NEONATICIDE AND THE "ETHOS OF MATERNITY": TRADITIONAL CRIMINAL LAW DEFENSES AND THE NOVEL SYNDROME

"Those juries knew that at or about the time of birth, dogs, cats, and sows . . . sometimes killed their own young. They were not prepared to extend less compassion and concern to a mentally sick woman than they would an excitable bitch."[1]

I. INTRODUCTION

The media is replete with reports of neonaticide, the killing of an infant within 24 hours of its birth.[2] Although hardly a new phenomenon,[3] only recently has this crime become the subject of serious sociological, psychological, and legal study. In fact, the term neonaticide was coined only in 1969 by Phillip Resnick in an article on the broader issue of fillicide.[4]

While media attention—and thus popular imagination as well—has focused on white, middle and upper class, suburban young women as the sensationalized "poster-girls" of neonaticide (how could *they*?), the act is in reality committed by women of "every age, of every race, ethnicity, and socio-economic class. They live in big cities and small towns, in housing projects and suburban luxury homes."[5] Their levels of education are equally diverse.[6]

Nevertheless, belying any differences, the scenario we see so often reported is common enough: A young woman carries a baby to term, typically while still living with her parents. One night, she finds herself writhing in pain from what she thinks is gastric distress and goes to the bathroom to relieve herself. Instead, she finds herself in labor. Alone in the bathroom while her parents and siblings sleep, she delivers a baby into the toilet and leaves it there. The arrival of the baby sets the young woman into a panic.

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[1] L. Abse, *Infanticide and British Law*, 6 CLINICAL PEDIATRICS 316-317 (1967).

[2] *See* C. M. Green & S. V. Manohar, *Neonaticide and Hysterical Denial of Pregnancy*, 156 BRIT. J. PSYCHIATRY 121 (1990); Blaine Harden, *Teen in Prom Baby Case is Charged with Murder*, L.A. TIMES, June 25, 1997, at A12; Pat Wiedenkeller, *Pregnancy, Denial, Tragedy*, NEWSDAY, Nov. 21, 1996, at A27; Barbara Kantrowitz, *Cradles to Coffins*, NEWSWEEK, July 7, 1997, at 52.

[3] *See* Green & Manohar, *supra* note 2, at 121.

[4] Phillip Resnick, *Child Murder by Parents: A Psychiatric Review of Fillicide*, 126 AM. J. PSYCHIATRY 325 (1969) [hereinafter Resnick, *Fillicide*]. Fillicide is the killing of a child by its parents. *Id.* The year after his article on fillicide, Dr. Resnick wrote an article devoted to the subject of neonaticide. Phillip Resnick, *Murder of the Newborn: A Psychiatric Review of Neonaticide*, 126 AM. J. PSYCHIATRY 1414 (1970) [hereinafter Resnick, *Neonaticide*].

[5] Michelle Oberman, *Mothers Who Kill: Coming To Terms With Modern American Infanticide*, 34 AM. CRIM. L. REV. 1, 23 (1996).

[6] *See id.*

She furiously cleans the bathroom of blood and afterbirth. Turning her attention to her dead baby, she puts it in a bag or wraps it in some towels. The baby is eventually found by another, disposed in some dark, unlikely receptacle, in a closet, trash-can, drawer, or dumpster. Later, the young mother, her parents and her friends deny any knowledge of the young woman's pregnancy.[7]

The commonality of this experience is further apparent beyond the recent past. Mythological, philosophical, religious, and historical texts alike demonstrate the age-old existence of infanticide generally and neonaticide more specifically. Psychiatry's "Medea Complex," for example, is eponymously derived from the ancient Greek myth of a spurned wife and mother who vengefully killed the children of her wayward husband.[8] In Ancient Greece, infanticide was sanctioned by law in some places, and was even defended by Aristotle and Plato.[9] As early as 315 C.E., Christian Canon Law abolished infanticide and held infanticide to be a culpable offense in response to the depopulation of the Roman Empire.[10] However, while "[u]nder Christianity, infanticide was forbidden as a policy, . . . it continued nonetheless to be practiced as an individual act, in which women, raped or seduced and then branded with their 'sin,' and under pain of torture or execution, [had] in guilt, self-loathing, and blind desperation done away with the newborns they had carried in their bodies."[11] Despite not being encouraged to do so outright by way of social and religious policy, "mothers who killed their infants or newborns received lesser sentences under both the laws of the church and the state than did parents who killed older children."[12] Thus, while the Church cannot be said to have expressly accepted the practice of neonaticide by way of more lenient treatment of the offender, its more indulgent treatment has been understood as recognizing the very real social pressures of "overcrowding and overpopulation;"

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[7] *See generally* Martha T. Moore, *Desperate Acts of Desperate Moms*, USA TODAY, June 25, 1997, at 3A; Faye Bowers, *Behind the Tragedy of Discarded Babies*, CHRISTIAN SCI. MONITOR, June 18, 1997, at 3; Kantrowitz, *supra* note 2; Jan Hoffman, *The Charge is Murder; An Infant's Death, an Ancient Debate*, N.Y. TIMES, December 22, 1996, at D4.

[8] *See* Neil S. Kaye, et al., *Families, Murder, and Insanity: A Psychiatric Review of Paternal Neonaticide*, 35 J. FORENSIC SCI. 133, 133 (1990). *See also* THOMAS BULFINCH, MYTHS OF GREECE AND ROME 161 (Bryan Holme ed. 1979).

[9] IAN F. BROCKINGTON, MOTHERHOOD AND MENTAL HEALTH, 430 (1996). For example, by law "[a]n Athenian father could dispose of his child at any time before the fifth day." *Id.*

[10] *See id.* at 431.

[11] ADRIENNE RICH, OF WOMAN BORN: MOTHERHOOD AS EXPERIENCE AND INSTITUTION 259 (1995).

[12] Kaye, *supra* note 8, at 134.

punishment was meted out accordingly.[13] The pages of history too abound with accounts of neonaticide:

> Among Mohave Indians, half-breeds [sic] were killed at birth. A merciless environment forced Eskimos to kill infants with congenital anomalies as well as one of most sets of twins. In China this practice was widespread as late as the 1800s. Daughters were sacrificed because they were unable to transmit the family name and imposed the burden on their parents of paying their marriage portion. It is claimed that the widespread murder of children in ancient times was first stemmed by the influence of the Christian religion.[14]

Thus read, population control and economic strains offer the most persistent historical explanations for these crimes.

In contemporary Western countries, however, where destitution and overpopulation are arguably less pronounced, neonaticide shocks our sensibilities, despite the fact that, as mentioned above, today's neonaticides cut across all economic classes and cultural strata.[15] Indeed, Amy Drexler, the suburban mother of the "Prom Baby",[16] was hardly a picture of poverty. Nonetheless, even in the contemporary United States we cannot easily dismiss the causal impact of social forces. As Professor Williams observes:

> Many seem to think that such tragedy [neonaticide] is inspired by some monstrous moral force that is both inhuman and unrelated to social influence. . . . [B]earing in mind that I want neither to forget the victims nor to forgive intentional violence,

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[13] *See id.*

[14] Resnick, *Neonaticide*, *supra* note 4, at 1414. Adrienne Rich makes similar observations:

> Throughout history numberless women have killed children they knew they could not rear, whether economically or emotionally, children forced upon them by rape, ignorance, poverty, marriage, or by the absence of, or sanctions against birth control and abortion. Although sickly and malformed infants of both sexes were killed or exposed, and twins perceived as monsters or as the product of a double impregnation by two different fathers, female children (and their mothers) have borne the brunt of official infanticidal practice, for various reasons; chiefly the expense of "marrying off" daughters and contempt for female life.

RICH, *supra* note 11, at 258. The prevalence of killing newborn daughters is attributed to numerous factors other than avoidance of an eventual dowry, including pure population control and, more radically, as an ultimate protection of their daughters: "Maori women killed girl infants to spare them a life of misery, degradation and slavery." BROCKINGTON, *supra* note 9, at 432. To be sure, however, not all cultures engaged only in selective, male-biased killing: "Selective male infanticide, the ultimate retaliation for male chauvinism, was practiced by the Amazons, by the Agni tribe in West Africa, and by a female community inhabiting the mountain fastness of the Beja Region in Portugal." *Id.*

[15] *See* Bowers, *supra* note 7, at 3.

[16] Harden, *supra* note 2, at A12. Amy Drexler was charged with murder after having given birth to a baby in a bathroom during her highschool prom in New Jersey. The baby was found in a plastic bag and had died either by suffocation or strangulation. *Id.*

> is it nonetheless possible to make some connection between the sudden prevalence of such cases and some of our recent social policies? After all, here it is Anno Domini 1997, the second decade of the AIDS plague and, *mirabile dictu*, we are actually defunding sex education in schools. The entire field of social work, including family therapy and guidance counseling, is under attack by powerful conservative think tanks . . . Our most popular forms of infotainment teach that violence holds the answer to all life's obstacles—but that complaining about being on the receiving end is 'political correctness' or 'victimology.' Incidents of rape and incest are underreported and disbelieved. Birth control or prenatal care for minors—to say nothing of abortion—is overshadowed by 'squeal laws' requiring parental permission for any number of medical procedures. Welfare 'reforms' have insured that life-on-one's-own for young single mothers has been made not only shameful but despicable, not only undesirable but materially unsustainable.[17]

Just as poverty, disease, and over-population served to frame (or, perhaps, map out the cause and effect of) historical instances of neonaticide, the current debates on and resolution of issues surrounding, *inter alia*, welfare, abortion, family values, and public school education provide the context for today's killings. While the historical justifications of "over-crowding" and dowry-avoidance are, perhaps, no longer persuasive or relevant in the American suburban landscape, the virulent, often violent attack on abortion rights and the continued stigma of single-motherhood have not. These issues serve, *at the very least*, as a context within which to view the complex influences and pressures of diverse social forces at work on these women.

However, the import of contextualizing cases of neonaticide within a larger framework does not end with a simple understanding of our current cultural and socio-political climate. The more salient point is that neonaticide be understood as a "clinical entity"[18] comprised of symptoms and behaviors that pervade the stages of pregnancy, delivery, and killing, such as the woman's denial of her pregnancy and a psychotic break at the time of delivery that results in the death of the newborn. The literature indicates that the women who go through this intense denial, dissociation, and rationalization of their pregnancies are prevented from both concealing their pregnancies in the true sense and from

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[17] Patricia J. Williams, *An Ear For An Ear; Punishment for Teenage Mothers Who Kill Their Babies*, NATION, July 28, 1997, at 10.

[18] Morris Brozovsky and Harvey Falit, *Neonaticide: Clinical and Psychodynamic Considerations*, 10 J. AM. ACAD. CHILD PSYCHIATRY 673, 679 (1971).

premeditating the killing of the newborn.[19] To this end, there has been some discussion of legally recognizing a putative Neonaticide Syndrome.[20] Such a syndrome would consist of evidence introduced by the testimony of expert witnesses of common patterns of behavior in cases of neonaticide, such as denial of pregnancy, and self-deluding rationalization of the physical manifestations of pregnancy. The evidence introduced would thus serve to explain the behavior of a particular defendant within a recognized and documented pattern of behavior and clinically verified symptoms.[21]

While it may be argued that traditional criminal law defenses such as involuntariness, insanity, and diminished capacity suffice to defend a woman charged with the murder of her newborn, without the additional testimony of an expert witness as to similar instances of conduct in other women by way of a Neonaticide Syndrome, such a limitation on her defense ignores the practical problems she faces. That is, while there may be seemingly apt defenses available at law, their adequacy is purely academic since the most pervasive behavior in these cases is the denial of the pregnancy,[22] a concept not immediately conceivable for the average juror because of deeply held notions of motherhood and the maternal function.[23] Indeed, the denial of pregnancy is the most significant symptom common to these women, as well as the leading reason for the psychotic breaks that occur at the time of delivery: The appearance of an infant after months of denying its existence results in reactive psychosis during which a woman either actively kills or leaves to die her newborn infant.[24] Since the killing of a neonate by its mother is fundamentally inconsistent with the conduct expected of a woman, the admissibility of evidence of Neonaticide Syndrome would work to counter the natural expectation of maternal care and further explain how it is entirely possible for a woman to deny what would appear to anyone most ostensibly undeniable, namely, her pregnancy.

Thus, legally admitting evidence of a Neonaticide Syndrome would serve a two-fold purpose: First, a recognized syndrome could be used to assist the trier of fact to conclude whether the defendant had the ability to form the *mens rea* required in the homicide statute under which she was charged. The jury would need this

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[19] *See* BROCKINGTON, *supra* note 9, at 446.

[20] *See* People v. Wernick, 215 A.D.2d 50 (N.Y. App. Div. 1995), *aff'd* 674 N.E.2d 322 (N.Y. 1996).

[21] *See id.* at 328 (Simons, J., dissenting).

[22] *See* Brozovsky & Falit, *supra* note 18, at 679.

[23] *See infra* Part IV.C.

[24] See Brozovsky & Falit, *supra* note 18, at 679-81.

testimony to come to a complete determination because the testimony would relate to information on which they have no real personal knowledge (i.e., denial of pregnancy).[25] Therefore, not only would a jury have at their disposal testimony regarding the particular defendant's mental state (including her denial) during her pregnancy, the delivery of her infant, and its death, expert witnesses would also be able to testify to the existence of these same symptoms and behaviors in other women so as to demonstrate that such behavior comprises a clinical entity recognized by the scientific community. In this regard, the denial of her pregnancy is rendered more believable and her perceptions more reasonable with such testimony, admission of which would entail no legal innovation as such testimony is already accepted in the case of Rape Trauma Syndrome in courts throughout the country.[26] With this information, a jury could come to an informed conclusion as to how the totality of symptoms experienced by a woman, including both her denial of her pregnancy and a psychotic episode at the time of the fatal act, militates against the intentionality element of the crime by way of a traditional defense (e.g., involuntariness, insanity and diminished capacity).[27] It is important to stress that recognizing a Neonaticide Syndrome would not create a new defense at criminal law. Instead, it would simply allow an expert witness to testify as to an aggregate of symptoms and behaviors bearing directly on a woman's ability to formulate the *mens rea* required for a conviction.

The second purpose served by recognizing a Neonaticide Syndrome is the formalization of the actual albeit unnamed practice of softer sentencing already occurring in the courts. That is, these women, although charged with murder, are seldom convicted of that crime.[28] There appears to be a tacit understanding by judges and jurors alike that the acts committed by these young mothers are not in fact premeditated or done with heartless malice but are rather the product of a mental disturbance.[29] This tacit understanding is illustrated by the courts' sentencing patterns; the young women generally receive suspended sentences, community service, probation, or short prison terms.[30]

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[25] *See Wernick*, 674 N.E.2d. at 327 (Simons, J., dissenting).

[26] *See infra* Part IV.A.i.

[27] For Defenses discussion, *see infra* Part VI.

[28] *See* Oberman, *supra* note 5, at 44-9.

[29] *Id.*

[30] *Id.* at 26.

Clearly, failing to admit a Neonaticide Syndrome would not completely prevent a woman charged with the killing of her newborn from putting forth a defense. If a Neonaticide Syndrome ultimately is not deemed to be acceptable as reliable evidence or if a court in a given jurisdiction might choose not to accept it for reasons of relevance or prejudice in favor of the defense, the accused may, as already stated, still assert pertinent criminal law defenses via traditional categories of involuntariness, insanity and diminished capacity. The psychiatric literature on neonaticide is full of references to Brief Psychotic Disorder[31] and what can be considered Depersonalization Disorder,[32] conditions currently recognized in the *Diagnostic Statistical Manual of Mental Disorders* ("DSM-IV"). A defense attorney may raise an insanity, diminished capacity, or involuntariness defense to the neonaticide, introduce evidence that her client suffered from one or another of these disorders, and argue that the disorder is a mental disease or defect within the meaning of the appropriate defense as it is defined in that jurisdiction. The advantage to this approach is that the there are no substantial evidentiary obstacles to surmount (i.e., admissibility under a *Frye* or *Daubert* hearing) since both of these disorders are already recognized in the *DSM-IV*.[33]

The purpose of this Note is not to trivialize the gravity of these killings, nor does it pursue an avenue that would allow women to "get away with murder." Rather, it is an attempt to combine both the legal and psychiatric literature on neonaticide in order to commence a serious exploration of the possibility that a syndrome explains how psychological factors such as denial, rationalization, Brief Psychotic Disorder, and Depersonalization Disorder may work to undermine the *mens rea* element of the murder statutes under which these cases are typically brought. Additionally, it is an attempt to adduce that, although recognizing a neonaticide syndrome would be the optimal manner to understand and defend fully cases of neonaticide, traditional criminal law defenses, in combination with the *DSM-IV* and its recognition of Brief Psychotic and Depersonalization Disorders, currently provide a means, albeit incomplete due to common societal misperceptions of the so-called maternal instinct,[34] to mount a credible legal defense.

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[31] *See infra* Part III.C.i.

[32] *See infra* Part III.C.ii.

[33] For a discussion of the evidentiary problems that may arise when attempting to introduce Neonaticide Syndrome into evidence, *see infra*, Part V. Note, however, the caveat in the *DSM-IV*, *infra* note 238.

[34] *See infra* Part IV.C.

This Note will begin by examining neonaticide as a crime charged under various homicide statutes and some of the case law available on the subject.

The second section of this Note will consist of a review of the psychiatric and medical literature on neonaticide and will summarize a case study taken from a case report on neonaticides to illustrate common attributes of women who commit neonaticide. This section is designed to consolidate the research already done on neonaticide by the psychiatric community in order to provide a clinical context for the killings, as well as an aggregation of behaviors which are common to the women who commit this crime.

The third section of this Note will explore the use of syndromes in criminal trials generally, with specific reference to Rape Trauma and Battered Woman Syndromes. These Syndromes will be discussed as illustrations of how syndrome evidence is received and used in courts. *People v. Wernick*,[35] the first case to mention Neonaticide Syndrome, and the issues raised at trial and on appeal will then be discussed. This section will further consider the behaviors of these women as possibly comprising a Neonaticide Syndrome that could be used in court as evidence that they could not form the intent required to support a conviction. This section will also examine the inclusion of Brief Psychotic Disorder and Depersonalization Disorder in the *DSM-IV* and the symptoms of these disorders. Finally, this section will argue that the existence of an ethos of maternity in our society is the thing that requires such a Syndrome to exist, since that ethos her prevents us from believing that she could deny her pregnancy.

The fourth section of this Note will review the admission of novel scientific evidence under *Frye* and *Daubert* and examine how Neonaticide Syndrome, and/or the use of both Brief Psychotic and Depersonalization Disorders featured in the *DSM-IV* might fare under each of these tests.

The fifth section of this Note will review the pertinent excuse defenses of involuntariness, insanity, and diminished capacity and how the putative Neonaticide Syndrome relates to the major approaches taken by the states to these defenses.

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[35] *See* People v. Wernick, 215 A.D.2d 50, (N.Y. App. Div. 1995); *aff'd* 674 N.E.2d 322 (N.Y. 1996).

II. NEONATICIDE: LEGAL CONSIDERATIONS

A. Elements

Infanticide, and therefore neonaticide, is not considered to be an offense distinct from murder in any American jurisdiction. While in the United States, infanticides are prosecuted under ordinary homicide statutes, other countries view infanticides differently from pure murder, treating it more leniently than is done in the United States.[36] Infanticides are so considered because

> [w]hether or not there is premeditation, there are other important factors at the moment of birth: various degrees and extremes of depression, despair, and desperation must be present in the minds of many of these women. The immediate psychological state may be dominated either by terror or fury. Most of the assaults on the infant, which employ suffocation or drowning, are compatible with panic. A minority, which involve head trauma or stabbing, testify to rage and hatred. . . . but the emotional extremes experienced by these women, in their pain, exhaustion and lonely peril, put the definition of insanity on trial. . . . mothers [feel] much anxiety . . . in the run up to a normal delivery aided by modern obstetrics, with its negligible mortality; is it possible to imagine the terror, anguish and despair of an ignorant girl facing such an ordeal alone, and that ruin that would follow discovery?[37]

The consideration of such factors led some jurisdictions to adopt statutes that are specifically directed towards infanticides. For example, in England, infanticides are prosecuted under the British Infanticide Act of 1922, which provides:

> Where a woman . . . causes the death of her child . . . under twelve months of age, but at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect . . . of lactation consequent upon the birth of the child, then, notwithstanding that the circumstances were such that but for this Act the offence would have amounted to murder, she shall be guilty of felony, to wit of infanticide, and may for such offence be dealt with and punished as if she had been guilty of the offence of manslaughter against the child.[38]

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[36] For a discussion on infanticide and neonaticide generally and the existence of infanticide statutes in Europe and Asia, *see* Oberman, *supra* note 5, at 7-17.

[37] BROCKINGTON, *supra* note 9, at 446.

[38] Oberman, *supra* note 5, at 15, citing the British Infanticide Act, 1938, 2 Geo. 6, ch. 36 (Eng.). The Act was amended in 1938 to include children of up to 12 months of age instead of simply newborn infants. *Id.*

The Act's reference to and "definition of 'disturbance' of the mind is more fluid and capacious than the modern insanity defense, thus making this defense available to virtually all women accused of killing their young children."[39] Hence, treatment of the crime as mere manslaughter instead of murder results in a more lenient treatment of the women who kill their children in countries which have infanticide statutes like England's. These jurisdictions which do have infanticides statutes appear to base those laws on a recognition of the severe stress of pregnancy and delivery, and "lactation-related hormonal imbalance."[40]

In the United States, "[t]he range of criminal charges brought against the neonaticide defendants . . . varies from unlawful disposition of a body, a misdemeanor, to first degree murder."[41] In the case where a neonaticide is prosecuted under an ordinary murder or manslaughter statute, as in any homicide, the prosecutor must prove *corpus delicti*,"the objective proof or fact that a crime has been committed" in order to obtain a conviction for the culpable homicide.[42] However, in this regard, cases of neonaticide present several problems. First, the prosecutor must establish the woman to be in fact the mother of the neonate. The hidden nature of the pregnancy in these cases, coupled with the furtive delivery and disposal of the dead neonate, render elusive the identity of the newborn's mother.[43] Connecting the corpse of a newborn found in a deserted alley to its mother is difficult enough without additional evidence pointing to a particular woman. This task is still more difficult where the mother never outwardly manifested her pregnancy.

Also problematic is that the prosecutor must demonstrate that the newborn was born alive.[44] Although the victim's being alive is always a prerequisite to homicide, the time at which human life begins varies with each jurisdiction. The traditional standard for determining whether a newborn was considered alive for the purposes of homicide was proof that the newborn had a separate and

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[39] *Id.*

[40] *Id.*

[41] *Id.* at 26.

[42] BLACK'S LAW DICTIONARY 344 (6th Ed. 1990).

[43] The concealment of the delivery by disposal of the newborn occurs in countless ways, such as incineration, flushing the cadaver in a toilet, burial, concealment in dresser drawers, bags, and suit cases, disposal in sewers, lakes, rivers, and even cannibalism. BROCKINGTON, *supra* note 9, at 444-5.

[44] *See* State v. Dickinson, 275 N.W.2d 599 (Ohio 1971).

independent existence from its mother.[45] Some jurisdictions have departed from this approach to hold that a child is born alive when it is capable of living independently from the mother, even if it is not actually independently living at the time of its death.[46]

Of course, there is an evidentiary hurdle faced in determining whether there was actually a live birth. While pathologists use several methods to establish that a newborn was born alive, such as proof of the aeration of the lungs,[47] their examination techniques are often inconclusive and must be considered along with other circumstantial factors, such as the time between the death of the newborn and the time the body was discovered.[48] Disputes over the sufficiency of evidence of the actual life of the newborn are often a primary subject on appeal.[49]

Finally, like in any prosecution, it must be proven that the death of the neonate was caused by its mother.[50] As will become apparent below, death by the criminal agency of the mother is a leading grounds for appeal in these cases, where the women claim that the infant had died during or immediately after birth, before she had a chance to attend to it.

B. Case Law

Neonaticide, despite its common occurrence, has generated little case law, and several attempts have been made to account for this dearth. One such explanation, discussed above, may be that the bodies of the newborns are never discovered due to the recondite nature of their disposal. Obviously, if the body of a neonate is

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[45] *See* Montgomery v. State, 44 S.E.2d 242 (Ga. 1947); Jackson v. Commonwealth, 96 S.W.2d 1014 (Ky. 1936); People v. Hayner, 90 N.E.2d 23 (N.Y. 1949); State v. Collington, 192 S.E.2d 856 (S.C. 1972); Morgan v. State, 256 S.W. 433 (Tenn. 1923).

[46] *See* People v. Chavez, 176 P.2d 92 (Cal. 1947); State v. Toney, 127 S.E. 35 (W. Va. 1925); Bennet v. State, 377 P.2d 634 (Wyo. 1963).

[47] *See* Logue v. State, 198 Ga 672, 32 S.E.2d 397 (Ga. 1944) (hydrostatic tests); Jackson v. Commonwealth, 265 Ky. 265, 96 S.W.2d 1014 (Ky. 1936) (examinations of color of the newborn's lungs); Heubner v. State, 131 Wis 162, 111 N.W. 63 (Wis. 1907) (examination of other vital organs for the presence of oxygen). *See also* Erik K. Mitchell and Joseph H. Davis, *Spontaneous Births into Toilets*, 29 J. FORENSIC SCI. 591 (1984) ("airway pulmonary edema foam, aeration of lungs and extrauterine materials on gastric content. . . . middle ear aeration and evaluation of the umbilical stump for signs of postnatal vital reaction." *Id.* at 591.).

[48] *See* Julie Wheelwright, *Death By Denial*, SCOTLAND ON SUNDAY, July 20, 1997, at 2.

[49] *See* discussion *infra* Part II .B.

[50] *See* State v. Dickinson, 275 N.W.2d 599 (Ohio 1971) The act causing the death of the infant may consist of an affirmative act by the mother or by omission, where the newborn dies of exposure or lack of medical attention immediately after the deliver. *See infra* Part II.B.

not found, the case will generally not be prosecuted.[51] Another factor may be that a neonaticide is difficult to attribute to any one person since the pregnancies are often denied and almost always hidden.[52] Indeed, in a study of sixty-two cases of neonaticide, one researcher was able to give the identity of the mother of a dead and discarded newborn in less than half of the cases.[53] In addition, many neonaticides remain unpublicized because the cases disappear through the pre-trial plea bargaining process or by poor media coverage.[54] Furthermore, even when cases are in fact appealed and decided, published opinions may be lacking. Finally, the "scarcity of appeals in these cases may reflect . . . that the outcomes are relatively lenient."[55] Thus, when a woman is sentenced to community service, probation, or counseling, she has no real incentive to appeal.

The following brief report on some of the available case law will review the current state of neonaticide in the courts, especially regarding the factors that tend to support murder and manslaughter convictions. It is in no way intended to be exhaustive.[56] Although not all of the cases necessarily fall within the rubric of an exculpating or mitigating psychosis, they must be reviewed in order to obtain a clear understanding of the way in which neonaticide is generally viewed by the courts, the charges that are frequently brought, the sentences imposed, and the objections raised to the convictions. Original charges are provided where they have been reported in the opinion.

In *State v. Richmond*,[57] a woman was charged with the murder of her newborn child.[58] At trial, she offered a physician's testimony on the existence of post-partum "puerperal mania or insanity" and argued that such mania often led to homicide.[59] The trial judge did not allow the testimony because there had not been a proper foundation for its introduction.[60] The Louisiana Supreme Court affirmed, holding that the expert testimony had no

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51 Note, however, that the body of the newborn need not be found or seen to establish *corpus delicti*, unless otherwise provided by statute. *See* Warmke v. Commonwealth, 180 S.W.2d 872 (Ky. 1944); Commonwealth v. Lettrich, 31 A.2d 155 (Pa. 1943).

52 Hoffman, *supra* note 7, at D4.

53 *See* BROCKINGTON, *supra* note 9, at 438.

54 *See* Oberman, *supra* note 5, at 26.

55 *Id.* at 26 n.107.

56 In the course of my research, I have found that the case law rarely, if ever, refers to "neonaticide" specifically. A good deal of creative research terms uncover the cases.

57 7 So. 459 (La. 1890).

58 *See id.*

59 *Id.*

60 *See id.*

relation to any proof already in evidence of her mental derangement at the time of birth and thus was irrelevant.[61] Her conviction and sentence to ten years imprisonment at hard labor were affirmed.[62]

People v. Ellwood[63] involved a woman who gave birth at her home and wrapped her newborn in a towel and plastic bag to dispose of it later in a lake.[64] At trial, she claimed that she thought that the baby was dead at the time of its birth.[65] She was convicted by a jury of second degree manslaughter.[66] On appeal, Ellwood challenged her conviction on several grounds, including insufficiency of evidence that the baby was born alive.[67] The New York Appellate Division found that the fact that she gave birth at home, that she placed the baby in a bag which she put in a nearby lake, along with the defendant's admission that the baby had been born alive constituted sufficient evidence to show that the infant was in fact born alive. Her other challenges to her conviction were deemed without merit and her conviction was affirmed.[68] Her sentence was not specified in the opinion.

People v. Ryan[69] involved an appeal from an involuntary manslaughter conviction. Ryan, a nurse, was found guilty of killing her newborn by wrapping it a towel and putting it into a valise.[70] The cause of death was determined to be "obstruction of blood aeration."[71] On appeal to the Illinois Supreme Court, Ryan contended that the newborn had already died before she wrapped it in a towel.[72] The court rejected that argument citing Ryan's contrary pre-trial and trial testimony, the testimony of the police, and several medical experts which all indicated a live birth.[73] As to Ryan's argument that the prosecutor had failed to prove that the newborn's death was the result of her criminal agency, the court rejected it on two grounds. First, the court found that Ryan's own testimony showed that she had at the very least made no attempt to ascertain whether the baby was living at birth and at the time it was

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61 *See id.*
62 *See id.*
63 205 A.D.2d 553 (N.Y. App. Div. 1994).
64 *See id.* at 553.
65 *See id.*
66 *See id.*
67 *See id.*
68 *See id.*
69 138 N.E.2d 516 (Ill. 1956).
70 *See id.* at 517.
71 *Id.*
72 *See id.* at 518.
73 *See id.* at 518-19.

wrapped in the towel and put in the overnight case.[74] Secondly, the court found that wrapping the newborn in a towel and placing it into an overnight case were sufficient to cause death.[75] The court affirmed her conviction of involuntary manslaughter.[76] The trial court's sentence was for three to ten years.[77]

In *People v. Weeks*[78] the Appellate Court of Illinois reversed a conviction of involuntary manslaughter.[79] Weeks, a twenty year-old woman, fell unconscious after an unattended birth in her bathroom.[80] The baby was born prematurely. When she awoke the next morning, she found that her infant had died during the night.[81] The next evening, Weeks placed the body of the newborn in the garbage as an admitted attempt to conceal the birth.[82] On cross-examination at trial, Weeks testified that she had screamed in pain during the birth but had not cried out for help or sought medical attention because she was "too embarrassed."[83] At the police station on the night of her arrest, Weeks had first denied giving birth to the child but later admitted to the delivery.[84] At no time did she assert that she had denied her pregnancy (her boyfriend, however, was the only other person besides herself who knew of the pregnancy tending to indicate that she had hidden her pregnancy from her family and friends).[85] The cause of the infant's death was not specifically established at trial.[86] Weeks appealed her conviction on insufficient evidence, asserting that the prosecution did not meet their burden of showing that she acted had recklessly.[87] In overturning her conviction, the court held that the prosecution had failed to prove beyond a reasonable doubt that she had been physically capable at the time of the birth to perform her legal duty to the newborn.[88] In reaching this conclusion, they pointed to the fact that Weeks had "testified that after

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74 *See id.* at 520.
75 *See id.*
76 *See id.* at 521.
77 *See id.* at 517.
78 450 N.E.2d 1351 (Ill. App. 2d. 1983).
79 *Id.* at 1355.
80 *See id.* at 1352.
81 *See id.*
82 *See id.*
83 *Id.* at 1353.
84 *See id.*
85 *See id.*
86 *See id.*
87 To obtain a conviction for involuntary manslaughter, the state had to prove beyond a reasonable doubt: "(1) that defendant did an act; (2) which caused the death of another; (3) and the act, which was such that it was likely to cause death or great bodily harm; (4) was performed recklessly." *Id.*
88 *See id.* at 1353-4.

the birth she was in pain, losing blood and felt weak; she covered the child with a blanket and lost consciousness until the next morning at which time the child was dead."[89] While the court recognized that the credibility of witnesses was a matter for consideration by the jury, it asserted that the jury could not "arbitrarily or capriciously reject the testimony of an unimpeached witness"[90] and reversed the conviction. Weeks had been sentenced to three years in prison by the trial court.[91]

In *People v. Doss*[92] the Appellate Court of Illinois refused to overturn a bench trial conviction of a fifteen year old girl for the murder in the first degree of her newborn.[93] The girl gave birth alone in a bathroom while her mother was out buying provisions for her daughter, who had been complaining of "severe menstrual cramps."[94] When Doss' mother came home from the store, she heard "a cry in her kitchen and discovered a newborn baby on top of the trash can, wrapped in a plastic garbage bag."[95] The mother promptly brought her daughter and the newborn to the hospital where the baby died from stab wounds to the chest.[96] Doss claimed that she did not know that she was pregnant until her eighth month because she had continued to menstruate until the seventh month of her pregnancy.[97] Doss' mother did not know that her daughter was pregnant.[98]

The trial court concluded that the wounds to the newborn had been intentionally dealt and were not the result of Doss attempting to detach the umbilical cord.[99] She was convicted of first degree murder and sentenced to 30 years in prison.[100] On appeal, the defendant challenged her conviction on several grounds. Doss contended that there was insufficient evidence to support a conviction of first degree murder and that she should have instead been convicted of involuntary manslaughter.[101] The court rejected this argument, stating that the Illinois first degree murder statute required a mental state which showed that "in performing the acts

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89 *Id.* at 1354.
90 *Id.*
91 *See id.* at 1352.
92 574 N.E.2d 806 (Ill. App. 2d. 1987).
93 *See id.* at 807.
94 *Id.*
95 *Id.*
96 *See id.*
97 *See id.*
98 *See id.*
99 *See id.* at 808.
100 *See id.*
101 *See id.*

that cause[d] death, an accused kn[ew] that such acts create[d] a strong probability of death or great bodily harm."[102] The court construed the statute to mean that no specific intent to kill needed to be shown, just that the act of killing was "voluntarily and willfully" done and would naturally lead to the destruction of another's life.[103] While Illinois had a statute which covered involuntary manslaughter, the court found that stab wounds constituted sufficient evidence to support the trial court's conviction under the first degree murder statute.[104]

The court also rejected Doss' alternative argument that the conviction should be reduced from first to second degree murder on a justification theory. Doss' justification claim consisted of an assertion that the "shock and fear of family disgrace"[105] brought about by the delivery led her to unreasonably believe that the killing was justified.[106] The court held that a reduction of first degree murder to second degree murder would obtain only when a defendant "is able to prove either that she was acting under a sudden and intense passion resulting from serious provocation, or she believed the circumstances, if they existed, justified the killing."[107] The court dismissed Doss' contention that she was acting under the heat of passion when confronted by the reality of the birth, holding that "a young child cannot cause the serious provocation required of second-degree murder."[108]

In *State v. Buffin*,[109] the 20 year old defendant gave birth at her parents' home where she lived.[110] When she went to the hospital for medical help after the birth, employees of the hospital called the police when they saw that she had all the concomitant signs of having given birth but could not locate the baby.[111] Buffin denied having given birth.[112] The body of the dead infant was found in a trash can in her bedroom.[113] The autopsy revealed that the baby had been born alive and had suffered burn marks and blows to its head (though it was unclear whether the head trauma were caused

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102 *Id.*
103 *Id.*
104 *See id.* at 808-9.
105 *Id.* at 809.
106 *See id.*
107 *See id.*
108 *Id.*
109 511 So.2d 1255 (La. Ct. App. 1987).
110 *See id.* at 1256.
111 *See id.*
112 *See id.*
113 *See id.*

by an object hitting its head or its head hitting the floor).[114] Expert testimony admitted at trial showed that while there was a strong chance that the amnesia the defendant claimed to have had regarding the delivery of the child was genuine, the possible amnesia had no bearing on whether or not she could have determined whether her conduct was right or wrong at the time of the death of the newborn.[115] Buffin was charged with second degree murder but pled guilty to negligent homicide.[116] She was sentenced to two years hard labor and subsequently challenged her sentence, contending that it was excessive.[117] The court rejected her claim, holding that a lower sentence would "depreciate the seriousness of the crime committed by the defendant."[118]

In *State v. Kinsky*,[119] Kinsky gave birth alone in her college dorm room.[120] She had previously been pregnant as a freshman in college, but had given the baby up for adoption.[121] Kinsky, a sophomore at the time of the second pregnancy, had hidden both pregnancies from her family and friends.[122] She testified that when she discovered that she was pregnant for a second time, she planned on giving up the baby for adoption as she had previously done.[123] After delivering the child, she wrapped it in some sheets and brought it to a dumpster. The body was subsequently found with a brassiere tightly tied around the baby's neck.[124] Kinsky was found guilty of second degree murder and was sentenced to a prison term of 121 months.[125] On appeal, the Kinsky claimed that the prosecution failed to prove that the baby had been born alive.[126] The Supreme Court of Minnesota found that the testimony of a radiologist at trial established both that the newborn's lungs had been "well aerated," indicating that the infant had been able to breathe before it died.[127] Kinsky contended that a mere showing of air in a newborn's lungs was insufficient to conclusively show that it had been born alive, citing *State v. Collington*.[128] She

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114 *See id.*
115 *See id.*
116 *See id.*
117 *See id.*
118 *See id.* at 1257.
119 348 N.W.2d 319 (Minn. 1984).
120 *See id.* at 321.
121 *See id.*
122 *See id.*
123 *See id.*
124 *See id.* at 322.
125 *See id.*
126 *See id.* at 322.
127 *Id.* at 324.
128 192 S.E.2d 856 (S.C. 1972). *See supra* text accompanying note 45.

also claimed that proof that the newborn had breathed was insufficient to prove that the neonate was "born alive and had an independent and separate existence from its mother," citing *Montgomery v. State*.[129] Avoiding having to make a pronouncement on the sufficiency of a showing of air in a newborn's lungs as proof of a live birth in Minnesota, the court noted that the radiologist also testified that skin around the infant's neck was discolored, indicating that blood was unable to return to the heart and therefore suggesting that there had been blood flow and therefore, life. None of these claims were successful and the appellate court affirmed her conviction.

Kinsky also argued that the trial court erred in not instructing the jury of the offense of concealing birth[130] as a lesser included offence of second degree murder. The court dismissed that argument, holding that concealment of birth was not a lesser included offense of murder because one could "commit second degree murder, as legally defined, without committing the offense of concealing birth, as legally defined."[131] Dismissing all of her arguments on appeal, the court affirmed Kinsky's conviction of second degree murder.[132]

In *Grahm v. State*,[133] the defendant was convicted of second degree murder.[134] The facts surrounding the case are vague. A baby was found dead in a bayou.[135] The state medical examiner was able to conclude that the full-term newborn had died from blows to the head at least four days prior to the autopsy.[136] Grahm denied pregnancy, delivery, or miscarriage[137] and agreed to submit to medical examinations[138] which showed a "substantial likelihood" that she had been pregnant and had delivered the infant.[139] In addition to this evidence, several witnesses testified that they believed Grahm had been pregnant.[140] Notwithstanding the evidence recited at trial, the Arkansas Court of Appeals reversed for insufficiency of evidence, reasoning that there was no real evidence that

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[129] Montgomery v. State, 44 S.E.2d 242 (Ga. 1947). *See supra* text accompanying note 45.

[130] MINN. STAT. § 617.22 (1982). It is a misdemeanor offense to "endeavor to conceal the birth of a child by any disposition of its dead body, whether the child died before or after birth." *Id.*

[131] *Kinsky*, 348 N.W.2d at 326.

[132] *See id.* at 327.

[133] 642 S.W.2d 342 (Ark. Ct. App. 1982).

[134] *See id.* at 342.

[135] *See id.* at 343.

[136] *See id.*

[137] *See id.*

[138] The opinion does not make clear how Grahm was linked to that particular infant.

[139] *Grahm*, 642 S.W.2d at 343.

[140] *See id.*

linked the dead newborn to Grahm and none to show that the death of the infant had been caused by her.[141] The court pointed out that while there was evidence tending to show that Grahm had recently been pregnant and that she had not disclosed the location of that baby (if in fact she had given birth), there were many reasons why a young woman would not admit pregnancy to others.[142] Since the naked showing of evidence that Grahm had given birth around the time the infant was found was insufficient to show that she had murdered the child in question, her conviction and sentence of three years imprisonment were reversed.[143]

In these eight, there was one conviction for first degree murder,[144] two for second degree murder,[145] three for various gradations of involuntary manslaughter,[146] one for negligent homicide,[147] and one for unspecified murder.[148] The sentences ranged from two years to ten years. Although this sample of cases is much too small to draw broad and general conclusions, it is interesting to note that the first degree murder conviction involved a case where the infant has suffered multiple stab wounds, while the more passive killings received convictions on lesser charges.[149]

The observations drawn from these cases do not widely differ from those made by Professor Oberman in her study on neonaticide:

> The sentences imposed ranged from intensive therapy, parenting classes, and probation to incarceration for thirty-four years. Convictions were reported in only fifteen of the forty-seven cases. Thus, despite the fact that at least twenty-nine of the defendants were charged with murder, far fewer were convicted. Still, at least ten of the fifteen women whose convictions were reported presently are serving prison sentences.[150]

These cases show that neonaticides frequently result in convictions for lesser crimes than originally sought by prosecutors and less severe sentences than those initially imposed by the trial courts.

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141 *See id.* The court discreetly stated: "There are young women who often times have their own reasons for never disclosing or admitting a pregnancy to others." *Id.*

142 *See id.*

143 *See id.*

144 *See supra* text accompanying notes 92-108.

145 *See supra* text accompanying notes 119-132, 133-143.

146 *See supra* text accompanying notes 63-91.

147 *See supra* text accompanying notes 109-118.

148 *See supra* text accompanying notes 57-62.

149 *See Doss*, 574 N.E.2d at 809; *see also* Oberman, *supra* note 5, at 26 ("[P]rosecutors were more likely to seek the most severe criminal sanctions where the newborns' bodies were mutilated in some fashion.").

150 Oberman, *supra* note 5, at 26.

III. NEONATICIDE: PSYCHIATRIC CONSIDERATIONS

A. Prenatal and Post-Partum Patterns of Behavior Documented in the Psychiatric/Medical Literature

The above review of the case law reveals an interesting trend: Of the eight cases presented, only one woman appealed her conviction based on the presentation of evidence of insanity at the time of the killing of the newborn,[151] while the other six women raised challenges to the sufficiency of evidence presented at trial relating to *corpus delicti* and *mens rea*.[152] One can only venture to guess as to why this is the case. Regardless, the lack of recourse to defenses involving assertions of mental disease or defect raises the question of how effectively the current understanding of pre- and ante-natal behaviors common to women accused of neonaticide affords them a proper defense.

Certain patterns consistently emerge from the studied instances of neonaticide, similarities which led one psychiatrist to view them as falling within a discrete "clinical entity."[153] An awareness of the attributes common to the women charged with the killing of their newborns is essential in order to allow today's practitioner to defend competently a woman charged with such a killing within traditional criminal law defenses. Furthermore, this understanding is indispensable to a concerted inquiry as to whether a Neonaticide Syndrome can be recognized and used by tomorrow's attorneys as evidence in the defense of these women.

The psychiatric literature on neonaticide recognizes two groups of mothers who kill their newborns.[154] The group which is the focus of this Note "are usually young immature primiparas. They submit to sexual relations rather than initiate them. They have no previous criminal record and rarely attempt abortion."[155] Furthermore, some of these women also "remain unaware of their pregnanc[ies], through psychotic or hysterical mechanisms" and as such cannot be said to premeditate the killings, or even conceal their pregnancies.[156] The second group largely consists of older women who, in contrast to the younger women, are thought to conceal their pregnancies and premeditate the killings of the newborns. This latter group falls outside the scope of this Note

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151 State v. Richmond, 7 So. 459 (La. 1890).
152 *See generally supra* Part II.B.
153 Brozovsky & Falit, *supra* note 18, at 679.
154 *See* Resnick, *Neonaticide*, *supra* note 4, at 1416 .
155 *Id.*; *see also* BROCKINGTON, *supra* note 9, at 447.
156 BROCKINGTON, *supra* note 9, at 446.

and reference to women who commit neonaticide is limited to the former group.[157]

This discrepancy between groups aside, the characteristic most readily observed of women who commit neonaticide is their proximity in age. While neonaticides are for the most part committed by women between the ages of 16 and 38,[158] close to 90% of the killings are committed by women under 25 years of age.[159] In one study the average age of the women was 17.[160]

In addition to being young, these women are also often characterized as being immature and inexperienced. Dr. Resnick observed that the women were typically young, immature, and either had never been pregnant or had previously had a single child.[161] The literature also characterizes these young women as having "[p]assivity . . . as an attitude to sexuality as well as to pregnancy,"[162] leading one expert to conclude that this characteristic is the "most important temperamental characteristic of these women."[163]

Another significant similarity between these women is their marital status: Less than 20% of the mothers are married.[164] In speaking about neonaticides committed by both married and unmarried women, Dr. Resnick identified the stigma of a child born out-of-wedlock as a key factor.[165]

Apart from the more obvious characteristics that tend to describe the immaturity of the women, in age and otherwise, there are numerous behavioral similarities that appear to be symptomatic of the women who commit neonaticide.

The most significant similarity, and perhaps the most important with respect to both defending a woman charged with the killing of her newborn and in the consideration of a Neonaticide Syndrome, is the denial of pregnancy. While "[i]n cases where

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157 *See* Resnick, *Neonaticide*, *supra* note 4, at 1416.

158 Kaye, *supra* note 8, at 134; *see also* Green & Manohar, *supra* note 2, at 122 (indicating that these cases of neonaticide typically involve teenagers or young women); Resnick, *Neonaticide*, *supra* note 4, at 1414.

159 *Kaye*, *supra* note 8, at 134; *see also* BROCKINGTON, *supra* note 9, at 447.

160 Oberman, *supra* note 5, at 23 n. 90. Note that in Professor Oberman's sample, "the mean age of the subjects . . . [was] 21, while the median age [was] 20." *Id.*

161 *See* Resnick, *Neonaticide*, *supra* note 4, at 1416.

162 BROCKINGTON, *supra* note 9, at 447; *see also* Resnick, *Neonaticide*, *supra* note 4, at 14-16.

163 BROCKINGTON, *supra* note 9, at 447 (citing H. Gummerbach, *Die Kriminalpsychologische Persönlichkeit der Kindesmörderinnen und ihre Wertung im Gerischtsmedizinischen Gutachten*, 88 WIENDER MEDIZINISCHE WOCHENSCHRIFT 1151 (1938)).

164 *See* Kaye, *supra* note 8, at 134; *see also* Green & Manohar, *supra* note 2, at 122; Oberman, *supra* note 5, at 23.

165 *See* Resnick, *Neonaticide*, *supra* note 4, at 1416; *see also* BROCKINGTON, *supra* note 9, at 447.

pregnancy has not been sought, recognition of pregnancy is often delayed. . . .",[166] some of the women accused of neonaticide "go through pregnancy, labour and delivery with no apparent awareness that they have been pregnant or that they have given birth."[167] Dr. Resnick reported that "a woman who desperately does not want to be pregnant can mentally foreclose attachment. 'This a foreign body going through her, not a baby, and the bonding never occurs. She doesn't think of it as her child but as an object to get rid of.'"[168] Factors contributing to denial of pregnancy are the isolation of some of these women, so that there is no other person such as a friend or a family member who "notice and comment on the change in appearance,"[169] as well as a "moral climate antagonistic to extramarital sexual relations, with its fear of disclosure."[170]

To say that these women merely ignored and avoided their pregnancies would be a gross understatement. Instead, "[t]he utilization of massive denial of the gravid state is a prominent feature of this clinical entity [neonaticide]."[171] This denial can take several forms, ranging from simple avoidance to complex rationalization. One such behavior common to the denial of pregnancy is "acting as though nothing were out of the ordinary" despite the fact that the pregnancy is physically apparent.[172] In other cases, "[w]hile awareness of pregnancy was evanescently present, at no time were affects associated with the gravid state experienced; that is, they never *felt* pregnant."[173] Thus, manifestations of their pregnancies were not experienced by the women as symptomatic of pregnancy but rather as unrelated conditions, such as tumors,[174] water retention, weight gain, dieting, "eating disorders . . . or pharmaceutical

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166 Finnegan, et al., *Denial of Pregnancy and Childbirth*, 27 CANADIAN J. PSYCHIATRY 672, at 672 (1982); *see also* BROCKINGTON, *supra* note 9, at 65-6.

167 *Id.*; *see also* BROCKINGTON, *supra* note 9, at 65-6.

168 Hoffman, *supra* note 7, at D4 (quoting Dr. Phillip Resnick).

169 BROCKINGTON, *supra* note 9, at 66.

170 *Id.*

171 Brozovsky & Falit, *supra* note 18, at 679.

172 *Id.*; *see also* J. Arboleda-Florez, *Neonaticide*, 21 CANADIAN PSYCHIATRIC ASS'N. J. 31, 32 (1976) ("Throughout her whole pregnancy, the patient went about her daily routine as if she were not pregnant.").

173 Brozovsky & Falit, *supra* note 18, at 679. For example, one of Brozovsky's subjects "rationalized her failure to menstruate as a sequel of her previous pregnancy." *Id.* Another subject bought clothes in preparation for a new school year despite the fact that she was seven months pregnant. *See id.*; *see also* Finnegan, *supra* note 166, at 673-4 ("it is characteristic of patients reported in the neonaticide literature that they rarely feel pregnant, even in the second or third trimester. Failure to identify symptoms at this point is no longer a question of inattention but of denial."); BROCKINGTON, *supra* note 9, at 66 ("The first sign of conception for most women is the cessation of menstruation; but vaginal bleeding my occasionally coexist with pregnancy, and gravid menstruation-like haemorrhages may deceive the mother.").

174 *See* BROCKINGTON, *supra* note 9, at 66.

treatment,"[175] and "obesity or unstable weight."[176] In addition, "[c]essation of the menses will also be less obvious in mothers who are breast-feeding, and those with a history of scanty or irregular menstruation, or with amenorrhea due to anorexia nervosa or the menopause."[177] The force of the denial experienced by these women can be quite formidable indeed: Several of the articles suggest that "the need to deny may be so powerful that the biological manifestations of the pregnancy may be influenced."[178] Some women actually experience weight loss, others do not show the attendant signs of pregnancy such as enlarged breasts and abdomens,[179] urinary frequency, and nausea,[180] while still others continue to menstruate throughout their pregnancies.[181] If not wholly absent, the symptoms of pregnancy may also be less pronounced.[182] More common, however, is the young woman who does go through the physical changes of pregnancy. The changes are attributed by her to things other than pregnancy, such as simple weight gain.[183]

In many cases, the denial of the mother may be so strong that it "affects not only her own perceptions and those of her family, but those of teachers, employers, and even physicians."[184] One of Brozovsky's subjects went to her physician "in one of her rare moments of suspecting that she was pregnant" in her fifth month of pregnancy.[185] A pregnancy test was done and the result was positive.[186] She returned a month later to report vaginal spotting which she thought was resurgence of her period.[187] The doctor, accepting her suggestion, did not order another pregnancy test to see if she was in fact pregnant, nor did he "perceive any abdominal protuberance, although she was in her fifth month. . . . [I]n these cases it is not uncommon for the patient's physician to miss the pregnancy and arrive instead at the patient's wished-for diagnosis.

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175 *Id.*
176 *Id.*
177 BROCKINGTON, *supra* note 9, at 66.
178 Brozovsky & Falit, *supra* note 18, at 679.
179 *See id.* at 679-80.
180 *See* Wheelwright, *supra* note 38, at 2.
181 *See* Brozovsky & Falit, *supra* note 18, at 679-80. Brozovsky cites a study where the incidence of continued menstruation during pregnancy was "strikingly high" in the neonaticide cases. *Id.* at 680. *See also,* BROCKINGTON, supra note 9, at 66.
182 *See* BROCKINGTON, *supra* note, at 66.
183 *See* Laura J. Miller, *Psychotic Denial of Pregnancy: Phenomenology and Clinical Management,* 41 HOSP.& COMMUNITY PSYCHIATRY 1233, 1235 (1990).
184 Brozovsky & Falit, *supra* note 18, at 679; *see also* Arboleda-Florez, *supra* note 172, at 33.
185 Brozovsky & Falit, *supra* note 18, at 679.
186 *See id.*
187 *See id.*

"[188] These pregnancies and subsequent births appear to veiled by "a complicity of silence," where friends and family do not notice the pregnancy.[189]

Significantly, the very same denial that was held during the course of the pregnancy "is maintained even during labor, not to disappear until the neonate emerges from the birth canal and begins to cry."[190] The literature abounds with reports of women mistaking labor pains for gas-pains, over-eating, colic, or menstruation.[191] The women's association of symptoms of pregnancy with other physical conditions goes on well into labor until the infant arrives.[192] However, by this point, "the patient is so confronted by reality that further maintenance of the denial is not possible, [and] an upheaval takes place."[193] The sight of the baby and its cry [has] a cataclysmic effect" on the young woman.[194]

While the literature does not indicate that the women who commit neonaticide suffer from any mental illness such as schizophrenia or depression and are not suicidal,[195] the articles do suggest that there is a "brief psychotic break" at the time of the delivery which often results in the murder of the newborn.[196] The onset of this psychotic break is thought to be precipitated be several factors, including the intense physical stress of the delivery (stressful under any circumstance) and the sudden and undeniable reality of the denied pregnancy.[197] Thus, "the trauma of delivery, followed by the crying of a newborn, crashes through the thickest walls of denial. Women try to stifle the wails by strangling the baby, stuffing tissues down its throat, drowning it in the toilet. They then throw the . . . corpses in trash compactors, leave them in dresser

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[188] *Id.*

[189] Arboleda-Florez, *supra* note 172, at 33; *see also* Wiedenkeller, *supra* note 2, at A27. Perhaps this very complicity explains how some of the births have occurred in the presence of friends and family members, who even at the time that the neonate is being born do not notice the delivery. In fact, "[i]n a series of three cases, one woman gave birth without her room-mate knowing, another in the same room as her employer's daughter, while a third delivered in the same room as both her parents." BROCKINGTON, *supra* note 9, at 438.

[190] Brozovsky & Falit, *supra* note 18, at 680.

[191] *See id.* (menstruation, drinking of water in excess).

[192] *See id.*

[193] *Id.* at 681. Both of Brozovsky's subjects threw their neonates out of the bathroom window after their births. He concluded: "In each of the cases . . . when the birth of the infant made further denial impossible, there was a temporary psychotic break." *Id.*

[194] *Id.* at 680.

[195] *See* P.T. d'Orban, *Women Who Kill Their Children*, 134 BRIT. J. PSYCHIATRY 560, 562 (1979); *see also* Resnick, *supra* note 4, at 1415; Green & Manohar, *supra* note 2, at 122; Edward Saunders, *Neonaticides Following "Secret" Pregnancies: Seven Case Reports*, 104 PUB. HEALTH REP. 368, 370 (1989); Kaye, *supra* note 8.

[196] Green & Manohar, *supra* note 2, at 674; Brozovsky & Falit, *supra* note 18, at 681; Resnick, *Neonaticide*, *supra* note 4, at 1417.

[197] *See* Wiedenkeller, *supra* note 2, at A27.

drawers, even toss them out windows."[198] Still, the "women who commit neonaticide often deny that they are pregnant or assume that the child will be stillborn. No advance preparations are made either for the care or the killing of the infant."[199]

Another key similarity in the documented cases of neonaticide is the fear these young women have of their parents, particularly their mothers: "Fear of abandonment by their mothers, or a highly disturbed mother-daughter relationship" is often apparent in the case studies.[200] This fear of rejection and abandonment by the mother is considered as one of the triggers of the denial characteristic of women who commit neonaticide.[201]

Whether it is the fear of abandonment or rejection by the woman's parents, or a fear of the social stigma attached to single motherhood,[202] it is precisely these kinds of fears which resurface at the time of the birth of the neonate, contributing to the break which leads to the killing. The literature suggests that "neonaticide stems from the ego disorganization which occurs when denial, so tenaciously clung to during the pregnancy and delivery, is made no longer tenable by the actual birth of the child. The sudden dissolution of denial confronts the girl with the overwhelming fear which had initially prompted the denial of the pregnancy."[203]

In addition to intense denial, the literature describes these women as experiencing some kind of dissociative state[204] at the time of delivery where "affective impulses [are transformed] directly into action, without the intervention of the whole personality."[205] Astonishingly, "the rejection of the reality [of pregnancy/child-

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198 Hoffman, *supra* note 7, at D4.

199 Resnick, *Neonaticide*, *supra* note 4, at 1416.

200 Brozovsky & Falit, *supra* note 18, at 681.

201 *See id.* Both of Brozovsky's subjects had been warned by their mothers that they would be "put away" or "thrown out" in the event of a pregnancy. *Id. See also* Resnick, *supra* note 4, at 1416 ("A prominent feature in several of the neonaticides was the inability of the unwed girl to reveal her pregnancy to her mother."); Arboleda-Florez, *supra* note 172, at 33 ("Her overwhelming fear of being thrown out and losing her parents' affection proved to be stronger than any ethical considerations about the life of her baby."); Saunders, *supra* note 195, at 370; Green & Manohar, *supra* note 2, at 123; Ruth Padawer, *Why Many Adolescents Hide Pregnancy*, RECORD, September 4, 1994, at A31.

202 *See* Resnick, *Neonaticide*, *supra* note 4, at 1416.

203 Brozovsky & Falit, *supra* note 18, at 681.

204 Dissociation is defined as "[a] disruption in the usually integrated fruitions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic." DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 766 (4th ed. 1994) [hereinafter DSM-IV].

205 Arboleda-Florez, *supra* note 172, at 32; Finnegan, *supra* note 166, at 674. All three subjects in the Finnegan study "demonstrated marked dissociation. Miss A spoke of being in a 'dazed state' while cleaning the bathroom, oblivious to the pounding on the door. Miss B, after the first delivery, lay in the bed with the baby for 36 hours, making no attempt to cut the cord or to call for help. Miss C, between cries of pain, would smile and look vaguely around her. She paid no attention to the baby after delivery." *Id.*

birth] continues after birth, during which some women will dissociate themselves from the experience, as if they are viewing themselves from above, watching someone else give birth to the child."[206] Dr. Margaret Spinelli, a psychiatrist at Columbia Presbyterian Hospital in New York City, evaluated nine mothers who committed neonaticide. She reported some of the girls saying things like "I watched myself deliver the baby," and "I don't think I felt pain, but I must have felt pain because I remember hearing myself scream."[207] Some psychiatrists see these symptoms as a "severe mental illness akin to multiple-personality disorder."[208] Dr. Spinelli recounts that some women that she has treated "describe a corrosive breakdown," that "[t]hey're dissociated from the pregnancy, intercourse and reproduction. . . . Then they deliver and they panic because they're not sure what's happening. It's like driving down a highway but not remembering how they got there; they're charged with killing their child and they don't even have their memories as their own defense."[209] Some of these women think that the baby was born dead.[210] In addition to experiencing a dissociative state, some of the case studies report the subjects as having auditory hallucinations, voices telling the woman to get rid of the baby.[211]

B. A Case Study

The following is a summary of one of three case studies on neonaticide reported in an article appearing in *The Canadian Journal of Psychiatry*.[212] The purpose of this summary is to clarify the symptoms and behaviors discussed above by way of illustration.

Miss A is a 24 year old university student who came from a religious prairie family.[213] She woke in the night, suffering from cramps and went to the washroom to relieve herself. Instead, she gave birth to her child, which dropped to the floor after it started to cry.[214] Miss A said that she tried to resuscitate the baby when she

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206 James W. Prado Roberts & Jason Method, *Denial of Pregnancy Called Common Among Teenagers*, ASHBURY PARK PRESS, June 10, 1997, at A4.

207 *Id.*

208 Kantrowitz, *supra* note 2, at 52.

209 Hoffman, *supra* note 7 (quoting Dr. Margaret Spinelli); *see* also Wheelwright, *supra* note 48, at 2.

210 *See* Jan Hoffman, *Teen-Agers Indicted for Murder in Newborn's Death*, N.Y. TIMES, December 10, 1996, at B1; *see also infra* Part II.B.

211 *See* Brozovsky & Falit, *supra* note 18, at 675 (Voice telling 15 year old girl to "[t]hrow [the baby] out of the window; get rid of it.").

212 Finnegan, *supra* note 166, at 672.

213 *See id.*

214 *See id.*

saw that it was neither breathing or moving.[215] Completely unaware of her relatives who were pounding on the washroom door for thirty minutes, Miss A cleaned the blood from the room.[216] She was later taken to the hospital to deliver the placenta, where the doctor observed that "she looked 'spaced out.'"[217] After being charged with the death of the newborn, she was given a psychiatric evaluation (conducted 10 months after the birth) which revealed the details of the periods surrounding her pregnancy and the delivery of her child.[218] While she admitted that she had sexual intercourse, she denied ever having known she was pregnant.[219] She credited her weight-gain during the pregnancy to a lack of exercise and her eating habits.[220] Miss A claimed that she continued to menstruate until her seventh month of pregnancy and that she did not have the physical signs associated with pregnancy (i.e., breast growth, nausea).[221] Her family was a strict one and "[r]eligious attitudes in the home precluded contact with physicians or the discussion of sexuality."[222] She remembered fearing being given up for adoption "when she observed her parents arguing about contraception with a social worker . . . ."[223] She recalled having been "teased for being fat and felt 'pressured to be perfect'."[224]

In reviewing the case of Miss A, the authors Finnegan, et al., focused on the denial of her pregnancy. The authors asserted that, as the early signs of pregnancy are not ordinarily detected by pregnant women in general, "[t]his is especially so for the primiparous patient who either may not recognize the early symptoms of pregnancy or may not associate these symptoms with being pregnant."[225] This observation is consistent with other findings: "Some women have 'false periods' and bleed even though they are pregnant. . . . It is not unheard of for a woman to have two or even three periods in early pregnancy."[226] Such continued menstruation clearly can lead a woman to believe that she is not pregnant. Finnegan, et al. further noted that, although an unwanted preg-

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215 *See id.*
216 *See id.*
217 *Id.*
218 *See id.*
219 *See* id.
220 *See id.*
221 *See id.*
222 *Id.*
223 *Id.*
224 *Id.*
225 *Id.*
226 FELICIA STEWART, ET. AL, UNDERSTANDING YOUR BODY 118-9 (1992); *see also* BROCKINGTON, *supra* note 9, at 66.

nancy often leads to late recognition of the signs of pregnancy,[227] more rare is when "pregnancy, labour and delivery [occur] with no apparent awareness that [the woman had] been pregnant or that [she had] given birth."[228] In speaking of Miss A specifically, Finnegan et. al., pointed to the extreme socio-cultural pressures under which the subject found herself. The authors also pointed to Miss A's guilt about engaging in sexual activity (she left the church when she began to have sexual intercourse),[229] as well as her fears of her family (the effect of an illegitimate child in a religious family).[230] The authors noted that pregnant women in general may have these same conflicts (religion, oedipal conflicts, unstable relationships with their partners) but deal with them effectively; in cases like Miss A's, "the anxiety generated is so great that powerful defenses must be called into action."[231] These defenses, as discussed above, include rationalization and denial.[232] Miss A's claim of menstruating into her seventh month of pregnancy may well have been symptomatic of her denial. Finnegan, et. al., noted that the strength of the denial in these women may be so strong that it "influence[s] the biologic manifestations of pregnancy."[233] They also noted that Miss A was dissociated during the pregnancy, a factor common to these mothers, raising the question of "whether [Miss A] experienced a brief psychotic break at the time of delivery."[234]

Miss A's case is particularly useful in this context because it catalogues a majority of the behaviors and symptoms experienced by women accused of killing their newborns. These factors include her youth, immaturity, incomplete physical manifestations of pregnancy, denial of pregnancy, dissociation during delivery, and a possible psychotic break leading to the killing of the newborn. Miss A's case also provides a useful back ground with which to consider the following discussion on Brief Psychotic and Depersonalization Dis-

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227 *See* Finnegan, *supra* note 166, at 672.

228 *Id.*

229 *See id.*

230 *See id.*

231 *Id.* at 673. For a discussion on the role of unresolved oedipal conflicts in neonaticide, *see* Resnick, *Neonaticide, supra* note 4, at 1417.

232 *See id.; see also* Arboleda-Florez, *supra* note 172, at 33; Catherine Bonnet, *Adoption At Birth: Prevention Against Abandonment Or Neonaticide*, 17 CHILD ABUSE & NEGLECT 501, 505 (1993); Green & Manohar, *supra* note 2, at 122; Kaye, *supra* note 8, at 134; Resnick, *Neonaticide, supra* note 4, at 1416; *see generally*, Robert I. Slayton and Paul H. Soloff, *Psychotic Denial Of Third-Trimester Pregnancy*, 42 J. CLINICAL PSYCHIATRY 471 (1981).

233 Finnegan, *supra* note 166, at 674.

234 *Id.*

orders, which are recognized in the *Diagnostic Statistical Manual of Mental Disorders*.[235]

C. *The DSM-IV, Brief Psychotic and Depersonalization Disorders*

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) is a compilation of "classification[s] of mental disorders that was developed for use in clinical, educational, and research settings."[236] It is compiled by the American Psychiatric Association and periodically revised. The criteria listed in the *DSM-IV* are used by psychiatrists to diagnose and treat mental disorders.

A mental disorder is defined by the *DSM-IV* as:

> a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.[237]

The *DSM-IV* is useful in determining whether it is acceptable to recognize a psychiatric disorder or symptom legally, because it "reflects a consensus about the classification and diagnosis of mental disorders. . . ."[238] The *DSM-IV*, as an authoritative source on

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235 DSM-IV, *supra* note 204.

236 DSM-IV, *supra* note 204, at xxiii.

237 *Id.* at xxi-ii.

238 *Id.* at xxiii. The authors caution:

> When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. The dangers arise because the imperfect fit between the question of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a *DSM-IV* mental disorder is not sufficient to establish for the existence for legal purposes of a 'mental disorder,' 'mental disability,' 'mental disease,' or 'mental defect.' In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the *DSM-IV* diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnos-

mental disorders, is therefore useful for evidentiary purposes in both a *Frye* and *Daubert* context since it sets out what is accepted by the psychiatric community as constituting mental disorders.[239]

Although the *DSM-IV* does not specifically mention a Neonaticide Syndrome, at least two listed symptoms or disorders repeatedly emerge in the discussions of neonaticide in psychiatric journals. The first is Brief Psychotic Disorder, the second Depersonalization Disorder.

i. Brief Psychotic Disorder

The first disorder to have been referred to in the neonaticide literature is Brief Reactive Psychosis, now called Brief Psychotic Disorder.[240] The *DSM-IV* notes that:

> Individuals with Brief Psychotic Disorder typically experience emotional turmoil or overwhelming confusion. They may have rapid shifts from one intense affect to another. Although brief, the level of impairment may be severe, and supervision may be required to ensure that . . . the individual is protected from the consequences of poor judgment, *cognitive impairment*, or action on the basis of *delusions*. There appears to be an increased risk of mortality (with a particularly high risk for suicide), especially among younger individuals.
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> . . . .

Brief Psychotic Disorder may appear in adolescence or early adulthood, with the average age at onset being in the late 20s or early 30s. By definition, a diagnosis of Brief Psychotic Disorder requires a full remission of all symptoms and a return to the premorbid level of functioning within 1 month of the onset of the distur-

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tic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.

Id.

239 *See infra* Part V.A-B. At this point in the Note, it is sufficient to simply note that *Frye's* "general acceptance" requirements are satisfied by the fact that the *DSM-IV* "reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication." *DSM-IV*, *supra* note 204, at xxiii. *Daubert's* scientific method requirement is satisfied by the fact that the *DSM-IV* was compiled by the "Task Force on *DSM-IV* and its Work Groups conducted a three stage empirical process that included 1) comprehensive and systematic reviews of the published literature, 2) reanalysis of already-collected data sets, and 3) extensive issue-focused trials." *Id.* at xviii.

240 DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 206 (3rd ed. revised 1980) [hereinafter DSM-III-R]. The psychiatric literature referred to throughout this Note were written while the *DSM-III-R* was current, explaining why references are made to "Brief Reactive Psychosis" as opposed to today's *DSM-IV's* "Brief Psychotic Disorder." Aside from a change in appellation, the two disorders are one and the same.

bance. In some individuals, the duration of psychotic symptoms may be quite brief (e.g., a few days).[241]

The *DSM-III-R* noted features that it associated with Brief Psychotic Disorder:

> [b]ehavior may be bizarre and may include peculiar postures, outlandish dress, screaming, or muteness. Suicidal or aggressive behavior may also be present. Speech may include inarticulate gibberish or repetition of nonsensical phrases. Affect is often inappropriate. Transient hallucinations or delusions are common. Silly or obviously confabulated answers may be given to factual questions. Disorientation and impairment in recent memory often occur.[242]

The features listed in the *DSM-III-R* are helpful in realizing what kind of factors are significant for the purposes of diagnosis.

Thus, the diagnostic criteria for Brief Psychotic Disorder are the presence of one or more of the following symptoms: 1) delusions; 2) hallucinations; 3) disorganized speech (e.g., frequent derailment or incoherence); 4) grossly disorganized or catatonic[243] behavior; these last at least one day but take no less than one month to return to pre-psychotic behavior. In making a diagnosis of Brief Psychotic Disorder, the clinician is to note if the episode's onset is within four weeks of the delivery of a child.[244] Finally, the psychotic episode cannot be better diagnosed as a "Mood Disorder With Psychotic Features, Schizoaffective Disorder, or Schizophrenia and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition."[245]

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241 *Id.* at 302-303 (emphasis added).

242 DSM-III-R, *supra* note 240, at 205.

243 Catatonic behavior is defined in the *DSM-IV* as: "Marked motor abnormalities including motoric immobility (i.e., catalepsy or stupor), certain types of excessive motor activity (apparently purposeless agitation not influenced by external stimuli), extreme negativism (apparent motiveless resistance to instructions or attempts to be moved) or mutism, posturing, or stereotyped movements, and echolalia or echopraxia."DSM-IV, *supra* note 204, at 764 (emphasis omitted). Stereotyped movements are defined as: "Repetitive, seemingly driven, and nonfunctional motor behavior (e.g., hand shaking or waving, body rocking, head banging, mouthing of objects, self-biting, picking at skin or body orifices, hitting one's own body)." *Id.* at 771. Echolalia is defined as: "The pathological, parrotlike, and apparently senseless repetition (echoing) of word or phrase just spoken by another person." *Id.* at 766. Echopraxia is defined as: "Repetition by imitations of the movements of another. The action is not a willed or voluntary one and has a semiautomatic and uncontrollable quality." *Id.*

244 *See id.*

245 *Id.* at 304.

ii. Depersonalization Disorder

A second category of mental disorder relevant to the discussion of neonaticide is that of Depersonalization Disorder.[246]

Episodes of depersonalization[247] are the essential characteristic of this disorder and are usually persistent or recurrent, although the *DSM-IV* specifies that "[a]t some time in their lives, approximately half of all adults may have experienced a single brief episode of depersonalization, usually precipitated by severe stress."[248] Critically, for the purposes of criminal defenses,[249] Depersonalization Disorder leads the individual to:

> [f]eel like an *automaton* or as if he or she is living in a dream or movie. There may be a sensation of being an *outside observer* of one's mental processes, one's body, or part of one's body. Various types of sensory anesthesia, lack of affective response, and a sensation of *lacking control of one's actions*, including speech, are often present. The individual with Depersonalization Disorder maintains intact reality testing (e.g., awareness that it is only a feeling and that he or she is not really an automaton) . . . .[250]

Another important aspect of Depersonalization Disorder is that the individual may experience derealization,[251] "an alteration in the perception or experience of the external world so that it seems strange or unreal (e.g., people may seem unfamiliar or mechanical)."[252]

Thus, the criteria for Depersonalization Disorder include: 1) persistent or recurrent episodes of the individual feeling like they are watching their body or mind from outside; 2) intact reality testing during the depersonalization episode; and 3) the depersonalization results in "clinically significant distress or impairment in social, occupational, or other important areas of functioning."[253]

Both Depersonalization Disorder and Brief Psychotic Disorder are highly evocative of the behavioral patterns documented in cases of neonaticide. Since they are recognized as valid disorders in the psychiatric community, they should prove to be extremely powerful tools for defense attorneys in defending neonaticide

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246 *See id.* at 488-90.

247 The *DSM-IV* defines depersonalization as: "An alteration in the perception or experience of the self so that one feels detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling like one is in a dream)." *Id.* at 766.

248 *Id.* at 489.

249 *See infra* Part VI for a discussion of defenses.

250 DSM-IV, *supra* note 204, at 488 (emphasis added).

251 *See id.*

252 *Id.* at 766.

253 *Id.* at 490.

cases, either by themselves as distinct disorders evincing the mental disability, disease, or defect necessary to plead an affirmative defense (i.e., involuntariness, insanity, or diminished capacity) and negate the mental element required to prove the crime, or as a grouping of symptoms that amount to a Neonaticide Syndrome. Both of these issues will be discussed below.

IV. SYNDROMES

As noted above, the case of *People v. Wernick*,[254] was the first to mention a Neonaticide Syndrome.[255] The symptoms, behaviors, and disorders discussed above (denial of pregnancy, Brief Psychotic and Depersonalization Disorders) may provide evidence helpful to the defense of a woman in a case of neonaticide, without the specific reference to the experience of similarly situated women (reference, as *Wernick* tells us, is unacceptable unless such evidence of a Neonaticide Syndrome is deemed reliable under *Frye* or *Daubert*).[256] However, since other women do in reality share her peculiar and disturbing experience—which has even been referred to by psychiatrists as a distinct "clinical entity—"[257] the current inadmissibility, for whatever reason, of such a Syndrome results in an incomplete defense, and thus an incomplete presentation of the evidence to the jury.

Syndromes, as discussed below, are used in the law to explain behavior. Although the conduct ordinarily explained by syndrome evidence appears at first blush to be fully within the unaided comprehension of a jury, the supposed understanding of conduct is actually informed by and reflects misperceptions based largely on sexist, classist, and racist assumptions held by jurors and society at large. Thus, syndrome evidence is used to counter those assumptions and aid a jury to come to an educated verdict that comports with reality.

In the case of the killing of a newborn, the opportunity for misunderstanding these women and their actions is practically axiomatic. Neonaticides consist of behaviors by women that are absolutely at odds with normative conceptions of motherhood and maternity commonly held by society. These set notions render the denial of pregnancy, unquestionably present in these cases, virtually inconceivable and, therefore, not on its face legally credible.

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254 215 A.D.2d 50 (N.Y. App. Div. 1995), *aff'd* 674 N.E.2d 322 (N.Y. 1996).

255 *See infra* Part IV.B for a detailed discussion of *Wernick*.

256 *Id.*

257 Brozovsky & Falit, *supra* note 18, at 679.

Yet, since the psychotic episodes thought to be experienced by these women at the time of delivery are in large part attributed to that very denial, any evidence of it would be crucial to a defendant's case.

The following section will first discuss the use of syndromes in the legal arena, particularly Rape Trauma Syndrome and Battered Woman's Syndrome, in order to provide background as to how syndrome evidence is currently received in the courts and to what ends it is used. The section will then review *People v. Wernick* to show the extent to which a Neonaticide Syndrome has been dealt with in a court of law. Finally, the section will explore commonly held assumptions regarding motherhood and maternity which prevent juries from understanding the true nature of these killings, and will argue that these misconceptions about motherhood and maternity require the recognition of a Neonaticide Syndrome to explain how denial of pregnancy is in reality a shared experience among these women. If a jury were to reach an accurate understanding of this denial as well as the other symptoms and behaviors common in these cases, based not only on the particular defendant's experience but on testimony about these cases at large, these women would be afforded a more complete and, therefore, fairer defense.

A. Syndromes Generally

The *DSM-IV* defines a syndrome as: "[A] grouping of signs and symptoms, based on their frequent co-occurrence, that may suggest a common underlying pathogenesis, course, familial pattern, or treatment selection."[258] In the legal context, syndromes are used when they are relevant to an issue in dispute and helpful to the finder of fact in reaching a verdict.[259] Although syndrome evidence is often attacked by critics for addressing issues the jury is competent to understand without the benefit of expert testimony, its main strength is that it counters myths and misconceptions about human behavior jurors may hold that can lead to erroneous decisions about the conduct of a party in an action. In other words, syndrome evidence contextualizes behavior for the purposes of legal judgment. A look at Rape Trauma Syndrome and Battered Woman Syndrome is illustrative of the point.

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258 DSM-IV, *supra* note 204, at 770.

259 *See, e.g.*, People v. Taylor, 552 N.E.2d 131 (N.Y. 1990) (using Rape Trauma Syndrome in criminal trial to help explain complainant's reaction to attack).

i. Rape Trauma Syndrome

Rape Trauma Syndrome (RTS) is a syndrome that has gained acceptance in court rooms around the country.[260] Essentially, RTS is "'the acute phase and long-term reorganization process that occurs as a result of forcible rape or attempted forcible rape. This syndrome of behavioral, somatic, and psychological reactions is an acute stress reaction to a life-threatening situation.'"[261] Among other things, RTS explains why a rape victim may remain silent after the rape and not expeditiously report it.

In *People v. Taylor*,[262] the Court of Appeals of New York held that RTS is admissible to explain why a complainant might not appear distraught after being raped.[263] The court recognized that popular misconceptions about rape made jurors less likely to convict the accused.[264] For example, a common fallacy is that, since rape is such a repugnant affront to bodily integrity, if a woman does not promptly complain about a rape there is a strong presumption in the minds of the jurors that she has fabricated the story.[265] Another misconception is that a woman who is raped has

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260 *See, e.g., id.*

261 Krista L. Duncan, Note, *"Lies, Damned Lies, And Statistics"? Psychological Syndrome Evidence in the Courtroom After Daubert*, 71 IND. L. J. 753, 759 (1996) (*quoting* Ann W. Burgess & Lynda L. Holmstrom, *Rape Trauma Syndrome*, 131 AM. J. PSYCHIATRY 981, 981-82 (1974)). The "acute phase" mentioned by Burgess & Holstrom consists of:

> impact, somatic, and emotional responses. Some of the impact responses [are] expressed, such as fear, anger and anxiety, whereas others [are] controlled, that is masked by an outwardly silent and calm victim. Somatic manifestations . . includ[e] physical shock, skeletal muscle tension, and gastrointestinal irritability. . .
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> . . . The reorganization phase process generally consisted of increased motor activity, rape-related phobias, nightmares, and difficulties maintaining close relationships.

Robert R. Lawrence, Note, *Checking the Allure of Increased Conviction Rates: The Admissibility of Expert Testimony on Rape Trauma Syndrome in Criminal Proceedings*, 70 VA. L. REV. 1657, 1669 (1984) (citing Burgess & Holstrom, *supra*); *see also* Cynthia F. Feagan, Note, *Rape Trauma Syndrome Testimony as Scientific Evidence: Evolving Beyond State v. Taylor*, 61 U. MO. KAN. CITY. L. REV. 145, 152 (1992). Though the Burgess & Holmstrom findings were criticized:

> The newer studies confirm those documented by Burgess and Holmstrom, with victims exhibiting fear, depression, guilt, increased motor activity, sleep disturbances, substance abuse, somatic complaints, sexual difficulties, and emotional disorders. "Indeed, although the early studies suffered from methodological deficiencies, their conclusions have been abundantly supported by every subsequent, more sophisticated study."

Duncan, *supra* note 261, at 760-1 (citations omitted) (emphasis omitted) (quoting David McCord, *The Admissibility of Expert Testimony Regarding Rape Trauma Syndrome in Rape Prosecutions*, 26 B.C. L. REV 1143, 1168 (1985)).

262 552 N.E.2d 131.

263 *Id.* at 138; *see also* People v. Hampton, 746 P.2d 947 (Colo. 1987).

264 *Taylor*, 553 N.E.2d at 136.

265 *See*, Morrison Torrey, *When Will We Be Believed? Rape Myths and the Idea of a Fair Trial in Rape Prosecutions*, 24 U.C. DAVIS L. REV. 1013, 1041-5. Torrey points out that "prompt complaint is contrary to most of the victim's experiences." *Id.* at 1042-3.

invited the assault by wearing revealing clothing or by accompanying a man to his apartment on a first date.[266] As members of the general populace, any given pool of jurors could certainly hold these misconceptions and thus allow their understanding of testimony and evidence at trial to be erroneously influenced.[267] While acknowledging that RTS is a "therapeutic concept," the *Taylor* court also noted that as an aggregate of symptoms and behaviors accepted within the relevant scientific community RTS could be helpful to a jury in deciding an issue of disputed fact and reaching a verdict because "patterns of response among rape victims are not within the ordinary understanding of the lay juror."[268] The court, however, limited the use of the Syndrome to explain why a complainant might not have seemed distraught after the assault (thus rebutting a defense attack on her credibility) and expressly banned the use of the Syndrome as proof that a rape actually occurred.[269] Other courts, however, have held that RTS is also admissible to explain a delay in the reporting of the rape by the victim[270] or that there was a lack of consent where intercourse is not in dispute.[271] RTS is not included in the *DSM-IV* as discrete disorder. Rather, "rape [is considered] one of the stressors that can lead to posttraumatic stress disorder."[272] This general consideration of Rape Trauma Syndrome as a subset of posttraumatic stress disorder (which is listed in the *DSM*)[273] leads to the conclusion that the Syndrome is generally accepted within the relevant scientific community.[274]

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266 *See generally id.*

267 *See id.* at 1047. Torrey reviews a study of potential jurors which reveals that their conceptions of rape closely parallel the misconceptions of society as a whole:

> [E]ven though nearly all of the 1,056 potential jurors (96 percent) believed a woman can be raped against her will, many attributed rape to the woman. The majority (66 percent) saw rape as being provoked by the victim's behavior or appearance. In addition, over one-third (34 percent) believed women should be held responsible for preventing their own rape. Eleven percent blamed women for rape, agreeing that a woman who was raped was asking for it. The authors concluded that if their findings could "be extrapolated to other populations, it would appear that rather substantial numbers of people attribute rape primarily to women, not to men."

Id. at 1047-8 (quoting HUBERT S. FEILD & LEIGH B. BIENEN, JURORS AND RAPE 3 (1980)).

268 *Taylor*, 552 N.E.2d. at 135-6. *See also* Rosemary C. Hunter, *Gender in Evidence: Masculine Norms vs. Feminist Reforms*, 19 HARV. WOMEN'S L.J. 127, 147 (1996) ("Rape trauma Syndrome . . . describes typical reactions to the experience of forced sexual assault.")

269 *Taylor*, 552 N.E.2d. at 139; *see also* People v. Bledsoe, 681 P.2d 291 (Cal. 1984).

270 *See Hampton*, 746 P.2d at 947.

271 *See e.g.*, State v. Brodniak, 718 P.2d 322 (Mont. 1986); State v. Huey, 699 P.2d 1290 (Ariz. 1985); State v. Marks, 647 P.2d 1292 (Kan. 1982).

272 *Taylor*, 552 N.E.2d at 134; *see also* DSM-IV, *supra* note 184, at 424 (listing sexual assault as an extreme traumatic stressor).

273 Duncan, *supra* note 261, at 761.

274 *Taylor*, 552 N.E.2d at 135.

Thus, RTS is useful to rebut attacks on the complainant's credibility by providing answers to why a complainant did not immediately report the assault or did not consent to the intercourse. Evidence of RTS is necessary because without it a jury could erroneously find, for example, that a complaint was fabricating her complaint due to the belief that a woman who had just been raped would report it right away.

ii. Battered Woman Syndrome

Another syndrome that has gained acceptance in courtrooms around the nation is Battered Woman Syndrome (BWS). Typically, a woman asserting BWS is on trial for the murder of her abusive partner and claims that the killing was done in self-defense and therefore is justified.[275] BWS was first articulated by Dr. Leonore Walker in 1979 as an attempt to convey to the jury "the structure of a battering relationship from the perspective of the abused woman."[276] Symptoms of BWS include cognitive disturbances (i.e., cognitive confusions, attention deficits, flashbacks), high arousal or anxiety (i.e., hypervigilance to cues of abuse, panic attacks, obsessive rumination), and avoidance (i.e., denial, repression, depression).[277] These symptoms closely parallel symptoms of posttraumatic stress disorder,[278] and as such the Syndrome is considered a subcategory of that disorder and is therefore deemed admissible.[279] Keenly aware of the cyclical abuse inflicted by her partner, the woman kills her abuser when he not acting in a physically abusive manner.[280] Evidence of "Battered Woman Syndrome

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[275] Self-defense is the use of force against an individual when being attacked by that individual, and is justifiable if the actor believes that such force "is immediately necessary for the purpose of protecting [herself] against the use of unlawful force by such other [individual] on the present occasion." MODEL PENAL CODE §3.04(1).

[276] Michael Dowd, *Dispelling the Myths About the "Battered Woman's Defense:" Towards a New Understanding*, 19 FORDHAM URB. L.J. 567, 572 (1992).

[277] Lenore E.A. Walker, *Battered Women Syndrome and Self-Defense*, 6 NOTRE DAME J. L. ETHICS & PUB. POL'Y 321, 327-8 (1992).

[278] *Id.* at 329. "In presenting the battered woman syndrome to a judge or jury it is often useful to demonstrate using the [Posttraumatic stress disorder] criteria chart. Most battered women easily meet those criteria, usually with more symptoms observed than is needed for the diagnosis." *Id.* For criteria chart of Posttraumatic Stress Disorder, see DSM-IV, *supra* note 204, at 424.

[279] Walker, *supra* note 277, at 327.

[280] Susan Murphy, *Assisting the Jury in Understanding Victimization: Expert Psychological Testimony on Battered Woman Syndrome and Rape Trauma Syndrome*, 25 COLUM. J. L. & SOC. PROBS. 277, 295 (1992). The theory of BWS is as follows:

> Dr. Walker describes the dynamic of battering relationships as a "Cycle of Violence," involving three phases: the tension-building phase, the acute battering incident, and the tranquil period of "loving contrition." The cycle begins with the tension-building phase, where minor battering incidents occur. The woman attempts to placate the batterer in an effort to prevent the escalation of

. . . is generally recognized for two purposes: (1) to dispel the common misconception that a reasonable person would not remain in an abusive relationship, and (2) to lend credibility to a defendant's perception of imminent danger and the need to kill the batterer."[281] BWS seeks to explain "prolonged endurance of physical abuse accompanied by attempts at hiding or minimizing the abuse, delays in reporting the abuse, or recanting allegations of abuse"[282] and goes to substantiate a defendant's claim of self-defense in explaining why the woman kills when she does.[283]

Before this Syndrome was articulated and deemed admissible in court, battered women who killed their abusers had little evidentiary ammunition with which to defend themselves against charges of murder. Raising self-defense was unsuccessful because the homicides did not always occur at the exact time where the woman was under attack. Thus, juries found themselves unable to conclude that the woman was acting reasonably by defending herself against an imminent threat of physical harm because they found either that no imminent danger was presented by an unarmed or, at that very moment, unthreatening partner, or that the woman's use of deadly force was excessive under the circumstances. In the rare instances that abused "women were successful in court, it was only at the expense of being perceived as insane."[284] The advent of the use of BWS changed this narrow understanding of a battered woman's situation by permitting testimony to show why the defendant perceived herself to be in imminent danger:

> Without that testimony, the jury is likely to find for the defendant only if they can envision themselves reacting in the same way. For a defendant whose perceptions truly are different from the norm, affected by a history of battering, the exclusion of expert testimony prevents validation of her perceptions.[285]

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violence, but these efforts become less effective as the cycle progresses and the tension grows. Eventually, the violence spirals out of control into an acute battering incident, in which the violence reaches the level of "rampage, injury, brutality, and sometimes death." The acute incident is followed by a period of loving contrition, in which the batterer exhibits loving behavior and tries to atone. A woman is most likely to kill the batterer during the tension-building phase. She is aware than at any point the violence may erupt into an acute incident in which she will lack the strength to protect herself.

Id. (quoting LENORE E. WALKER, TERRIFYING LOVE 42-44 (1989)).

281 Murphy, *supra* note 280, at 298.

282 People v. Christel, 537 N.W.2d 194, 196 (Mich. 1995).

283 In these cases, evidence of the Syndrome is admitted so that the jury may determine the reasonableness of the defendant's self-defense claim. *See e.g.*, State v. J.Q., 617 A.2d 1196 (N.J. 1993); People v. Wilson, 487 N.W.2d 822 (Mich. 1992).

284 Dowd, *supra* note 256, at 570.

285 Murphy, *supra* note 280, at 297.

Thus, testimony on BWS aids the jury in understanding the reasonableness of the woman's perception of imminent danger, and her ensuing use of self-defense, where they would otherwise be reluctant to believe that she actually faced imminent bodily harm. In contrast to the jury viewing her as a cold-hearted killer or a crazed woman, the "testimony about Battered Woman's Syndrome transforms the battered woman into 'everywoman,' a reasonable person who uses force in self-defense."[286]

Rape Trauma Syndrome and Battered Woman Syndrome are two examples of syndromes used as evidence to aid the finder of fact in deciding a contested issue (e.g., was the defendant's apprehension of imminent threat reasonable?). Syndromes help juries to contextualize the behavior of the assertor of the syndrome within a larger perspective of similarly situated people.[287] The aim of such evidence is to provide the jury with information about the assertor that may well be outside their common experience or knowledge, despite the assumption that this same knowledge is quite within their understanding.[288] Despite the general perception and criticism of syndrome evidence as elucidating issues the jury already understands and has been traditionally allowed to determine on its own, such as "reasonableness,"[289] a layperson's knowledge of "reasonableness" within the context of an abusive relationship cannot be assumed. Syndrome evidence:

> differ[s] from the traditional use of expert testimony because [it does] not seek to educate the jury about a field with which the ordinary person is unfamiliar, such as a scientific process or specialized field of knowledge. Instead, [this] type . . . of psychological testimony address[es] an area once thought to be the one exclusive area of juror expertise — judgments about people's mental states, and how those mental states are reflected in a person's behavior. In some sense this testimony is subversive, because it questions society's existing morals by countering conventional myths and misconceptions of human nature.[290]

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286 Dowd, *supra* note 276, at 574.

287 *See e.g.*, Murphy, *supra* note 280, at 294-5 ("A proffer of expert testimony on Battered Woman Syndrome includes a general description of the syndrome and the pattern of psychological symptoms which results from living in a battering relationship.").

288 *See generally* People v. Taylor, 552 N.E.2d 131 (N.Y. 1990).

289 *See id.* at 282 (Courts "may reject the evidence entirely on the ground that the testimony 'invades the province of the jury,' or is not 'beyond the ken of the average juror.'"); *see also* David McCord, *Syndromes, Profiles and Other Mental Exotica: A New Approach to the Admissibility of Nontraditional Psychological Evidence in Criminal Cases*, 66 OR. L. REV. 19, 26 (1987).

290 Murphy, *supra* note 280, at 281-82.

Syndrome evidence serves as a powerful means of combating myths by allowing experts to testify to "knowledge [that] would enable the jurors to disregard their prior conclusions as being common myths rather than common knowledge."[291] Although it is, perhaps, "subversive" or rather, atypical, it is nonetheless necessary to contextualize fully a woman's behavior in the face of fundamentally *atypical* circumstances, e.g., an abusive relationship, a sexual assault, or even a denied pregnancy.

Still, syndrome evidence is not only criticized for addressing what the jury already knows, understands, and is ordained to decide without the help of an expert. Syndrome evidence is often reproached for lacking in precedent since psychological testimony was traditionally used only in regard to insanity, because it is incongruous with the law's subjective approach to problems as opposed to mechanical processes of the scientific method, and that it is out of the experience of lawyers and the courts.[292] Another challenge to the use of syndrome evidence is that it is dangerous because this testimony is given by scientists and thus lends inordinate and unjustified credence to that evidence, and therefore tempts the jury to favor the person asserting the syndrome (be it the defendant who is seeking to use the syndrome evidence to advance a defense or the prosecution who uses it to strengthen the credibility of a complainant, as in a case where there was a delayed report of a rape) without really considering whether the party raising the syndrome *truly* fits the profile. Nevertheless, these considerations must be balanced against the fundamental right of an accused to use all legal means to defend herself in a criminal proceeding[293] in addition to ensuring that our legal system reaches appropriate and just results.

Clearly, society's conceptions about the behavior of rape victims and battered women do not comport with the realities exposed by research in the social sciences. Expert testimony on syndromes effectively reveals those misconceptions and provides relevant information through which a jury can make an intelligent and informed decision. Also, against arguments of its potential abuse, it must be noted that syndrome evidence is closely moni-

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[291] *Id.* at 298.

[292] McCord, *supra* note 289, at 25-26.

[293] *See e.g.*, Chambers v. Mississippi, 410 U.S. 284, 294 (1973). The Court stated:

> The right of an accused in a criminal trial to due process is, in essence, the right to a fair opportunity to defend against the State's accusations. The rights to confront and cross-examine witnesses and to call witnesses in one's own behalf have long been recognized as essential to due process.

Id.

tored by the courts and is allowed for very narrow purposes. Furthermore, the jury is empowered to give syndrome evidence the weight and credence it desires, the same as it might with *any* other kind of evidence. As long as the court is able to determine that the evidence passes the rigors of a *Frye, Daubert,* or any other standard of reliability and admissibility, that the evidence is relevant to the inquiry at hand, and that it is narrowly admitted so as not to actually invade the function of the jury, syndrome evidence serves as probative evidence that aids the trier of fact to come to an informed conclusion on a disputed issue.

B. People v. Wernick *and "Neonaticide Syndrome"*

People v. Wernick[294] is the first case in which a court referred to the aggregate of symptoms present in a case of neonaticide as "Neonaticide Syndrome." The case is important because it has in many ways laid the beginnings of a movement to recognize a Neonaticide Syndrome as evidence in these cases.

Stephanie Wernick awoke several times one night bleeding heavily.[295] She repeatedly went to the bathroom in her dorm to tend to bleeding she attributed to an unusually heavy period.[296] Two residents in the dorm heard "faint cries" coming from the bathroom and went to investigate.[297] There, they saw Wernick's feet standing in a pool of blood in one of the bathroom stalls.[298] When asked how she was, Wernick calmly said that she was and asked one of them to get her a tampon.[299] She stayed in the stall for a good deal of time while her friends intermittently checked to see if she was doing well.[300] Later, her roommate found her in the shower.[301] When she asked if there was anything that she could do to help, Wernick asked her to dispose of an untied bag where she said she had put all of her dirty clothes.[302] The bag actually contained the body of an infant that had just been delivered.[303] Wernick then went to sleep without having cleaned the blood from the

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294 215 A.D.2d 50 (N.Y. App. Div. 1995), *aff'd* 674 N.E.2d 322 (N.Y. 1996).

295 *See* Brief for Appellant at 6, People v. Wernick, 674 N.E.2d 322 (N.Y. 1996) (Indictment No. 78249) [hereinafter *Wernick Brief*].

296 *See id.*

297 *See id.*

298 *See id.*

299 *See id.*

300 *See id.* at 7.

301 *See id.* at 8.

302 *See id.*

303 *See id.*

bathroom floor.[304] She bled through the night, as she had not delivered the placenta.[305]

As Wernick slept, a custodian at the college found the bag containing the infant.[306] The bag was traced back to Wernick.[307] When she was found "she was described as appearing to be in shock, pale green [in] appearance, agitated, shivering while wrapped up in a blanket in a room described as very hot, lying in bed with fresh blood on the sheets."[308] While others were trying to convince her to go to the hospital, she refused, saying that she had to take a final exam in the morning.[309] Once she was calmed down, she was driven by ambulance to a medical center.[310] In the ambulance, she started to remember the delivery and told the ambulance technician "that she delivered a baby in the toilet, wrapped the baby in a pink towel, cleaned herself up with toilet paper, took a shower and when she came out of the shower, the baby was gone."[311] At trial, it was found that Wernick asphyxiated the newborn by "stuffing toilet paper down his throat."[312]

Wernick was charged with first and second degree manslaughter.[313] Her attorney raised the insanity defense "claiming that she lacked the substantial capacity to know and to appreciate the nature and consequences of her conduct or that such conduct was wrong."[314] To establish this defense, Wernick had several expert witnesses testify about her mental state at the time of the crime.[315] Their general conclusions were that "upon giving birth, the defendant suffered from a brief reactive psychosis because she could no longer deny the reality of her pregnancy" and that "during this psychotic state, the defendant was able to perform purposeful acts, such as stuffing toilet paper in the infant's mouth, but that she was unable to appreciate the nature and consequences of her conduct."[316] While the court permitted the defense experts to testify to their observations and opinions of Wernick's own conduct, the court did not permit the connection to be made between the de-

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304 *See id.*
305 *See id.*
306 *See id.*
307 *See id.*
308 *See Id.* at 9 (citation omitted).
309 *See id.*
310 *See id.*
311 *See id.*
312 People v. Wernick, 215 A.D.2d 50, 51 (N.Y. App. Div. 1995).
313 *See id.*
314 *Id.*
315 *Id.*
316 *Id.*

fendant and other cases like hers because it would have allowed "neonaticide syndrome," an untested psychological syndrome, to enter into the courtroom without first passing the rigors of the *Frye* test.[317]

The court did not conduct a *Frye* hearing in this case. The prosecution requested a *Frye* hearing on the issue of "neonaticide syndrome" because they expected the defense experts to use it in their testimony.[318] The defense, however, challenged the motion, "stating that he had no intention of presenting neonaticide as a syndrome."[319] Since no *Frye* hearing was held, the trial court made "specific evidentiary rulings regarding the expert's testimony as the trial progressed."[320] Consequently, each time one of the defense experts testified to Wernick's state shortly before, during and after the delivery, the prosecution's objections were sustained when the defense attempted to elicit circumstances around her conduct by referring to the neonaticide literature.[321]

Several issues were raised on appeal.[322] The first was that expert testimony should have been admissible at trial. The New York Appellate Division affirmed the trial court's ruling on the admission of the expert testimony because that testimony tended to support the existence of Neonaticide Syndrome, a syndrome that had not been checked for reliability in a *Frye* hearing.[323] Since the defense opposed the *Frye* hearing when moved for by the prosecution

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317 *Id.* The Court cited People v. Weinstein, 591 N.Y.S.2d 715 (N.Y. Sup. Ct. 1992), for the proposition that:

> [I]n an insanity defense case, the existence of a mental disease or syndrome or the validity of a theory of human behavior must be generally accepted in the field of psychiatry or psychology before experts may discuss such matters in their testimony at trial. If general acceptance has been attained, a psychiatric expert then "must be permitted" to state a diagnosis and to give a reasonable explanation for a finding that the defendant does or does not suffer from the mental disease, or that that person is or is not affected by the syndrome, or that a theory of human behavior does or does not explain the defendant's conduct.

Id. at 722.

318 People v. Wernick, 674 N.E.2d 322, 323 (N.Y. 1996)

319 *Id.*

320 *Id.*.

321 *See id.* The following literature on neonaticide was turned over to the prosecution by the defense: R. L. COHEN, PSYCHIATRIC CONSULTATION IN CHILDBIRTH SETTINGS, (R.L. Cohen, ed., 1988); Brozovsky & Falit, *Neonaticide: Clinical and Psychodynamic Considerations*, 10 J. AM. ACAD. CHILD PSYCHIATRY 673 (1971); P. Finnegan et al., *Denial of Pregnancy and Childbirth*, 27 CANADIAN J. PSYCHIATRY 672 (1982); C. M. Green & S.V. Manohar, *Neonaticide and Hysterical Denial of Pregnancy*, 156 BRIT. J. PSYCHIATRY 121 (1990); L.J. Miller, *Psychotic Denial of Pregnancy: Phenomenology and Clinical Management*, 41 HOSP. & COMMUNITY PSYCHIATRY 1233 (1990); E. K. Mitchell and J.H. Davis, *Spontaneous Births Into Toilet*, 29 J. FORENSIC SCI. 591(1984); Philip J. Resnick, *Murder of the Newborn: A Psychiatric Review of Neonaticide*, 126 AM. J. PSYCHIATRY 1414 (1970); and Edward Saunders, *Neonaticide Following Secret Pregnancies*, 104 Pub. Health Rep. 368 (1989). *See* Wernick Brief, *supra* note 198, at A22.

322 *See* People v. Wernick, 215 A.D.2d 50, (N.Y. App. Div. 1995).

323 *See id.* at 52.

and did not move for one itself, the issue of whether Neonaticide Syndrome is in fact accepted by the relevant scientific community was not preserved for appellate review and was therefore not decided.[324]

Another issue raised on appeal was that the trial court's refusal to admit the experts' testimony on Neonaticide Syndrome violated New York Criminal Procedure Law, which provides that psychiatrists or psychologists "must be permitted to make any explanation reasonably serving to clarify his diagnosis and opinion."[325] The court dismissed this contention, affirming the trial court's exclusion of the evidence because those rulings did not "preclude . . . [the defense experts] from referring to the relevant literature or to their relevant experiences in expressing opinions regarding the defendant's mental state before, during, and after the crime."[326]

The Appellate Division's decision was appealed to New York Court of Appeals, the state's highest court.[327] The relevant issue raised in that appeal was that the "appellant was denied due process rights by the trial court's refusal to allow the defense experts to explain their reliance upon out of court scientific evidence in forming their expert opinions . . . ."[328] The defendant argued that her experts were not intending to testify that she suffered from Neonaticide Syndrome, or even that it exists. Rather, they were going to argue that she had suffered a Brief Reactive Psychosis[329] and that "their proffered testimony was introduced to explain [that] diagnosis and not to establish a fact."[330] Wernick further asserted that "she merely attempted to show that clinical studies have established patterns of conduct of young women, reflecting certain similar characteristics, who have suffered from a genuine pathological denial of their pregnancies and subsequently killed their newborns immediately after birth."[331] The Court rejected

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324 *See id.* at 53.

325 *Id.* (quoting N.Y. CRIM. PROC. LAW § 60.55(1) (McKinney 1995)).

326 *Id.* The trial judge stated at trial:

> I am not preventing the witness from testifying as to the basis of his opinions. I am just preventing him, as I said, from setting up a specific profile that he has gleaned from the literature, as to why young mothers, or mothers kill their babies . . . . Certainly, the Doctor can testify as to this specific defendant, and what led him to his conclusions, based upon his own experiences, his reading of the literature, his studies of her, without quoting this common theme from the literature.

Id..

327 *See* People v. Wernick, 674 N.E.2d 322, (N.Y. 1996).

328 *Wernick Brief, supra* note 191, at 7-9.

329 *See* discussion *supra* Part III.C.i.

330 *Wernick*, 674 N.E.2d at 324.

331 *Id.*

this argument, characterizing it as a "refined strategy" and as a way to get the jury to hear evidence of Neonaticide Syndrome without having it tested in a *Frye* hearing for its general acceptance in the relevant scientific community.[332] The court also analyzed the dilemma under New York Criminal Procedure Law and concluded that the precedents controlling that rule endorsed the policy that "evidence offered by a psychiatric expert be of a kind established as generally accepted in the profession as reliable" and that "CPL 60.55(1) does not overrule the reliability need for a *Frye* or *Frye*-like hearing in all instances when a party seeks to present novel scientific or psychiatric or medical evidence."[333]

Judge Simons dissented and argued that Criminal Procedure Law (CPL) section 60.55 provided for a broad rule of admissibility in the limited set of cases to which it is applied.[334] Judge Simons also made a bright-line distinction between the rationales behind CPL 60.55 and *Frye*. Judge Simons argued that, while *Frye's* focus is on the admissibility of reliable evidence, the focus of CPL section 60.55 is on allowing a testifying psychiatrist to explain the basis for his or her diagnosis.[335] Judge Simons argued that CPL section 60.55 was "enacted to relax the common-law rules on admissibility when: (1) an expert who has examined the defendant; (2) offers an opinion of the defendant's mental condition at the time of the crime; (3) in support of the affirmative defense of mental disease or defect."[336] Any testimony given by the expert pursuant to this rule is to allow the trier of fact to understand scientific issues of which they have no expertise or prior knowledge.[337] Judge Simons thus reassured that the expert's examinations of the defendant tended to show that she had suffered a reactive psychosis and was unable to appreciate the consequences and wrongful nature of her actions.[338] The foundation for that evidence was the psychiatrist's personal examination of her over time.[339] Under CPL section 60.55, said Judge Simons, the psychiatrists should have been able to show how that evidence brought them to the conclusion that she had suffered a psychotic break at the time of the killing by referring to the neonaticide literature, as it is common in the field to rely on other colleagues' work and experience. Those studies were

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332 *See id.*
333 *Id.*
334 *See id.*at 326 (Simmons, J., dissenting).
335 *See id.* at 326-7.
336 *Id.* at 327.
337 *See id.*
338 *See id.*
339 *See id.*

"facially reasonable because they were written by legitimate practitioners and published in recognized medical journals. The evidence was thus 'data . . . of the kind ordinarily accepted by experts in the field.'"[340] In not allowing the testimony, Judge Simons concluded, the court deprived the defendant of the ability to fully present her affirmative defense of insanity.[341]

C. *Neonaticide Syndrome and the "Ethos of Maternity"*

Neonaticide Syndrome does not appear in the DSM-IV as a discrete psychiatric disorder. The psychiatric community, however, already recognizes neonaticides as falling within a "clinical entity,"[342] albeit without yet having recognized it as a distinct syndrome. Why they have not is unclear. Perhaps since neonaticide evades treatment because these mothers deny and hide their pregnancies, such evasion has thus far prevented the psychiatric community from conducting systematic studies of the symptoms commonly present in women who commit neonaticide. The observations of the medical community of women who kill their newborns are made only *after* the murder of the newborn occurs. And at that point, the criminal justice system has already taken charge of the women.

Nonetheless, simply because a Neonaticide Syndrome has not as yet been recognized as a distinct disorder catalogued in the *DSM-IV* does not automatically bar its acceptance as evidence in a legal context that aids a jury to fully understand the precise mental condition of a woman at the time of the death of her infant. Indeed, both Battered Woman's Syndrome and Rape Trauma Syndrome, both commonly accepted in courts around the country, are considered to be legally legitimate syndromes notwithstanding the fact that neither of them appear in the *DSM-IV* as independent and recognized disorders. Instead, Rape Trauma Syndrome and Battered Woman Syndrome are understood to fall within the ambit of Posttraumatic Stress Disorder and derive their acceptance therefrom.[343]

Perhaps the most important question to ask is: Why is a Neonaticide Syndrome needed in the defense of women who are accused of killing their newborns? Why isn't the testimony of a psychiatrist as to the singular instance of behavior by a particular defendant not enough to mount a sufficiently cogent and com-

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340 *Id.* (quoting People v. Sugden, 323 N.E.2d 169 (1974)).
341 *Id.* at 326.
342 Brozovsky & Falit, *supra* note 18, at 679.
343 *See supra* Part IV.A.i.

plete defense? The answer is that the neonaticides discussed in this Note share one common, overriding, and essential characteristic: The denial of pregnancy by the woman who commits the neonaticide.

The medical reports on neonaticides abound with accounts of the denial of pregnancy. Indeed, the reports, as discussed in section II.A of this Note, are similarly replete with other symptoms associated with the "clinical entity" of neonaticide,[344] such as dissociative states, brief psychotic breaks, rationalization, delusions, hallucinations, and catatonia.[345] Since in any criminal prosecution for homicide the prosecution must show beyond a reasonable doubt that the defendant possessed the *mens rea* requisite to the crime, at the very least, the psychotic breaks, command hallucinations and dissociative states common in cases of neonaticide speak to the mental states of the mothers at the time of the killing. The rationalization, denial of pregnancy, and catatonia serve to contextualize the mental disorders and behaviors within the pregnancy experience of the women falling into the "clinical entity."

The literature on neonaticide points out that it is the arrival of the newborn which breaks down the walls of denial of the pregnancy which the woman has created. This sudden and massive destruction of her denial comes in the form of a psychotic break at the time of birth. At this point, the newborn is actively killed or is simply left to die. However, it is precisely this wall of denial, the most relevant aspect of these cases, which the public (read jurors) find the most incredible, that is, not reasonably believable. How could a woman really not know that she was pregnant?

The difficulty that the general public may have in contemplating the possibility of a woman denying her pregnancy is precisely the reason why evidence of Neonaticide Syndrome should be admitted. The placement of the mental state of these mothers within a larger framework is critical for a complete understanding of these cases of neonaticide because, without it, the jury is strongly disinclined to accept a woman's assertion that she did not know she was pregnant as plausible, notwithstanding the psychiatric community's support of the existence of that kind of denial, both by a particular defendant and by other similarly situated women. Of course, not all neonaticides are committed by the mothers who are the subject of this Note: Amy Grossberg, the 18 year old who delivered a baby in a motel room she rented with her boyfriend at no

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[344] *See supra* Part III.A.

[345] *See supra* Parts III.A-B.

point claimed that she did not know she was pregnant.[346] Accordingly, those cases which have elements of premeditation would be unable to benefit from the use of a Neonaticide Syndrome, since the underpinnings of the Syndrome are based in the denial of pregnancy.

What makes the denial of pregnancy such a difficult concept to understand or accept are socio-culturally shared notions of maternity and motherhood. In cases of neonaticide, these notions prevent jurors from understanding denial of pregnancy because it seems entirely implausible that a woman could do so, given the primacy of motherhood, both to a woman's role as a member of society and her function as a person. Indeed, the role of mother and the act of "mother love" for her child "has achieved the status of a moral imperative."[347] It is important, then, to examine briefly the origins of these ideas.

Today's prevailing conceptions of motherhood are derived not surprisingly from yesterday's culture and history,[348] but the expectations that societies have placed on women as the primary care-takers of children have changed with each era. The changing role and responsibility of a woman as mother has mostly centered around the support systems available to women, such as wet-nurses,[349] extended-families, public school, day-care, and after-school programs, all of which ensure that children are provided for and supervised. In large part, the place women have taken in the paid labor force has redefined their responsibilities and society's expectations of them as mothers. Today, double-income families are the norm, not to mention a necessity. However, while the social status and position of women evolve with market forces and pressures, women continue to be primarily seen as mothers, or at the very least, essentially maternal: "In a time when society values the fulfillment of women as persons, we have an ethos of maternity that denies them that very thing."[350] Thus, whether it be the arrival

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346 *See e.g.*, Jan Hoffman, supra note 210, at B1 (Grossberg and her boyfriend Brian Peterson were indicted on two counts of first degree murder. The first count charged that they intended to cause the death of the newborn, the second charged that they recklessly abused or neglected the baby, which led to its death.); *see also* Thom Grier, *An American Tragedy*, U.S. NEWS & WORLD REPORT, Dec. 2, 1996, at 13. The couple is currently seeking to separate their trials "since the teens' versions of what happened the morning their baby died are so different, 'one cancels the other out.'" Laura Itlaliano, *Baby Slay; Duo's Bitter End*, N.Y. POST, March 7, 1998, at 9.

347 SHARI L. THURER, THE MYTHS OF MOTHERHOOD; HOW CULTURE REINVENTS THE GOOD MOTHER xvi (1994).

348 *Id.* at xv.

349 *See id.* at 175-76.

350 *Id.* at xxvii.

of a child that signals the dutiful resignation of a woman, at least for a while, from the board room to the nursery, or the absence of a child that makes a woman "barren"[351] and therefore less than a complete woman, this "ethos of maternity" creates, describes, and articulates what a woman *is* in our society.[352]

Conception, gestation, and childbirth are some of the more basic and natural functions of human life. However, as a culture we have conceptually, even morally integrated those biological functions into the institution of the family and the result has been the ethical institutionalization of motherhood itself. Adrienne Rich comments:

> Institutionalized motherhood demands of women maternal "instinct" rather than intelligence, selflessness rather than self-realization, relation to others rather than the creation of self. Motherhood is "sacred" so long as its offspring are "legitimate". . . . It is "woman's highest and holiest mission," according to a socialist tract of 1914; and a racist southern historian of 1910 tells us that "woman is the embodied home, and the home is the basis of all institutions, the buttress of society."[353]

These descriptions may strike us as being archaic notions of the role of women in our society. However, we see that these same suppositions have worked to narrow the force of decisions like *Roe v. Wade*,[354] decisions which seek to recognize legally the place of women in society apart from the maternal role so ferociously protected and maintained.

Under this rubric, motherhood is presumed to be the most natural state for a woman. Society has so culturalized maternity that it has totally absorbed womanhood itself. These two terms, "motherhood" and "maternity," absent a very good explanation (infertility), become interchangable with "woman." To be a woman is to be a mother, or at least maternal.

When "motherhood" and pregnancy do come, it usually is warmly welcomed. Ironically, while pregnancy is seen as a "natural" state for women, not all expectant women are met with such approbation. Old fashioned American "Family Values" condemn

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[351] *See* RICH, *supra* note 11, at 22 ("The term 'barren woman' was easy for me to use, unexamined, fifteen years ago. As should be clear throughout this book, it seems to me now a term both tendentious and meaningless, based on a view of women which sees motherhood as our only positive definition.").

[352] This argument has been made by many other critics. *See, e.g.*, SHULAMITH FIRESTONE, THE DIALECTIC OF SEX (1970).

[353] RICH, *supra* note 11, at 42.

[354] 410 U.S. 113 (1973), *limited by* Webster v. Reprod. Health Servs., 492 U.S. 490 (1989), *modified by* Planned Parenthood v. Casey, 505 U.S. 833 (1992).

the single mother. The "WelfareQueen"—who as far as we are told is *always* a mother as if that makes her more irresponsible —is seen as the woman who uses her sex and many children as a way to hustle a living off of the government. The mother of the "crack baby" taxes society with her sickly and drug dependent issue, and working mothers can never do enough for their children. In our society, our mothers are hyphenated and modified. The more modified, the less likely these mothers fit within traditional notions of family and motherhood, and therefore, womanhood. The terms that we use to define and understand these and all women, along with accompanying sexist, racist, and classist subtexts, make clear that motherhood, womanhood, gender, race, and culture are inextricably linked. The very fact that our understanding of womanhood itself is so politically charged calls into question the validity of the "understanding" itself.

As a society, we are repelled by actions taken by anyone which endanger and injure children. Acts of violence against children are immediate media sensations and spring-boards for commentary on various "hot" social issues. However, when it is a child's mother that commits those actions, our reactions take on abhorrence, rage, and disbelief. Indeed, "on delivering a child, a woman becomes a factotum, a life-support system. Her personal desires either evaporate or metamorphose so that they are identical with those of her infant."[355] Since a child is regarded as an extension of its mother, how is it that she could do anything to actively harm it?

Enter the woman who is accused of killing her newborn. Even more inconceivable than actions taken by a woman that hurt her own child is the capability of a woman to deny the very fact of her pregnancy. Our society exults in the state of pregnancy too ardently, or perhaps rather, the "blessing" of a pregnancy is too cherished a cliché to accept such a proposition. At the very least, the physical signs of pregnancy should alert a woman, as well as those around her, that a fetus is growing within her. During gestation, a woman is thought to go through various mental stages that strengthen her ties to her infant:

> A normal pregnancy poses a new developmental task for the mother, which can be conceptualized as proceeding through four stages: acceptance of the pregnant state, affiliation with the fetus, prepatory behavior, and development of a reality-based perception of the neonate. . . . The mother's emotional ties with

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355 THURER, supra note 347, at xvii.

> the fetus progressively become strengthened, and antenatal attachment behavior emerges.[356]

Thus, society considers motherhood to start even prior to the birth of a child, only to be further strengthened after birth and throughout the child's life. However, antenatal bonding assumes a woman's awareness of pregnancy, and that awareness purportedly reaches psychologically sure and unshakeable proportions. Pregnancy is presumed to be a categorically symbiotic relationship as is later maternal instinct. Divergence from the antenatal bond, indeed from any connection between mother and child, is unthinkable because it is simply "unnatural." This same logic informs the movement to restrict the right of women to obtain abortions and the prosecution for fetal abuse. Since pregnancy and maternity give women their very identity, the denial of their offspring, born or unborn, becomes the denial of their very selves.

The refusal of the courts to admit evidence of a Neonaticide Syndrome isolates the experience of the accused woman, making her experience a veritable aberration although in fact, it is a common occurrence. The great advantage in legally recognizing a Neonaticide Syndrome would be that the woman could contextualize the central, already accepted mental disorders of Brief Psychotic and Depersonalization Disorders with a framework which includes the other characteristics of neonaticide, such as the massive denial and rationalization of pregnancy, youth, and inexperience. Indeed, these cases of neonaticide present situations where intense denial of pregnancy are repeatedly documented to have occurred.[357] A review of the psychiatric literature on the subject reveals that these instances of neonaticide are not isolated instances, but occur with eerie and astonishing similarity in the United States, as well as in Canada and Great Britain.[358] However, because notions of the prenatal maternal bond are so deeply ingrained in the way the mother/child relationship is socially constructed and perceived, denial and rationalization are too easily dismissed in considering these cases. While at first glance it seems as if the jury could easily decide and understand whether an accused woman was pregnant, the cases of and research on neonaticide demonstrate that a woman's own knowledge of her pregnancy is not systematically as clear-cut as is presumed and may require expert testimony in cases where denial of pregnancy has occurred.

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356 Miller, *supra* note 183, at 1235.

357 *See supra* Part III.

358 *See supra* Parts III. A. & B.

Such evidence is vitally important where proof of the woman's knowledge is an element of the crime with which she is charged, or where her defense is one of involuntariness, insanity, or diminished capacity since the point where the denial is no longer tenable appears to produce the onset of psychotic episodes during which the neonates are killed.

The admissibility of evidence of a Neonaticide Syndrome would not force a jury to conclude anything at all about the particular defendant. The syndrome would strictly be another piece of evidence offered by the defendant to counter the state's case against her, and the weight granted to it would be entirely at the jury's discretion. Furthermore, the syndrome would not be used as proof in itself that the defendant was in fact insane, but only evidence to that effect. The jury would still have to determine whether the Syndrome evidence constituted a mental disease or defect sufficient to warrant excuse under insanity, diminished capacity, or involuntariness.

Nor would the recognition of a Neonaticide Syndrome hail the creation of a new defense in criminal law. Rather, its recognition would simply allow an expert witness to testify as to the totality of symptoms and conduct common in cases of neonaticide, factors which have a direct relation of a woman's ability to formulate the *mens rea* required to convict her of a culpable homicide.

Battered Woman Syndrome and Rape Trauma Syndrome essentially operate to dispel commonly held misconceptions about abusive relationships and rape. The courts that admit these Syndromes as explanations of behavior do so because without the Syndrome evidence, juries are likely to allow their understanding of abuse or rape, which is flawed by the various myths described above, to inform their notions of legal issues such as "reasonableness" and "consent." Syndrome evidence affords the assertions of the defendant's equitable consideration as it both dispels misconceptions and contextualizes her behavior. So too would the perceptions and experience of a neonaticidal mother contextualize her behavior.

V. The Evidentiary Problem

Before novel scientific evidence like Neonaticide Syndrome can be admitted at trial to prove a particular point, it must undergo a hearing to which the jurors are not privy in order to determine its reliability.[359] There are two court-established tests for this

[359] See e.g., Wernick, 674 N.E. 2d 322 (N.Y. 1996).

purpose: The older is the *Frye* test,[360] the more recent the *Daubert* test.[361] While the *Daubert* test, enunciated by the United States Supreme Court, controls in the federal court system, the *Frye* test continues to be applied in many state jurisdictions.[362]

A. The Frye *Test*

Frye v. United States[363] articulated the "general acceptance" standard which served as the governing test for the admissibility of scientific evidence in the federal court system until its abrogation by the Supreme Court in its 1993 decision *Daubert v. Merrell Dow Pharmaceuticals.*[364] Although only a district court decision, *Frye* has proven to be a powerful and tenacious holding. Despite the *Daubert* Court's ruling that *Frye* had been superceded by the adoption of the Federal Rules of Evidence,[365] many state courts continue to employ the *Frye* test in determining the admissibility of "scientific evidence."[366]

In 1923, the Court of Appeals of the District of Columbia decided *Frye v. United States.*[367] Frye, who had been convicted of second degree murder,[368] argued in his appeal that the lower court's rejection of evidence taken from a systolic blood pressure deception test constituted reversible error.[369] The defendant's attorney "offered the scientist who conducted the test as an expert to testify to the results obtained."[370] The court denied the admission of the testimony, as well as an offer by defendant's counsel to conduct the test in front of the jury.[371] In affirming the lower court's ruling, the *Frye* court held:

> Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-

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360 *See* Frye v. United States, 293 F. 1013 (D.C. Cir. 1923).
361 *See* Daubert v. Merrell Dow Pharms., Inc., 509 U.S. 579 (1993).
362 *See, e.g.*, People v. Wernick, 674 N.E.2d 322 (N.Y. 1996).
363 293 F. 1013 (D.C. Cir. 1923).
364 509 U.S. 579 (1993).
365 *See Daubert*, 509 U.S. at 587.
366 *See* Duncan, *supra* note 261, at 753 ("In many jurisdictions, *Frye* even survived the different test of admissibility adopted by the Federal Rules of Evidence and its parallel state counterparts.").
367 293 F. 1013 (D.C. Cir. 1923).
368 *See id.* at 1013.
369 *See id.* at 1013-14.
370 *Id.* at 1014, *replaced by* Daubert v. Merrill Dow Pharms., Inc., 509 U.S. 579 (1993) (construing FED. R. EVID. 702).
371 *See id.*

> recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs.[372]

The holding in *Frye* provided the federal courts with a standard to use in deciding whether or not novel or controversial scientific evidence would be admissible. The *Frye* standard involves two parts:

> First, there must be a theory that is generally accepted in the appropriate scientific community. The general acceptance of the theory serves as a proxy for the existence of valid scientific principles underlying the theory. Second, there must be methods, implementing the theory, which are generally accepted in the appropriate scientific field. The general acceptance of methods serves as a proxy for the existence of a valid and reliable scientific technique to utilize the theory in practice.[373]

Despite its federal origin, *Frye*'s "general acceptance test" standard was adopted by most state courts.[374] In fact, even though *Frye* is no longer controlling in the federal court system, state courts continue to apply it.[375]

B. Daubert

Prior to its decision in *Daubert v. Merrill Dow Pharmaceuticals, Inc.*[376] in 1993, the United States Supreme Court had not made a ruling on the place of scientific conclusions in the law.[377] While the *Frye* test was in effect in both the federal courts and many state courts, at no time did a United States Supreme Court majority cite to *Frye* until they overruled it seventy years later in *Daubert*.[378] Prior to *Daubert* the Court "relied upon the conclusions of scientific research without any consideration of the validity of the methods that produced those conclusions."[379]

Daubert came to the United States Supreme Court from a California tort action claiming that birth defects suffered by the claim-

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372 Frye, 293 F. 1013 at 1014.

373 Lawrence B. Ebert, *Frye after Daubert: The Role of Scientists in Admissibility Issues As Seen Through Analysis of the DNA Profiling Cases*, 1993 U. CHI. L. SCH. ROUNDTABLE 219, 224 (1993).

374 *See* JOSHUA DRESSLER, UNDERSTANDING CRIMINAL LAW 218, n.110 (1995); Duncan, *supra* note 241, at 753; James Q. Wilson, *Trial By Science*, Nat'l Rev., Mar. 10, 1997, at 38.

375 *See, e.g.*, People v. Wernick, 674 N.E.2d 322 (N.Y. 1996).

376 509 U.S. 579 (1993).

377 *See* Laurens Walker & John Monahan, *Daubert and the Reference Manual: An Essay on the Future of Science in Law*, 82 VA. L. REV. 837, 840 (1996).

378 *See id.*

379 *Id.*

ants were caused by the use of Bendectin.[380] In a motion for summary judgment, Merrill Dow Pharmaceuticals submitted the affidavit of an epidemiologist that reviewed the literature on Bendectin and its relationship to birth defects.[381] On the basis of these studies, Merrill Dow's expert concluded that there was no link between the use of Bendectin and human birth defects.[382] The petitioners responded with eight experts of their own who testified that Bendectin could in fact cause birth defects.[383] While their conclusions were based on live animal studies, pharmacological studies, and "'re-analysis' of previously published epidemiological (human statistical) studies,"[384] the United States District Court for the Southern District of California granted the respondent's motion for summary judgment because the petitioner's evidence did not meet the *Frye* test: the petitioner's evidence on Bendectin was not "'sufficiently established to have general acceptance in the field to which it belong[ed].'"[385] Affirming the court's decision, the United States Court of Appeals for the Ninth Circuit stated that "expert opinion based on a scientific technique is inadmissible unless the technique is 'generally accepted' as reliable in the relevant scientific community,"[386] thereby reaffirming *Frye*. On review, the United States Supreme Court held that *Frye* had been superceded by the adoption of the Federal Rules of Evidence.[387] The Court specifically pointed to Rules 401,[388] 402,[389] 702,[390] and 703[391] in

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380 *See Daubert*, 509 U.S. at 582.

381 *See id.* at 583. Merrill Dow's expert's affidavit consisted of review of more than 30 different studies which involved more than 130,000 patients. *See id.* at 582.

382 *See id.*

383 *See id.* at 583.

384 *Id.*

385 *Id.*

386 *Id.* at 584.

387 *See id.* at 587.

388 Rule 401, the "Definition of 'Relevant Evidence,'" reads: "'Relevant evidence' means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." FED. R. EVID. 401.

389 Rule 402, on "Relevant Evidence Generally Admissible; Irrelevant Evidence Inadmissible" reads: "All relevant evidence is admissible, except as otherwise provided by the Constitution of the United States, by Act of Congress, by these rules, or by other rules prescribed by the Supreme Court pursuant to statutory authority. Evidence which is not relevant is not admissible." FED. R. EVID. 402.

390 Rule 702, on "Testimony by Experts" reads: "If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise." FED. R. EVID. 702.

391 Rule 703 on "Bases of Opinion Testimony by Experts" reads: "The facts or data in the particular case upon which an expert bases an opinion of inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence." FED. R. EVID. 703.

holding that *Frye's* "general acceptance" standard had not been incorporated into the Federal Rules.[392] Instead, the Court held that *Frye's* "rigid 'general acceptance' requirement would be at odds with the 'liberal thrust' of the Federal Rules and their 'general approach of relaxing the traditional barriers to opinion testimony.'"[393]

Although the Court refused to read the *Frye* "general acceptance" standard as having been incorporated into the Federal Rules of Evidence, it did not allow for the unfettered introduction of scientific evidence. In enunciating the new standard, the Court listed several requirements needed to be met by a party seeking to introduce new scientific evidence. First, relevance and reliability continue to be threshold requirements for the admission of such evidence.[394] Second, pursuant to Rule 104(a), the trial judge "must determine at the outset . . . whether the expert is proposing to testify to (1) scientific knowledge that (2) will assist the trier of fact to understand or determine a fact in issue."[395] The Court provided guidelines for the determination of "whether the reasoning or methodology underlying the testimony is scientifically valid and of whether that reasoning or methodology properly can be applied to the facts at issue."[396] One of the factors to be considered in the determination of the validity and applicability of the evidence is "whether [the evidence] can be (and has been) tested."[397] Another factor is "whether the theory or technique has been subjected to peer review and publication."[398] While publication and peer review may be considered in determining the admissibility of the evidence, the Court signaled that a lack of either is "a relevant, though not dispositive, consideration in assessing the scientific validity of a particular technique or methodology on which an opinion is premised."[399] A third factor is the "known or potential rate of error . . . and the existence and maintenance of standards controlling the technique's operation."[400] Lastly, the Court noted that recourse to the "general acceptance" standard might be had in de-

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392 *See Daubert*, 509 U.S. at 588.

393 *Id.*

394 *See id.* at 590-92.

395 *Id.* at 592.

396 *Id.* at 592-93.

397 *Id.* at 593. The Court stated that "[s]cientific methodology today is based on generating hypothesis and testing them to see if they can be falsified; indeed, this methodology is what distinguishes science from other fields of human inquiry." *Id.*

398 *Id.*

399 *Id.* at 594.

400 *Id.*

termining the validity of scientific evidence, although, like peer review and publication, it is not dispositive.[401]

To summarize, the Court held that the proper standard to be applied in determining the admissibility of scientific evidence is Rule 702, since "[i]ts overarching subject is the scientific validity—and thus the evidentiary relevance and reliability— of the principles that underlie a proposed submission. The focus . . . must be solely on principles and methodology, not on the conclusions that they generate."[402] Thus, the 702 inquiry is three-tiered: 1) The proffered expert testimony must be of scientific knowledge; 2) the proffered expert testimony must assist the trier of fact in determining factual issues in the case; and 3) the expert witness must be qualified as such "by knowledge, skill, training, or education."[403] To temper the impact that such scientific evidence might have on an overly impressionable jury, the Court pointed to the evidentiary catch-all Rule 403[404] as a safeguard against prejudice.[405]

C. *Neonaticide Syndrome,* Frye, *and* Daubert

To be accepted as a legitimate syndrome for use in a courtroom, Neonaticide Syndrome would in all probability have to be subjected to the rigors of a *Frye* or *Daubert* hearing to test its credibility as novel scientific evidence. Neonaticide Syndrome has not yet undergone either of these tests in a court of law and, at this point, its success in one of these hearings is purely speculative. Nonetheless, in the following section, this Note seeks to point out the factors that would probably be considered in a *Frye* or *Daubert* determination.

In a *Frye* jurisdiction, the main factor considered in an analysis of Neonaticide Syndrome would be whether the syndrome has been generally accepted within the scientific community.[406] It is difficult to say whether the literature on neonaticide reveals sufficient agreement by the psychiatric community that a syndrome in

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[401] *See id.* ("Widespread acceptance can be an important factor in ruling particular evidence admissible, and 'a known technique which has been able to attract only minimal support within the community' may properly be viewed with skepticism.").

[402] *Id.* at 594-95.

[403] *See* Bert Black, *Winning the Expert Wars in the Age of Daubert*, SB16 ALI-ABA 13, 16 (1996).

[404] Rule 403, on the "Exclusion of Relevant Evidence on Grounds of Prejudice, Confusion, or Waste of Time" reads: "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." FED. R. EVID. 403.

[405] *See Daubert*, 509 U.S. at 595.

[406] *See id.*

fact exists. In this regard, it should be noted that there has been no major article contradicting or calling into question the current findings on neonaticide as they are discussed above. To be sure, a review of the available literature demonstrates that neonaticides are considered to be a distinct "clinical entity,"[407] with numerous characteristics repeatedly surfacing in the case studies on the women who commit this crime. In addition, besides the characteristics themselves, there are recognized mental disorders alluded to in the literature on neonaticide — e.g., Brief Psychotic Depersonalization Disorders. It is beyond dispute that these two disorders are generally accepted within the scientific community according to the *Frye* standard because they are found in the *Diagnostic and Statistical Manual on Mental Disorders* (*DSM*), the authoritative book on mental disorders recognized by the American Psychiatric Association. The relevant articles on neonaticide appear in the major professional journals and are open to peer review. Of course, these considerations would also be supported by the testimony of psychiatrists who could affirmatively state whether or not Neonaticide Syndrome is in fact a legitimate syndrome with clinical dimensions.

In a *Daubert* jurisdiction, the inquiry would focus more broadly on whether Neonaticide Syndrome is relevant to the issues it is intended to support.[408] Since Neonaticide Syndrome would be used as evidence of a mental disease or defect for the purposes of mounting a defense to a charge of homicide, it would certainly be considered relevant. The second and more difficult issue is the reliability of Neonaticide Syndrome. The factors necessarily considered under a *Daubert* approach would be the "testability" of the evidence, the rate of error and existence of standards by which the method is controlled, whether the theory has been subjected to peer review and publication, and its general acceptance within the relevant scientific community.[409] If Neonaticide Syndrome were to be considered a part of either Brief Psychotic or Depersonalization Disorders, then the inquiry on methodology would probably center primarily on whether the *DSM-IV* reflects the use of a methodology that is a part of "good science," which is the formulation of hypotheses and their subsequent testing for falsification.[410] Surely, the *DSM-IV* meets those standards. Furthermore, as noted in the above *Frye* discussion, the articles on neonaticide are published in the

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[407] *See* Brozovsky & Falit, *supra* note 18, at 679 (describing neonaticide as a "clinical entity.").

[408] *See Daubert*, 509 U.S. at 591-92.

[409] *See id.* at 593-95.

[410] *See id.* at 593-94.

profession's leading journals and are thus exposed to peer review, a factor that the *Daubert* Court considered probative.[411] Finally, the testimony of psychiatrists in the field conclusively affirming or disaffirming Neonaticide Syndrome would be crucial, considering that there is no direct mention of Neonaticide Syndrome in the literature.

Of course, whether Neonaticide Syndrome would pass the *Frye* or *Daubert* standards depends on the jurisdiction and their local approach to each standard. This section does not pretend to predict how Neonaticide Syndrome would fare under either of these standards. Rather, it notes factors that would most likely be considered in that determination.

VI. DEFENSES

American criminal law demands a morally culpable state of mind in order to obtain a conviction for a crime. The affirmative defenses of involuntariness, insanity, and diminished capacity recognize that a mental disability may be grounds for excuse when that disability prevents a defendant from intending to act in a criminally blameworthy way. Thus, evidence of a recognized mental disorder, whether within the purview of a recognized Neonaticide Syndrome encompassing Depersonalization or Brief Psychotic Disorders or any other recognized mental disorder, or alternatively, through Depersonalization Disorder or Brief Reactive Psychosis without the contextualization afforded by Neonaticide Syndrome, is but the first step in defending a homicide charge. The defendant must also be able to show that the disorder can properly be regarded as a mental disease, defect, or disability under the relevant defense statute. The following is a brief summary of the insanity, diminished capacity, and involuntary act defenses, and a discussion of how the use of Brief Psychotic and Depersonalization Disorders may fare under each of these defenses.

A. Involuntariness

The involuntary act defense is often presented when an actor commits a crime at a time during which she is unable to control her actions.[412] Put otherwise, the action is performed without a connection between the muscles and mind of the actor.[413] The

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[411] *See id.* at 594.

[412] *See* 2 PAUL H. ROBINSON, CRIMINAL LAW DEFENSES 261 (1984) [hereinafter ROBINSON II].

[413] *See id.*

defense "provides a general excuse whenever 'the minimum indispensable connexion between mind and body present in all normal action, and generally required for responsibility,' is missing."[414] Other articulations of this defense are that the actor commits the crime while she "is 'not the master of the situation,'"[415] or that the conduct was "not the assertion of a human agent."[416] The involuntary act defense provides a complete defense to a crime.[417]

While the specific formulation of the defense differs between jurisdictions, it can be summarized as such: "an actor is excused for his conduct constituting an offense if, as a result of (1) any mental or physical disability, (2) the conduct is not a product of the actor's effort or determination."[418] The disability requirement in involuntariness is critical to the defense as it makes the conduct sought to be punished "blameless."[419] Although the involuntariness defense is not subsumed under an exhaustive list of disabilities, unconsciousness,[420] epilepsy, and dissociative states[421] are understood as satisfying this requirement.[422] Of particular import in this regard is that the "involuntary act defense . . . is permitted without regard to the cause of the involuntariness. Anything that causes an actor to perform a criminal act that 'is not a product of [his or her] determination' will qualify for the defense."[423]

i. Involuntariness, Neonaticide and Depersonalization Disorder

Involuntariness can be used as a complete defense to a homicide charge in a case of a neonaticide. As discussed above, the psychiatric literature suggests that these women go through some kind

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414 *Id.* (quoting H.L.A. HART, PUNISHMENT AND RESPONSIBILITY 99 (1973)).

415 *Id.* (quoting Bratty v. Att'y Gen. N. Ir., 3 All E.R. 523, 526 (1961)).

416 *Id.* (quoting G. FLETCHER, RETHINKING CRIMINAL LAW 433 (1978)).

417 *See, e.g.*, People v. Newton, 87 Cal. Rptr. 394 (Cal. Ct. App. 1970).

418 ROBINSON II, *supra* note 412, at 260 (borrowing section (b) of this definition from MODEL PENAL CODE §2.01(2)(d)).

419 *See, e.g., Newton*, 87 Cal. Rptr. at 394.

420 *See, e.g., id.*

421 *See, e.g.*, People v. Lisnow, 151 Cal. Rptr. 621 (Cal. App. Dep't Super. Ct. 1978).

422 ROBINSON II, *supra* note 412, at 262. In fact, the lack of a "list" of specific disabilities which has been criticized as "broadening the defense to cases beyond instances of complete lack of volition" in that conditions such as hypnotism and somnambulism, which arguably do not completely deprive the actor of all volition and are not traditional disabilities as understood in other criminal defenses, has satisfied the disability requirement for the involuntary act defense. *See* Paul H. Robinson, *A Functional Analysis of Criminal Law*, 88 Nw. U. L. REV. 857, 898 (1994).

423 Robinson, *supra* note 422, at 897. Robinson argues that the lack of "a specific disability requirement [in the involuntary act defense] might be justified on the ground that the lack of control in many involuntary act cases is so complete and dramatic that no other requirement is needed to assure blameworthiness. It is irrelevant whether the muscular movement comes from a grand mal seizure or from a reflex action. Such total lack of volition is an obvious and convincing ground for exculpation." *Id.* at 897-98.

of dissociative state where they are oblivious to what surrounds them.[424] Recall the case study of Miss A[425] who, "[i]n a 'dazed state,'" cleaned the washroom where she had delivered her baby, "oblivious to alarmed relatives who remained outside the locked door for thirty minutes," and who was described by the attending physician who saw her when she was brought to the hospital as "spaced out."[426] The reports also suggests that these women feel as if they are observing their own actions while outside their body.[427] The literature further contains reports of auditory hallucinations where the women are commanded to rid themselves of the infant.[428]

The Depersonalization Disorder[429] contained in the *DSM-IV* appears to cover dissociative states these women experience during and soon after their deliveries. The feelings of being like an automaton, an outside observer of mental and physical efforts, and the sensation of lacking control of one's actions fit squarely within the involuntary act defense.[430] As discussed above, dissociative states may fulfill the disability requirement to obtain a successful automatism defense.[431] In cases of neonaticide when the defense of involuntariness or automatism is raised, it should be argued that the dissociative state (Depersonalization Disorder) is a mental disability, which makes the killing of the neonate not the result of the woman's effort or determination. As such, the woman's conduct is excused because it was not within her control.

B. Insanity

While controversial, the insanity defense exists in nearly all American jurisdictions in some form or another.[432] The defense has held such a tight grip on American jurisprudence because the

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424 *See supra* Part III.A.
425 *See supra* Part III.B.
426 Finnegan, *supra* note 166, at 672.
427 *See supra* Part III.A.
428 *See id.*
429 *See* DSM-IV, *supra* note 204, at 488.
430 *See id.*
431 *See supra* Part III.C.ii.
432 *See generally* UTAH CODE ANN. §76-2-305(1) (1953) (stating that evidence of mental illness can be admitted to rebut the mental state required as an element to an offense, but mental illness is not otherwise a defense); State v. Searcy, 798 P.2d 914 (Idaho 1990) (holding that insanity defense not constitutionally mandated, and Idaho Code § 18-207 allowing evidence of mental disease or defect but not general insanity defense is constitutional); State v. Korell, 690 P.2d 992 (Mont. 1984) (holding that Montana's abolition of insanity defense does not violate due process or the 8th Amendment). *But see* Sinclair v. State, 132 So. 581 (Miss. 1931) (declaring that abolition of insanity defense would be unconstitutional); State v. Strasburg, 110 P. 1020 (Wash. 1920) (declaring that abolition of insanity defense would be unconstitutional).

criminal law is an "expression of the moral sense of the community" and:

> [t]he fact that the law has, for centuries, regarded certain wrong-doers as improper subjects for punishment is a testament to the extent to which that moral sense has developed. Thus, society has recognized over the years that none of the three asserted purposes of the criminal law—rehabilitation, deterrence and retribution—is satisfied when the truly irresponsible, those who lack substantial capacity to control their actions, are punished.[433]

Thus, despite attacks, the insanity defense has generally been seen as essential in a system that punishes only where moral responsibility is present. Although there are four main formulations of the insanity defense in American jurisdictions, this Note focuses on two:[434] the *M'Naghten* test[435] and the Model Penal Code ("MPC") test.[436] These are both affirmative defenses, which place the burden on the defendant to raise the defense, as well as to prove it by a preponderance of the evidence.[437]

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[433] United States v. Freeman, 357 F.2d 606, 615 (2d Cir. 1966) (citing MOBERLY, RESPONSIBILITY 1-24 (1956)). Expanding on the notions of deterrence, rehabilitation, and retribution as the reasons for having criminal law to begin with, the court noted:

> What rehabilitative function is served when one who is mentally incompetent and found guilty is ordered to serve a sentence in prison? Is not any curative or restorative function better achieved in such a case in an institution designed and equipped to treat just such individuals? And how is deterrence achieved by punishing the incompetent? Those who are substantially unable to restrain their conduct are, by definition, undeterrable and their "punishment' is no example for others; those who are unaware of or do not appreciate the nature and quality of their actions can hardly be expected rationally to weigh the consequences of their conduct. Finally, what segment of society can feel its desire for retribution satisfied when it wreaks vengeance upon the incompetent? Although an understandable emotion, a need for retribution can never be permitted in a civilized society to degenerate into a sadistic form of revenge.

Id. (citing Wechsler and Michael, *A Rationale of the Law of* Homicide, 37 COL. L. REV. 701, 752-61 (1937)).

[434] The two other tests, the Durham Rule and the Federal Statutory Definition, are not discussed here as they are in a practical sense irrelevant to this discussion. The Durham Rule is not followed in any jurisdiction as it was overruled in *United States v. Brawner*, 471 F.2d 969 (1972), and there is little chance that a neonaticide would be tried in federal court.

[435] *See* M'Naghten's Case, 8 Eng. Rep. 718 (H.L. 1843).

[436] *See* MODEL PENAL CODE § 4.01.

[437] *See* 1 PAUL H. ROBINSON, CRIMINAL LAW DEFENSES 12-13 (1984) [hereinafter ROBINSON I].

i. *M'Naghten*

The *M'Naghten* Test, or the "right and wrong test,"[438] was derived from a landmark English case decided in 1843.[439] Under *M'Naghten*, to invoke a successful insanity defense:

> it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.[440]

Thus, the focus of the *M'Naghten* test is on the cognitive capacity of the defendant.[441] A defendant is judged insane if it can be proven she did not know right from wrong at the time of the commission of the crime, or if it can be proven that she did not understand the nature and quality of her act.[442] Some courts treat *M'Naghten* as if these ideas were two separate prongs,[443] while others treat them as one and the same.[444]

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[438] Billiot v. State, 454 So. 2d 445, 461 (Miss. 1984) (citation omitted).

[439] *See M'Naghten's Case*, 8 Eng. Rep. at 718.

[440] KADISH & SCHULHOFFER, CRIMINAL LAW AND ITS PROCESSES 933 (1995) (citing *M'Naghten's Case*, 8 Eng. Rep. 718) [hereinafter KADISH].

[441] *See* DRESSLER, *supra* note 3574, at 319.

[442] This is true because there is no "utility in the punishment of people who, at a moment, would commit acts which, if done when they were in sane minds, would be crimes. What is the utility of punishing people if they be beyond the control of the law for reasons of mental health?" KADISH, *supra* note 440, at 934 (citing *M'Naghten's Case*, 8 Eng. Rep. at 718.). Courts have also criticized the *M'Naghten* test:

> Because M'Naghten focuses only on the cognitive aspect of the personality, i.e., the ability to know right from wrong, we are told by eminent medical scholars that it does not permit the jury to identify those who can distinguish between good and evil but who cannot control their behavior. The result is that instead of being treated at appropriate mental institutions for a sufficiently long period to bring about a cure or sufficient improvement so that the accused may return with relative safety to himself and the community, he is ordinarily sentenced to a prison term as if criminally responsible, and then released as a potential recidivist with society at his mercy.

United States v. Freeman, 357 F.2d 606, 618 (2d. Cir. 1965). Other criticisms of the rule include: that *M'Naghten* does not allow for the recognition of degrees of incapacity, *see id.*; that *M'Naghten* too tightly restricts expert testimony because they may only testify as to whether the defendant knew right from wrong, thereby compelling the expert "to test guilt or innocence by a concept which bears little relationship to reality. He is required thus to consider one aspect of the mind a 'logic-tight compartment in which the delusion holds sway leaving the balance of the mind intact.'" *id.* at 619 (quoting GLUECK, MENTAL DISORDER AND THE CRIMINAL LAW 169-70 (1925)); and that *M'Naghten* limits expert testimony in such a way that it deprives the judge or jury of "information vital to their final judgment." *Id.* at 620. The critique concludes that psychiatrists "should provide grist for the legal mill, should furnish the raw data upon which the legal judgment is based. It is the psychiatrist who informs as to the mental state of the accused—his characteristics, his potentialities, his capabilities. But once this information is disclosed, it is society as a whole, represented by judge or jury, which decides whether a man with the characteristics described should or should not be held accountable for his acts." *Id.* at 619-20.

[443] *See, e.g.*, Montgomery v. State, 151 S.W. 813 (Tex. Crim. App. 1912).

[444] *See, e.g.*, Jessner v. State, 231 N.W. 634 (Wis. 1930).

The "defect of reason" imposition requires there to be a medically recognized mental disorder at the time of the commission of the crime.[445] As with diminished capacity,[446] the requirement that there be medical recognition of the disorder "lends the necessary credibility to this objectively unconfirmable claim of abnormality."[447] The presence of the 'abnormality' in the *DSM-IV* as an authoritative source for mental disorders may help to satisfy the disability requirement in all insanity formulations.[448]

Despite criticisms, many states continue to use the *M'Naghten* Rule as their test for insanity.[449] Some jurisdictions broadened *M'Naghten* by adding the "irresistible impulse test," which "relieve[s] [one] of criminal responsibility when his mental condition

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[445] ROBINSON II, *supra* note 412, at 286. The *M'Naghten* and ALI tests both have this requirement, and evidence of prior or present mental disease or defect has only evidentiary effect. *See id.* at n.8.

[446] *See infra* Part VI.C.

[447] ROBINSON II, *supra* note 412, at 287 ("[C]ommunity recognition of the severity of the abnormality is essential if those who engage in prohibited conduct are to be excused without endangering the effectiveness of the general prohibition against that conduct.").

[448] Note the American Psychiatric Association's caveat to the *DSM-IV*. *See supra* note 238 (a clinical diagnosis of a disorder listed in the *DSM-IV* is usually insufficient without more to establish mental disease or defect); *see also* Adams v. State, 330 S.E.2d 869 (Ga. 1985) (declaring jury may reject expert and lay testimony on insanity); Billiot v. State, 454 So. 2d 445 (Miss. 1984) (declaring jury may reject evidence of insanity).

[449] *See, e.g.*, State v. Patterson, 740 P.2d 944, 949 (Alaska 1987) (indicating that the Alaska insanity statute incorporates only the first prong of the *M'Naghten* test); People v. Skinner, 704 P.2d 752, 752 (Cal. 1985) (recognizing that Proposition 8 changed the test for insanity from the ALI standard back to the *M'Naghten* rule); Patten v. State, 467 So. 2d 975, 978 (Fla. 1985) (stating that

> [t]he law does not hold a person criminally accountable for his conduct while insane, since an insane person is not capable of forming the intent essential to the commission of a crime. A person is sane and responsible for his crime if he has sufficient mental capacity when the crime is committed to understand what he is doing and to understand that his act is wrong. If at the time of an alleged crime a defendant was by reason of mental infirmity, disease, or defect unable to understand the nature and quality of his act or its consequences or, if he did understand it, was incapable of distinguishing that which is right from that which is wrong, he was legally insane and should be found not guilty by reason of insanity.

(quoting *Fla. Std. Jury Instr. Crim. Cases*, 2.11(b)-1 (S.Ct.Comm. 1976))); Laney v. State, 421 So. 2d 1216, 1218-19 (Miss. 1982) (rejecting the ALI rule and affirming the use of the *M'Naghten* rule because

> [s]uch a rule in effect would provide for the acquittal of those who commit criminal acts and assert that they did such act or acts because of so-called uncontrollable urges or irresistible impulses. *Though the M'Naghten Rule may not be a perfect means to test criminal responsibility . . . it is the safest of the rules proposed. M'Naghten better protects society's needs* . . . .

(citing Hill v. State, 339 So. 2d 1382 (Miss. 1976))); Ybarra v. State, 679 P.2d 797, 800 (Nev. 1984) (reaffirming *M'Naghten* test as the rule for insanity in Nevada); TEX. PENAL CODE ANN. §8.01(a) (West 1994) ("It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease of defect, did not know that his conduct was wrong.").

is such as to deprive him of his will power to resist the impulse to commit the crime."[450]

a. *M'Naghten* and Brief Reactive Psychosis

As described above, an insanity defense in a *M'Naghten* jurisdiction focuses on the cognitive capacity of the defendant. Generally, if the defendant can show that, because of a defect of reason or disease of the mind, she did not know right from wrong at the time of the crime or that she did not understand the nature and quality of her act, she will be judged legally insane under *M'Naghten*. Admission of evidence on Brief Psychotic Disorder is probative on the issue of the defendant's state of mind at the time of the neonaticide. The *DSM-IV* includes delusions, hallucinations, and disorganized or catatonic behavior as criteria for a diagnosis of Brief Psychotic Disorder.[451] Critically, and especially with regard to the requirements of the *M'Naghten* test, the *DSM-IV* suggests that supervision of the individual may be necessary to protect the individual "from the consequences of poor judgment, *cognitive impairment*, or acting on the basis of *delusions*."[452] The *DSM-IV* does not provide a detailed list of the stressors that commonly lead to such a disorder, but it does note that "[t]he precipitating event(s) [of the psychotic break] may be any major stress," and adds that the diagnosis may note whether or not the psychotic break occurred within four weeks post-partum.[453]

The review of the literature on neonaticide reflects a general consensus that the women who commit neonaticide suffer Brief Psychotic Disorder at or around the time of the homicide.[454] The literature chronicles delusions and hallucinations, and confusion and catatonic behavior.[455] As noted above, the *DSM-IV* cautions that the individual who has Brief Psychotic Disorder suffers from cognitive impairment.[456] Indeed, as the psychiatrists testified in the *Wernick* case, the psychotic break impairs the defendant's cognitive capacity so as to render the defendant unable to appreciate the nature of her act.[457] The delusions, the command hallucinations urging the mother to dispose of the baby out of the window,

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[450] Graham v. State, 547 S.W.2d 531, 540 (Tenn. 1977) (Choosing the MPC standard over other insanity tests).
[451] *See* DSM-IV, *supra* note 204, at 302, 304.
[452] *Id.* at 302 (emphasis added).
[453] *Id.*
[454] *See supra* Part III.A.
[455] *See id.*
[456] *See* DSM-IV, *supra* note 204, at 302.
[457] *See* People v. Wernick, 674 N.E.2d 322, 328 (N.Y. 1996).

and the catatonic behavior that are shown in the literature speak to the inability to appreciate the very nature of the homicide. Brief Psychotic Disorder is symptomatic of these neonaticide cases, and the *DSM-IV* recognizes that cognition is impaired. If the defense expert can show that the defendant suffered from the Disorder, a persuasive case can be made that she lacked the cognitive ability to realize the nature and quality of her act.

ii. American Law Institute Rule (Model Penal Code)

Model Penal Code section 4.01(1) provides that "[a] person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law."[458] The MPC approach was "adopted by roughly half the states and by all but one of the federal circuit courts of appeal."[459]

The MPC's approach to insanity enjoys widespread appeal because it "views the mind as a unified entity and recognizes that mental disease or defect may impair its functioning in numerous ways" as opposed to the compartmentalizing (intellect, emotion, will) vision of *M'Naghten*.[460] Thus, one prong focuses on the cog-

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[458] MODEL PENAL CODE § 4.01(1) (1985).

[459] KADISH, *supra* note 440, at 948. See, *e.g.*, 720 ILL. COMP. STAT. 5/6-2 (West 1993) ("A person is not criminally responsible for conduct if at the time of such conduct, as a result of mental disease or mental defect, he lacks substantial capacity to appreciate the criminality of his conduct."); TENN. CODE ANN. § 39-11-501 (1997) ("It is an affirmative defense to the prosecution that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature or wrongfulness of such defendant's acts."); VT. STAT. ANN. tit. 13, §4801 (1998) ("A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks adequate capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law."); United States v. Davis, 592 F.2d 1325 (5th Cir. 1979) (declaring that the ALI standard is the correct standard in the 5th Circuit); Graham v. State, 547 S.W.2d 531, 541 (Tenn. 1977).

> While we recognize that this test, like any other test of insanity, is not perfect and will itself produce problems, we are persuaded that it is the best test of insanity in existence today, combining as it does, the essential elements of cognition, volition and capacity to control behavior In actuality, it is essentially a refinement and restatement of the full M'Naghten rules.

Id.

[460] U.S. v. Freeman, 357 F.2d 606, 622 (2d. Cir. 1966). When adopting the MPC rule as the standard in the second circuit, the court noted that:

> The rule . . . reflects awareness that from the perspective of psychiatry absolutes are ephemeral and gradations are inevitable. By employing the telling word "substantial" to modify "incapacity," the rule emphasizes that "any" incapacity is not sufficient to justify avoidance of criminal responsibility but that "total" incapacity is also unnecessary. The choice of the word "appreciate," rather than "know" in the first branch of the test also is significant; mere intellectual awareness that conduct is wrongful, when divorced from appreciation or understanding of the moral or legal import of behavior, can have little significance.

Id. at 622-23.

nitive aspects of behavior and the other on the volitional aspects of behavior. Furthermore, although the MPC test does not classify mental disorders, "the [s]ection is couched in sufficiently precise terms to provide the jury with a workable standard when the judge charges in terms comprehensible to laymen."[461] Thus, the fear of experts making "moral or legal pronouncement[s]" as to the state of the defendant is lessened and the real power to decide causation and other ultimate legal issues was given back to the judge and the jury.[462]

Although the MPC test has been widely employed, it quickly lost favor after a jury found John W. Hinkley, Jr., not guilty by reason of insanity for his attempted assassination of then-President Ronald Regan in 1982.[463] The MPC test was seen as being too lax and, as a result, some states either dropped the MPC test for a reinstatement of the *M'Naghten* rule, or developed even more stringent tests for insanity.[464]

a. MPC Test and Brief Psychotic Disorder

As discussed above, the MPC test has both a cognitive aspect and a volitional aspect, the satisfaction of *either* being grounds for an insanity verdict. The cognitive aspect rids the defendant of criminal responsibility when it can be shown that the defendant suffered from a mental disease or defect that made her lack the substantial capacity to appreciate the wrongfulness of her conduct. The volitional aspect rids the defendant of criminal responsibility when it can be shown that, because of a mental disease or defect, the defendant was unable to conform her conduct to the requirements of the law.

Evidence of Brief Psychotic Disorder is useful to satisfy either the volitional or cognitive aspect of the MPC test. The cognitive impairment demonstrated by the literature and acknowledged by the *DSM-IV* (e.g., hallucinations, delusions, disorganized or catatonic behavior) is clearly relevant as to whether the defendant had the substantial capacity to appreciate the criminality of her conduct. Similarly, the volitional aspect of the MPC test can be satisfied by a defense also based on Brief Psychotic Disorder. In

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461 *Id.* at 623.

462 *Id.*

463 *See* KADISH, *supra* note 440, at 948.

464 *See id.* at 953. *See, e.g.*, People v. Skinner, 704 P.2d 752 (Cal. 1985). Kadish notes, however, that "[b]y one recent count, 21 states now adhere to some form of the M'Naghten rule, and 22 states currently use the Model Penal Code test." *Id.* at 954 (citing John Ogloff, *A Comparison of Insanity Defense Standards on Juror Decision Making*, 15 L. & HUMAN BEHAVIOR 509, 510 (1991)).

suggesting supervision of an individual who suffers from Brief Reactive Disorder, the *DSM-IV* points out that this individual can be expected to act on the basis of delusions,[465] an impairment of one's ability to conform one's conduct to the law. The catatonic behavior that is symptomatic of this Disorder provides a useful basis for defense, especially in cases where the young mother is charged with homicide based on omission. The case studies suggest that, while many of the homicides are actively and positively inflicted by the mother, there are many cases in which the mother fails to rescue her baby from a toilet or is unable to move subsequent to the delivery and thus leaves the child to die.[466] Similarly, Depersonalization Disorder may be a good defense under the MPC volitional aspect in that the dissociative state leaves the mother with the sensation that she is unable to control her own movements (e.g., sensory anesthesia, sensation of lacking control over one's own actions).

C. Diminished Capacity

The diminished capacity defense comes in two forms. The first is a use of a mental defect to negate the mental element of the crime charged.[467] The second is the recognition of partial insanity to "mitigate [the charge from] murder to manslaughter even though the defendant entertained the culpable state of mind required by the statutory definition of murder."[468] Diminished capacity is considered a failure of proof defense.[469]

Although jurisdictions vary widely as to whether they will allow diminished capacity to exculpate a defendant, there are four general ways in which diminished capacity is treated in American jurisdictions.[470] They are: (1) the admission of evidence of mental disease or defect that negates the mens rea element of the crime charged,[471] (2) the admission of evidence of a mental disease or

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465 *See* DSM-IV, *supra* note 204, at 320.

466 *See, e.g.*, Arboleda-Florez, *supra* note 172, at 32; Saunders, *supra* note 195, at 370-71.

467 *See* ROBINSON I, *supra* note 437, at 474.

468 *Id.* at 474. The second form of diminished capacity, sometimes called partial responsibility, will not be discussed here as it is not followed by a single American jurisdiction. *See* KADISH *supra* note 440, at 1008-09.

469 *See* ROBINSON I, *supra* note 437, at 72 ("Failure of proof defenses consist of instances in which because of the conditions that are the basis for the 'defense,' all elements of the offence charged cannot be proven.").

470 *See id.* at 273-75.

471 *See id.* at 273. *See, e.g.*, Campbell v. State, 576 S.W.2d 938, 945 (Ark. 1979) ("Even if the mental disease or defect did not constitute a defense, evidence of it was relevant on the question of his culpable mental state and especially on the element of premeditation.") (citation omitted); Hendershott v. People, 653 P.2d 385 (Colo. 1982). The *Hendershott* court stated that:

defect to negate the specific intent element of a crime charged,[472] (3) the admission of evidence of mental disease or defect to negate premeditation or malice aforethought in a murder charge,[473] and (4) the total exclusion of evidence of mental disease or defect in cases where the defendant is not legally insane.[474]

The effect of the above approaches to diminished capacity results in the failure of proof of the *mens rea* element of the crime charged. However, many homicide statutes contain lesser included offenses. Since these offenses have "lesser culpability requirements," the failure of proof of the greater offense often leads to a conviction based on the lesser offense.[475] The "ultimate reduction effect results from the comparative culpability elements of the different offenses, not from a special rule that, when faced with diminished responsibility due to mental illness, generates diminished liability. If there is no lesser included offense, or if the mental ill-

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> [t]he formulation and the limitation of affirmative defenses . . . must be distinguished from accused's right to present reliable and relevant evidence to controvert the prosecution's case against him. . . . [I]t would be a violation of due process to require the prosecution to establish the culpable mental state beyond a reasonable doubt while, at the same time, to prohibit a defendant from presenting evidence to contest this issue.

Id. at 391.

[472] *See* ROBINSON I, *supra* note 437, at 274. *See, e.g.*, State v. Jacoby, 260 N.W.2d 828, 836 (Iowa 1977) ("Diminished responsibility is an appropriate defense in any crime which requires proof of a specific intent as an element, and if supported by the evidence, should be the subject of an appropriate instruction.") (citation omitted); State v. Jackson, 714 P.2d 1368, 1373 (Kan. 1986) ("Evidence of diminished capacity is admissible only for the limited purpose of negating specific intent and is not a substitute for a plea of insanity."); People v. Mangiapane, 271 N.W.2d 240, 249 (Mich. Ct. App. 1978) ("[T]he defense known as diminished capacity comes within this codified definition of legal insanity. . . . [P]sychiatric testimony on the issue of defendant's capacity to form the specific intent comes within the codified definition of legal insanity."); State v. Muir, 432 A.2d 1173, 1176 (R.I. 1981) ("[D]efendant does not possess sufficient mental capacity to form the requisite mens rea that is a necessary element of a specific-intent crime.") (citation omitted).

[473] *See* ROBINSON I, *supra* note 437, at 275. *See, e.g.*, State v. Padilla, 347 P.2d 312, 314 (N.M. 1959) (allowing "proof of mental derangement short of insanity as evidence of lack of deliberate or premeditated design"); Commonwealth v. Walzack, 360 A.2d 914, 920 (Pa. 1976) ("The thrust of [diminished capacity] is to challenge the capacity of the actor to possess a particular state of mind required by the legislature for the commission of a certain degree of the crime charged.").

[474] *See* ROBINSON I, *supra* note 437, at 275. *See, e.g.*, Bates v. State, 386 A.2d 1139, 1143-44 (Del. 1978) ("[U]ntil established by the General Assembly as a provision collateral to the Statutes governing insanity and extreme emotional distress, the doctrine of diminished responsibility may not be invoked in this State."); Zeigler v. State, 402 So. 2d 365, 373 (Fla. 1981) ("During the guilt phase of the trial, testimony regarding the mental state of a defendant in a criminal case is inadmissable in the absence of a plea of not guilty by reason of insanity.") (citation omitted); State v. Necaise, 466 So.2d 660, 664 (La. Ct. App. 1985) ("[M]ental defect or disorder short of insanity cannot serve to negate specific intent and reduce the degree of the crime.") (citation omitted); State v. Bouwman, 328 N.W.2d 703 (Minn.1982) (diminished capacity not recognized in Minnesota).

[475] Paul H. Robinson, *Criminal Law Defenses: A Systematic Analysis*, 82 COLUM. L. REV. 199, 206 (1982).

ness also negates an element of any lesser included offense, the mental illness will prevent conviction altogether."[476]

While diminished capacity is recognized as a defense to criminal conduct, it is more "[p]roperly understood . . . not [as] a defense at all but merely a rule of evidence,"[477] which requires that the prosecution prove all elements of its case against the defendant beyond a reasonable doubt. *Mens rea* is one of those elements, and the presentation of expert testimony relating to the presence of a mental disease or defect serves as evidence to rebut the assertion that the defendant acted with a culpable state of mind.

i. Diminished Capacity, Brief Psychotic Disorder and Depersonalization Disorder

Since diminished capacity is a failure of proof defense, the defense need only show evidence that because of a mental disease or defect, the defendant was unable to form the requisite intent to commit the crime charged. For example, since neonaticides are often brought on first degree murder charges,[478] a diminished capacity defense would work to introduce evidence of a mental disease or defect, which would show that the defendant did not have the capacity to form the intent statutorily required for a first degree murder conviction.

Both Depersonalization and Brief Psychotic Disorder are disorders that could serve as the mental disease or defect which negate the *mens rea* required for first degree murder. The automatism, catatonic behavior, sensor anesthesia, and cognitive impairment symptomatic of these disorders can serve to negate *mens rea*; the defendant, in a catatonic state, could not have the capacity to form the intent required for first degree murder. As with the above examples, the neonaticide literature is replete with showings of cognitive impairment, delusions, disorientation, hallucinations, grossly disorganized behavior, and catatonia.

VII. Conclusion

When so starkly stated, the killing of a defenseless infant moments after birth by its own mother, no less naturally shocks common notions of decency as it calls out for some punishment at law. Yet, few circumstances involving any homicide could be described

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476 *Id.*

477 United States v. Pohlot, 827 F.2d 889, 897 (3rd Cir. 1987).

478 *See* Oberman, *supra* note 5, at 81. Professor Oberman observes that the women are rarely convicted of this offense. *See id.*

in such a cut and dried, one-sided manner—and certainly not the circumstance of a young woman in a state of denial and psychosis. Considerable evidence shows that a specific subgroup of the women who commit neonaticide are not cold-hearted killers but, rather, terrified immature mothers who experience clinically recognized disorders at the very time of the homicide, mothers who, because of intense psychological defenses have not acknowledged their pregnancies, and as such, were unable to premeditate the killing of their newborn infant.[479] As observers, we might easily condemn these women for not seeking pre-natal care, for not taking advantage of abortion (for once the procedure is recommended) or adoption procedures, or for engaging in sexual intercourse in the first place. The issue in the courtroom, however, is not what we think of these women in the light of some abstract subjective social morality. The issue, like in all other criminal prosecutions, is whether the defendant is objectively guilty beyond a reasonable doubt for the crime charged. Invariably, the crime charged in neonaticide cases is some grade of homicide, from murder to manslaughter, and the requisite *mens rea* must be shown in order to warrant a conviction.

Because our criminal law rightly recognizes that a culpable state of mind is required to justify a conviction for almost every crime, there are defenses that allow a defendant to counter the state's proof of criminality, and either negate the *mens rea* of the crime charged or simply show that she was unable to control her behavior. Evidence to this effect compels the trier of fact to consider the defendant's true state of mind at the time of the crime to determine whether the crime was done with the culpable mental element required for a conviction. The literature on neonaticide makes a convincing case that women who kill their newborn infants go through their pregnancies in an array of psychological defense mechanisms and suffer from distinct and recognized mental disorders. Despite the horror of killing an infant, these disorders bear directly on the mother's ability to form the *mens rea* required for a conviction under any given homicide statute.

Involuntariness, insanity and diminished capacity serve as affirmative defenses which a woman charged with a neonaticide can use for her defense. Depersonalization and Brief Psychotic Disorders are recognized mental disorders that seem to surface in these particular cases of neonaticide, and can thus be used as the mental disease, defect, or disability necessary to assert one of those de-

[479] BROCKINGTON, *supra* note 9, at 446.

fenses. Successful use of those defenses would work to undermine the proof of *mens rea* mounted by the prosecution and thus reduce the offense under which the defendant could be convicted, perhaps serve as a mitigating factor at the time of sentencing, or even lead to her acquittal.

The above formulated approach to defending a woman charged with any neonaticide seems complete enough. However, the neonaticides which are the subject of this Note, those pervaded with a denial of the pregnancy itself, pose an additional problem. The claim a woman charged with this particular kind of neonaticide is as follows: Despite the hint at a tautology, she simply was not aware of her pregnancy because of her very denial of it, so that, when the delivery occurred and the neonate appeared, her denial was no longer tenable, so that, further, during a psychotic episode she either killed or neglected to care for the neonate in the first few hours of its life. The pragmatic problems with the credibility of such a claim are readily apparent. Although the law currently allows a woman to make such a claim through expert witnesses testifying to that individual woman's denial of her pregnancy, it has not yet afforded her the opportunity to make reference to the countless other women who have shared in that same denial of their own pregnancies. Her claim is perceived as the spinning of a farfetched tale that should be taken no more seriously than any bedtime story (albeit one with no fairy tale ending). The dangerous result is that this woman's crime is seen as a total aberration while in reality it frequently occurs and is ultimately better responded to and treated by psychiatric help than incarceration. Furthermore, convictions of these women result in an imperfect use of the criminal justice system, whose purpose is to condemn those who commit crimes with the requisite moral culpability.

The recognition of a Neonaticide Syndrome would allow an expert witness to testify to the denial of pregnancy, not only the defendant's but other women's as well, as an actual occurrence, an experience shared by these women. Why isn't it enough to admit evidence of only the defendant's denial? Why are we interested in the experiences of other women? What prevents us from believing that a woman could deny her own pregnancy?

In order to understand why a Neonaticide Syndrome is needed to present an complete defense, we must examine the myths and misconceptions we hold as a society about motherhood and maternity that operate to inform how women are viewed. The task is daunting not only due to its obvious complexity but because, "as with most myths, the current Western version [of motherhood]

is so pervasive that, like air, it is unnoticeable,"[480] and moreover because "we are inevitably caught up in our own cultural vortex, we fail to question our most basic suppositions."[481] However, the myth of motherhood influences every perception of a woman's conduct toward her child and children. Any apparent conflict a woman may have regarding motherhood "is tantamount to being a bad person; it violates cultural taboo."[482] Yet, we "have invented a culture of motherhood that excludes the experience of the mother," a culture that views what is the simple biological function of the female as a "moral destiny,"[483] indeed, even as women's socially preferred, perhaps *exclusive* form of self-definition, so that but a casual perusal of a newspaper may reveal a headline reading: "WHY DO MOTHERS KILL: THEY ARE KILLING THEMSELVES."[484]

The myth of motherhood, so ingrained in the way in which the ambitions, desires, and needs of women are viewed and accommodated, cannot include in its account a state of mind so abominable, unnatural, and depraved that a child could be imperiled by its own mother. Instead, more congruous to the myth is a rejection of the denial of pregnancy as a reality, an adherence to the worship of the blessing of pregnancy as the "gift of life," and a belief in antenatal bonding that "transforms" a woman into a mother even before her child is born.

What this Note has attempted to demonstrate, however, is that the myth does not function so neatly in reality; that neonaticides, however truly appalling, are typically committed under circumstances wholly alien to the common notions of woman and mother, and as such require a broader prism of judgment—one based not on a subjective socio-cultural standard but, as the law should always require, on objective contextual criteria. Merely recognizing a Neonaticide Syndrome would not, of course, guarantee just outcomes in *all* cases of neonaticide, but without such a legally admissible syndrome, it likely that at least *some* cases will be decided with an unfair presentation of the facts and result in an equally unfair punishment of the accused. That likelihood at least should be argument enough in its favor.

Judith E. Macfarlane

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480 *Id.*
481 THURER, *supra* note 347, at xv.
482 *Id.* at xiv.
483 RICH, *supra* note 11, at 267.
484 RICH, *supra* note 11, at 257.