> The majority of authorities distinguish automatism from insanity because the unconsciousness at the time of the alleged criminal action need not be the result of a mental disease or defect, and a criminal defendant found not guilty by reason of unconsciousness–as distinct from insanity– is not subject to commitment to a mental heath institution.

Id. (citations omitted); *see also Hinkle*, 200 W. Va. at 285 ("[T]he weight of authority in this country suggests that unconsciousness, or automatism as it is sometimes called, is not part of the insanity defense . . . ."); *cf.* McClain v. State, 678 N.E.2d 104, 107 (Ind. 1997) (noting split in jurisdictions but electing to distinguish automatism from insanity). The Canadian courts also draw a distinction between the insanity and automatism defenses. ROLLIN M. PERKINS & RONALD N. BOYCE, CRIMINAL LAW 992 n.45 (3d ed. 1982).

170. United States v. Berri, 33 M.J. 337, 341 n.9 (C.M.A. 1991) ("What the status of unconsciousness might be under the Uniform Code of Military Justice, we do not decide here."). Without mentioning the COMA's opinion in *Berri*, the Army Court of Military Review tacitly recognized the automatism defense, but failed to fully develop it. However, the court did note–relying solely upon the cases cited by the appellant–that when presented with an automatism defense courts have examined the defendant's motivation for the misconduct and whether the defendant suffered from a condition that affected cognitive abilities at the time of the offense. United States v. Campos, 37 M.J. 894, 901 (A.C.M.R. 1993). Similar to a mental responsibility defense, an automatism defense contains "a mental component in the form of loss of cognitive functioning . . . . " *Hinkle*, 200 W. Va. at 285.

171. *See Berri*, 33 M.J. at 341 n.9 (stating that the common law and the Model Penal Code view the defense in terms of *actus reus*, but some jurisdictions treat unconsciousness as an affirmative defense).

172. State v. Connell, 493 S.E.2d 292, 296 (N.C. Ct. App. 1997); *Hinkle*, 200 W. Va. at 286; *Reed*, 693 N.E.2d at 992-93; Recent Decisions, *supra* note 8, at 264 n.91 (citing U.S. and English cases).

173. *Connell*, 493 S.E.2d at 296 ("Unconsciousness would be a complete defense because 'the absence of consciousness not only precludes the existence of any specific mental state, but also excludes the possibility of a voluntary act without which there can be no criminal liability.'") (citation omitted); *see* Davidson & Walters, *supra* note 169, at 25 ("If no *actus reus* is present, technically speaking, no 'act' giving rise to criminal liability exists.").

174. United States v. Braley, C.M.O. 3-1944, at 511-14. After receiving a blow to the head that had rendered him temporarily unconscious, Braley, while acting irrationally, pulled out a pistol and shot another sailor. *Id.* at 511-13. The subsequent murder conviction was set aside because Braley's injury caused him to act "on an automatic level." *Id.* at 513. Additionally, the accused was "unable to comprehend the nature and consequences of his acts or to distinguish right from wrong. *Id.* at 513-14. Here, the Navy Board appeared to combine the two defenses of insanity and automatism.

175. 33 M.J. 337 (C.M.A. 1991); *see generally* Davidson & Walters, *supra* note 169, at 17.

176. *Hinkle*, 200 W. Va. at 285 ("[U]nconsciousness does not necessarily arise from a mental disease or defect."); McClain v. State, 678 N.E.2d 104, 108 (Ind. 1997); *Reed*, 693 N.E.2d at 988 (stating that it "need not be the result of a disease or defect of the mind") (citation omitted); *see, e.g.*, *Connell*, 493 S.E.2d at 296 (stating that a defendant who indecently touched child while allegedly asleep entitled to present automatism defense).

177. *Connell*, 493 S.E.2d at 296 (Automatism "precludes the existence of any specific mental state . . . .")

178. *See Hinkle*, 200 W. Va. at 286 ("[T]he burden can be placed on the defendant to prove insanity" [but] "once the issue of unconsciousness or automatism is raised by the defense, the State must disprove it beyond a reasonable doubt in order to meet its burden of proof with respect to the elements of the crime.").

offer expert testimony during the trial on the merits concerning the accused's mental state at the time of the crime.[179]

A significant achilles heel for a PMS or postpartum mental illness based automatism defense is that the defense may fail if the misconduct is foreseeable.[180] State courts have rejected automatism as a complete defense when the behavior was the result of voluntary intoxication, a "black-out" when the defendant had a history of them, and a blow to the head received in a fight started by the defendant.[181] Accordingly, evidence that the accused previously suffered from an acute postpartum reaction, or that she engaged in similar PMS-related misconduct would be relevant to rebut the two respective defenses. Nonetheless, even under such circumstances an accused may still offer evidence of unconscious or automatic behavior to rebut the mens rea element of a charge, such as knowledge, specific intent, willfulness and premeditation.[182]

Conclusion

Insanity defenses are infrequently used, difficult to prove, rarely successful, and often controversial. Indeed, insanity defenses are often considered the defense of last resort. Criminal defenses based on a postpartum mental illness or PMS in particular are no less controversial.[183] Indeed, even the leading authority on PMS, Dr. Katharina Dalton, has posited that it "is now the duty of both legal and the medical professions to ensure that the plea of PMS will not be abused . . . ."[184]

Military defense counsel must be particularly sensitive to the potentially hostile reaction of the finder of fact to these hormonal defenses. In the case of PMS, the defense may be trivialized or ridiculed as the raging hormone defense. In the case of postpartum illness, counsel will be attempting to excuse a woman from killing or injuring the most sympathetic victim imaginable—a baby. Nonetheless, with the proliferation of women into the armed forces, coupled with the growing recognition of PMS and postpartum mental illness as legitimate mental maladies, military practitioners should be familiar with their characteristics and potential as criminal defenses.

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179. MCM, *supra* note 121, R.C.M. 701(b)(2).

180. PERKINS & BOYCE, *supra* note 169, at 993; Davidson & Walters, *supra* note 169, at 24; *see Hinkle*, 200 W. Va. at 287.

181. PERKINS & BOYCE, *supra* note 169, at 993-94; Davidson & Walters, *supra* note 169, at 24-25; *cf. Hinkle*, 200 W. Va. at 287 n.24 ("The defense of unconsciousness must be distinguished from 'black-outs' caused by the voluntary ingestion of alcohol or nonprescription drugs . . . ."); State v. Morganherring, 517 S.E.2d 622, 641 (N.C. 1999) ("The defenses of voluntary intoxication and automatism are fundamentally inconsistent . . . .").

182. Davidson & Walters, *supra* note 169, at 25.

183. JANE M. USSHER, WOMEN'S MADNESS: MISOGYNY OR MENTAL ILLNESS? 248, 249 (1991) (describing PMS and PND as "counterfeit concoctions"). "The other favourite of the mental misogynists is women's wandering womb, which makes a transition from the Victorian disease, hysteria, to the late-twentieth-century syndromes, premenstrual syndrome (PMS), post-natal depression (PND) and menopausal syndrome." *Id.* at 248; Recent Decisions, *supra* note 8, at 267 (noting that "fears among the public that all women charged with crimes could escape liability merely by asserting the PMS defense"); DERSHOWITZ, *supra* note 57, at 334 (listing PMS as an "abuse excuse").

184. DALTON, *supra* note 6, at 173.