The Psychiatrist's Guide to Right and Wrong: Part III: Postpartum Depression and the "Appreciation" of Wrongfulness

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Whether or not the psychiatrist testifies on the ultimate issue in insanity defense cases, it is critically important that he familiarize himself with the applicable legal standards and interpretations in order properly to relate his clinical findings to the relevant criteria for insanity and thereby enhance the probative value of his testimony. This is the third in a series of articles which attempts to explicate judicial and statutory standards of insanity and correlate them with the psychiatrist's findings of psychopathology. This article analyzes the Model Penal Code formulation of insanity, with especial emphasis on the all important distinction between "know" and "appreciate." This formulation permits the defendant possessed of mere surface knowledge or cognition to be exculpated, requiring that he have a deeper affective appreciation of the legal and moral import of the conduct involved if he is to be held criminally responsible. The Model Penal Code approach more readily lends itself to application as a standard of responsibility in cases involving affective disorders. An important disorder within this group, postpartum depression, is discussed in the context of raising the insanity defense in a case of infanticide.

In almost all litigated insanity defense cases, the principal issue in dispute is whether the defendant knew or appreciated the wrongfulness of his conduct.*

Far from being a mere pedantic exercise, the precise interpretation to be accorded to wrongfulness in a particular case may be dispositive in regard to the ultimate outcome.[1] References in the M'Naghten rules to the appropriate standard of wrongfulness were ambiguous, resulting in a divergence of judicial opinion as to whether wrongfulness means *legal wrong*, *subjective moral wrong*, or *objective moral wrong*. These three judicial standards of wrongfulness were analyzed in a previous paper in the context of case

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* This article will discuss *cognitive* legal tests for insanity and will not deal with *volitional* tests. APA has stated that psychiatric knowledge relevant to cognitive tests is more reliable and has a stronger scientific basis, whereas "the line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk."[4] In cognitive tests, a determination of insanity almost never deals with the first prong of the legal test (i.e., whether the defendant knew or appreciated the "nature and quality" of his act), but decisively turns on the second prong (i.e., whether he knew or appreciated that what he was doing was wrong).

law from jurisdictions which follow each of the respective standards.[2] A subsequent paper systematically analyzed a classificatory scheme of delusions (subdivided according to content) to determine which delusional subtypes were likely to be exculpatory within a particular jurisdiction.[3] The analysis demonstrated that in most cases, exculpation will depend on the specific *content* of a defendant's delusions and whether, as a result of his delusions, he was unable to know or appreciate the wrongfulness of his act (wrongfulness to be determined according to the law of the jurisdiction in which the act was committed [the *lex loci delicti commissi*]).[3]

In 1982, APA issued its *Statement on the Insanity Defense*,[4] recommending that psychiatric disorders potentially leading to exculpation "should usually be of the severity (if not always of the quality) of conditions that psychiatrists diagnose as psychoses."[4] A broad range of psychotic psychopathology may or may not rise to the level of insanity, including delusions, hallucinations, gross disorganization of behavior, incoherence or marked loosening of associations, and extreme affective disturbances. There is no perfect correlation, however, between specific mental states that defendants manifest and legal insanity standards.

For heuristic purposes, the earlier paper selectively focused on an analysis of delusions in terms of their effect on a defendant's knowledge or appreciation of wrongfulness. Similarly, in order to clarify the effect of major affective disturbances on culpability, this article will restrict the focus of its inquiry to an important disorder within this group: postpartum depression.

"To Know or Appreciate": The Model Penal Code Formulation

The problem of defining the criteria of tests for legal insanity is one of the most difficult and controversial in the criminal law. The M'Naghten test turns on whether the defendant did not *know* the nature or quality of his act or *know* that it was wrong. The test thus addresses itself to the defendant's knowledge alone. Under that language, a psychotic defendant could be found sane

> even though his "knowledge" of the nature or wrongfulness of his act was merely a capacity to verbalize the "right" (i.e., socially expected) answers to questions put to him relating to that act, without such "knowledge" having any affective meaning for him as a principle of conduct. Such a narrow, literal reading of the M'Naghten formula has been repeatedly and justly condemned.[5]

The fact that a defendant may be "able to verbalize [mechanically] the right answer to a question" e.g., to respond that murder is wrong, or "the fact that he exhibited a sense of guilt, as by concealment or by flight, is often taken as conclusive evidence that he knew the nature and wrongfulness" of his conduct.[6] "Yet, one of the most striking facts about the abnormality of many psychotics is that their way of knowing" differs significantly from that of the normal person.[6] It may be compared to "the knowledge children have of propositions they can state, but cannot understand. It has no depth and is divorced from comprehension."[6] The M'Naghten rule improperly

confines the inquiry to the defendant's cognitive capacity.† One shortcoming of this restriction is that it authorizes a finding of responsibility in cases in which the defendant's knowledge of the wrongfulness of his conduct or its consequences "is a largely detached or abstract awareness that does not penetrate to the affective level."[8] "It seems clear that the knowledge that should be deemed material in testing responsibility is more than merely surface intellection [or cognition]; it is the appreciation that sane men have of what it is that they are doing" and the legal and moral import of their conduct.[6] Psychosis, even in its most extreme forms, may not destroy the minimal awareness required by M'Naghten, yet may still impair one's ability to use such knowledge in determining conduct (i.e., impair the capacity that rational individuals have "to guide their conduct in the light of knowledge").[6] Insofar as a formulation centering on mere surface knowledge or cognition does not readily lend itself to application to emotional abnormalities,‡ the M'Naghten test has been regarded as "less than optimal as a standard of responsibility in cases involving affective disorders."[8]

The formulation of the Model Penal Code[8] (followed or adopted in some form by a majority of the jurisdictions in this country) is "based on the view that a sense of understanding broader than mere cognition" provides the best opportunity for reconciling the traditional concept of legal and moral accountability with contemporary scientific knowledge about psychiatric dysfunction.[6] In this formulation, a new dimension is accorded the word "know" by following it with "appreciate." The inquiry now would be not merely whether the defendant lacked *knowledge* of the nature or the wrongfulness of his conduct, but also whether he was lacking in capacity§ to *appreciate* its nature or wrongfulness. Psychiatrists should take careful note of this change. "The use of 'appreciate' rather than 'know' conveys a broader sense of understanding than simple cognition."[8] By adding the requirement of appreciation to that of knowledge, psychiatrists are permitted to testify and explicate the distinction between mere verbalization and a deeper comprehension of wrongfulness, as discussed above. In order to properly relate his findings to the relevant legal criteria for insanity and thereby enhance the probative value of his testimony, under this formulation the psychiatrist can take into consideration that "to know or appreciate" encompasses more than just the minimal awareness of facts or the ability to mechanically repeat what has happened. He can weigh the defendant's "affective" or "emotional" knowledge in considering whether he appreciated in depth that his act was wrong (so as to be

† This perceived narrowness of the classic insanity test appears to have been by design. The framers of M'Naghten formulated a purely cognitive test selectively oriented towards delusional insanity only.[7]

‡ As one Court stated: "The M'Naghten Rule does not concern itself with the emotional state of a defendant, and in the instant case the appellant knew on a cognitive intellectual level the nature of his acts."[9]

§ Lack of "substantial capacity" (in the formulation of the Model Penal Code) is a more realistic measure than the *total* impairment required for exculpation under M'Naghten.

capable of logically or rationally directing his actions). By adding the requirement of appreciation to that of knowledge, the insanity dialogue is expanded to include a broader and more comprehensive view of mental functioning. As Goldstein[10] stated:

> [Knowledge] can exist only when the accused is able to evaluate his conduct in terms of its actual impact upon himself and others and when he is able to appreciate the total setting in which he is acting.

A classical example of the distinction between *knowledge* and *appreciation* is afforded by the historical case of *Hadfield.*[11] Hadfield suffered from the delusion that he was destined to be another messiah, to be sacrificed by the state, and to become a martyr to mankind's salvation.[7] It is undeniable that he *knew* it was wrong (in the sense of being both illegal and contrary to public standards of morality) to attempt to shoot King George III.[7] In fact, his express object in making the attempt was precisely to evoke public condemnation and capital punishment so that he might then return, like Christ, to save the world.[7] However, as a result of his messianic delusion, it could not be said that Hadfield *appreciated* the wrongfulness of his conduct. (Of course, Hadfield was not acquitted on the basis of this refinement and expansion of *M'Naghten* as embodied in the Model Penal Code formulation. His successful insanity defense, in 1800, predated the Model Penal Code by 150 years and was based on a far simpler legal test.[12])

In the following section, postpartum depression will be considered in terms of its exculpatory potential within jurisdictions which follow the Model Penal Code formulation (i.e., did the defendant know or appreciate the nature or wrongfulness of his conduct?).

Postpartum Depression

In DSM-III-R,[13] postpartum depression is classified as a major depressive episode. Psychiatric illness associated with pregnancy and the postpartum period has been recognized since the time of the ancient physicians, Hippocrates, Celsus, and Galen.[14] Many feel that the special conditions of pregnancy play a role in the precipitation of postpartum depression. Such conditions include (1) hormonal changes, (2) altered body image, (3) activation of conflicts relating to pregnancy, and (4) intrapsychic reorganization of assuming motherhood.[15] Asch and Rubin[16] have noted: "The postpartum woman can exhibit a variety of emotional responses, ranging from the almost ubiquitous "blue period" to deeper depression and finally to massive psychotic reactions."[16] Epidemiological studies confirm a marked increase in psychosis following childbirth.[17] The clinical symptomatology centers around the patient's maternal role and relationship to the baby. Depression, insomnia, irritability, lability of mood, confusion, obsessions, disorientation, depersonalization, hallucinations, and delusions may be present. The patient may become obsessed with the baby's welfare or may manifest guilt or feelings of inadequacy with regard to her care of the baby or ability to love it. The mother may hear voices telling her to kill the baby or express beliefs that

the baby is dead or defective in some way. The movie *Rosemary's Baby*[18] presents many of the classical clinical manifestations of postpartum depression, creatively transformed into a gothic tale of demonic possession.[16] These patients may come to the attention of the forensic psychiatrist when infanticide results from a postpartum illness. Asch[19] and others[20, 21] have reported that the incidence of infanticide in this condition has been neglected and underestimated. It is hypothesized that a large proportion of "crib deaths" or cases of sudden infant death syndrome (SIDS) are actually covert infanticides, manifestations of postpartum depression in the mother.[19]‖ [It should be emphasized, however, that all mothers who kill their babies during the postpartum period are not suffering from psychosis or depression. Resnick[22] and Pasewark *et al.*[23] diagnosed many of these women as suffering from personality disorders or neuroses. Resnick[22] proposed a classification system based on the mother's apparent motivation for infanticide, which included a number of nonpsychotic motives (e.g., unwanted child, altruism, and spouse revenge). These studies demonstrate the fallaciousness of the layman's perception that mothers who kill their own child must always be "crazy."

Case Example

Ms. A is a 38-year-old woman charged with murdering her two small children, ages four years and two months, respectively. After the birth of each child, she become very "blue" or depressed, withdrawn, "weepy at the drop of a hat," and filled with feelings of despair. She became obsessed with a growing conviction that "there is no hope in this world for children." She became progressively depressed and preoccupied with thoughts of death and dying, feeling that there was no reason to go on. She thought that she would be "carrying out God's plan" for herself and the children by killing them first and then committing suicide. At no time did she experience hallucinations or delusions involving a "divine command" to kill the children. She talked to the children about her plan, in a confused and rambling fashion, coming to believe that they understood and acquiesced in her scheme. After smothering both children to death, she was interrupted before she could complete her plan and kill herself. (Asphyxia is the most frequent documented cause of death in infanticides.[19])

A psychiatric expert, retained by the defense, found that, prior to the asphyxiation of her children, there were clearcut signs of *major depression*,¶ characterized by persistent and severe depression, vegetative signs, feelings of worthlessness and excessive guilt, recurrent thoughts of death, and a specific plan for committing suicide and killing

‖ Asch and Rubin[16] also describe postpartum reactions in the father, grandmother, adoptive mother, and in successive generations.

¶ The precise diagnosis was major depression with mood congruent psychotic features, based on the presence of delusional feelings of inappropriate guilt and worthlessness and poor reality testing (e.g., believing that her infant could understand and acquiesce in her plan). For heuristic purposes, the delusions and other psychotic distortions (that affect her *knowledge* as opposed to her *appreciation*) will not be considered here in order to restrict our focus to the impact of affective disorders *per se*.

her children as well. [*Postpartum depression* was noted as an equivalent diagnosis.] He opined that she was not criminally responsible for her conduct because she could not *appreciate* the wrongfulness of her act. Although she displayed "surface knowledge" that it was wrong to kill, he believed that her profound depression, overwhelming despair, and obsession with suicide and killing the children (expressed by her belief that they would all be "better off dead") interfered with her capacity on an emotional level. She *knew* the difference between right and wrong on an *intellectual* level, but could not *appreciate* in depth that her act was wrong on an *emotional* or *affective* basis.

A psychiatric expert retained by the prosecution disagreed, finding that she was neither psychotic nor suffering from a major depression at the time of the offense. He stated that she had "full conscious appreciation of the nature and consequences of her actions. . . . was quite aware that her behavior was criminal. . . . [and] did not lose her capacity for moral judgment, but rather, in a despairing mood, acted selfishly and impulsively." His diagnosis was mixed personality disorder.

Just prior to trial, the defendant entered into a plea bargain agreement, pleading guilty to manslaughter. Thus, there was no opportunity to have a full airing of the psychiatric issues at trial or to reach a verdict based on a careful appraisal of the psychiatric testimony.#

Discussion

In 1924, the English Parliament passed a specific Infanticide Act, reducing the crime of infanticide during the postpartum period from murder to a lesser offense.[24] "This act took official recognition of the fact that infanticide was often a specific expression of a psychopathological reaction to childbirth."[16] To date, there has been no comparable legislation in this country. Cases of infanticide are often prosecuted vigorously and murder convictions are sought even when the mother is clearly psychiatrically impaired. (A number of these women are found not guilty by reason of insanity. One study showed that women who commit infanticide in New York State were overrepresented in a study population of insanity acquitees.[23]**) However, it is not clear how often the insanity defense is raised in postpartum infanticide cases or how often it proves ultimately successful.†† The modern psychiatric perspective on this issue would appear to provide a sound basis for successful use of the insanity defense in many of these cases. The close relationship between postpartum depression (or psychosis), infanticide, and suicide is well-established.[25, 26]

Although her lawyer attempted to persuade her that there was an excellent chance of acquittal on the grounds of insanity, the defendant (perhaps in response to overwhelming feelings of guilt) insisted on pleading guilty.

** Exculpation is favored where sympathy can be aroused for the perpetrator of infanticide. It is inequitable when the "sympathy factor" bolsters the insanity defense of depressed mothers who kill their child but is unavailing in cases involving equally depressed fathers. (Fathers have a significantly greater likelihood of being incarcerated than mothers.[22])

†† Halpern and Sussman[27] argue persuasively that, in jurisdictions in which the prosecution is sympathetic to the mother's condition, it is more conducive to her best interests to avoid the insanity defense and instead plead guilty to a lesser offense in order to receive a no-incarceration sentence with a finite term of probation and outpatient treatment.

In this regard, the authoritative textbook *Modern Clinical Psychiatry* states:

> More homicides are committed by depressed women than by depressed men. Usually the victim is not only a member of the patient's family but the one who has apparently been the most loved. It has been suggested that the homicide may be regarded as an extension of the suicidal impulse. As suicide is an act of aggression against self, then the homicide . . . might be considered an extension of aggression to include not only the self but those nearest the self, the victim being almost a part of the self. *An example of this psychopathology is manifested when a depressed mother kills both herself and her child.*[28] [emphasis supplied]

Distinctions between mother and baby, self and object, may be blurred during the postpartum period. Impaired reality testing, magical thinking, and maternal impulses to get rid of the "bad part" of herself may lead to suicidal attempts. If the baby comes to represent the "bad part" to be exorcised, it may become the victim of suicidal drives which are displaced.[16]‡‡

Conclusion

The M'Naghten rule addresses itself to the defendant's *knowledge* of the wrongfulness of his act. Individuals suffering from affective disorders may possess mere surface knowledge or cognition of the wrongfulness of their act, but such knowledge may lack any depth or understanding of the import of the conduct in question. A shortcoming of the M'Naghten formulation is that it authorizes a finding of responsibility in such individuals, whose knowledge of wrongfulness is a largely detached or abstract awareness, which fails to penetrate to the affective level. The Model Penal Code formulation conveys a broader sense of understanding than simple cognition by use of the term "appreciate." The Model Penal Code approach more readily lends itself to application as a standard of responsibility in disturbances of mood or affect. For example, women suffering from postpartum depression who commit infanticide may be able to distinguish right from wrong intellectually, yet may lack capacity to *appreciate* in depth the wrongfulness of their act on an affective level. These individuals may be exculpated in jurisdictions relying on the Model Penal Code.

‡‡ This displacement of aggression and blurring of ego boundaries may extend to older children (as illustrated by the Case Example) as well as to the newborn. Psychodynamic interpretations of this type attempt to explain a phenomenon that is otherwise, from a commonsense point of view, abhorrent and incomprehensible. Even physicians have difficulty accepting the idea that a mother might kill her own child.[23, 29]

References

1. Morris N: "Wrong" in the M'Naughten rules. Modern Law Rev 16:435–40, 1953
2. Goldstein RL, Rotter M: The psychiatrist's guide to right and wrong: judicial standards of wrongfulness since *M'Naghten*. Bull Am Acad Psychiatry Law 16:359–67, 1988
3. Goldstein RL: The psychiatrist's guide to right and wrong. Part II. A systematic analysis of exculpatory delusions. Bull Am Acad Psychiatry Law 17:61–7, 1989
4. Insanity Defense Work Group: American Psychiatric Association statement on the insanity defense. Am J Psychiatry 140:681–8, 1983
5. People v. Wolff, 394 P.2d 959, 961 California (1964)
6. State v. Smith, 574 P.2d 548, 554 Kansas (1977)
7. Fingarette H: The Meaning of Criminal Insanity, Berkeley, California, University of California Press, 1972
8. Model Penal Code § 4.01
9. State v. Everett, 520 P.2d 301, 305 Arizona (1974)
10. Goldstein A: The Insanity Defense. New Ha-

ven, Connecticut, Yale University Press, 1967, p 49
11. Hadfield's Case, 27 Howell 1281 (1800)
12. Quen JM: Anglo-American criminal insanity: an historical perspective. Bull Am Acad Psychiatry Law 2:115–23, 1974
13. Diagnostic and Statistical Manual of Mental Disorders (ed 3 rev). Washington, DC, American Psychiatric Association, 1987
14. Hamilton JA: Postpartum Psychiatric Problems. St. Louis, MO, C.V. Mosby Co., 1962
15. Kane FJ: Postpartum disorders, in Comprehensive Textbook of Psychiatry (ed 4). Edited by Kaplan HI, Sadock BJ. Baltimore, Maryland, Williams & Wilkins, 1985
16. Asch SS, Rubin LJ: Postpartum reactions: some unrecognized variations. Am J Psychiatry 131:870–4, 1974
17. Herzog A, Detre T: Psychotic reactions associated with childbirth. Dis Nerv System 37:229–35, 1976
18. Movie based on Levin I: Rosemary's Baby. New York, Dell Publishing Co., 1968
19. Asch SS: Crib deaths: their possible relationship to postpartum depressions and infanticide. J Mount Sinai Hospital (New York) 35:214–20, 1968
20. Button JM, Reivich RS: Obsessions of infanticide: a review of 42 cases. Arch Gen Psychiatry 27:235–40, 1972
21. Athony EJ: A group of murderous mothers. Acta Psychotherapy (suppl) 7:1–6, 1959
22. Resnick PJ: Child murder by parents: a psychiatric review of filicide. Am J Psychiatry 126:325–34, 1969
23. Pasewark RA, Pantle ML, Steadman HJ: Characteristics and disposition of persons found not guilty by reason of insanity in New York State, 1971–1976. Am J Psychiatry 136:655–60, 1979
24. McIlroy AL: Influence of parturition upon insanity and crime. Br Med J 1:303–4, 1928
25. Hopwood JS: Child murder and insanity. J Ment Sci 73:95–108, 1927
26. Melges FT: Postpartum psychiatric syndromes. Psychosom Med 30:95–108, 1968
27. Halpern AL, Sussman RB: Psychotic mother charged with infanticide: new dispositional developments. NY State J Med 80:1553–6, 1980
28. Kolb LC: Modern Clinical Psychiatry. Philadelphia, W.B. Saunders Co., 1977, pp 454–5
29. Editorial. JAMA 181:42, 1962