

**THE HAND THAT ROCKS THE CRADLE: REFLECTIONS ON  
POSTPARTUM PSYCHOSIS AND THE DEFENCE OF  
PATHOLOGICAL CRIMINAL INCAPACITY**

## **1 Introduction**

Early one Saturday morning in a quiet neighbourhood in San Antonio, Texas, Otty Sanchez attacked her new-born baby son with a steak knife and two Samurai swords. She then bit off three of his toes, decapitated him and ate bits of his hand. She stabbed herself in the neck and screamed: "I've killed him! The devil made me do it." Little Scotty Sanchez was only four weeks old (facts obtained from *You Magazine* 13 August 2009). Otty Sanchez was later diagnosed with schizophrenia and also with a rare mental condition that affects 500 to 1 000 new mothers worldwide – postpartum psychosis (Comer "Fundamentals of abnormal psychology" (2008) 349; Sadock and Sadock *Kaplan and Sadock's Synopsis of psychiatry* (2003) 526–527; Hammen and Watkins *Depression* (2008) 21).

The idea of a mother killing her new-born baby is horrific. On face value it would appear as one of the most atrocious criminal acts perpetrated on the most vulnerable and defenceless of victims. The reality is, however, that mothers who kill their infants often perform these horrific criminal acts as a result of their suffering from serious mental disorders frequently unknown to themselves or close family members. Postpartum psychosis is one such example. The phenomenon of postpartum psychosis has only fairly recently received attention as a mental disorder affecting mothers of new-born babies.

Postpartum psychosis is not included as a distinct diagnostic entity or mental disorder within the diagnostic framework of the DSM-IV. The DSM-IV is used frequently by mental health professionals to diagnose individuals with specific mental disorders (American Psychiatric Association *Diagnostic and statistical manual of mental disorders* (2000) ("DSM-IV")). Postpartum psychosis is, in addition, often confused with its less serious counterpart – postpartum depression. Postpartum psychosis is, instead, a much more serious and devastating phenomenon which frequently results in infanticide or suicide.

Within the ambit of the defence of pathological criminal incapacity or insanity, the question to be assessed is whether a woman who kills her new-born as a result of postpartum psychosis is able to invoke the defence of pathological criminal incapacity. A further question which merits consideration is whether postpartum psychosis is sufficient to exonerate the mother of the new-born of criminal responsibility or whether such postpartum psychosis will merely serve to mitigate sentence and as such for purposes of diminished criminal capacity. In this contribution the author addresses the phenomenon of postpartum psychosis against the backdrop of the defence of pathological criminal incapacity.

## **2 A synopsis of the defence of pathological criminal incapacity**

Within the South African context, the defence of pathological criminal incapacity is embodied in section 78(1) of the Criminal Procedure Act 51 of 1977 ("the Act"). Section 78(1) provides that an accused is not criminally responsible for an act or omission which constitutes an offence if, at the time of the commission of the alleged offence, the accused suffered from a mental illness or mental defect

which rendered him or her incapable of appreciating the wrongfulness of his or her act; or of acting in accordance with an appreciation of the wrongfulness of his or her act (Snyman *Criminal law* (2008) 170; Burchell and Milton *Principles of criminal law* (2005) 373; Strauss *Doctor patient and the law* (1991) 130; Louw "Principles of criminal law: Pathological and non-pathological criminal incapacity" in Kalisi *Psycho legal assessment in South Africa* (2006) 40; Van Oosten "The insanity defence: Its place and role in criminal law" 1990 *SACJ* 1; Krieglner and Kruger *Hiemstra Suid-Afrikaanse strafproses* (2008) 13-13; Du Toit *et al Commentary on the Criminal Procedure Act* (2007) 13-8). According to Snyman 171, the test for pathological criminal incapacity comprises a pathological or biological leg which entails that an accused should have suffered from a mental illness or mental defect at the time of the commission of the offence; and a psychological leg which entails that the accused should have, as a result of a mental illness or mental defect, lacked the capacity of appreciating the wrongfulness of the act or of acting in accordance with such appreciation. The test applied is accordingly a so-called "mixed" test in that pathological as well as psychological factors are taken into account in determining whether an accused lacked criminal capacity (*ibid*). The Rumpff Commission distinguished between three categories of mental functions present in human beings, namely, the cognitive function which invariably refers to a person's understanding of, conception of or insight into an act; the affective function which relates to an individual's feelings or emotions which could range from pleasurable to unpleasant and could include intense emotional feelings such as jealousy or hatred; and also the conative or volitional function which relates to a person's inability to control his or her behaviour by means of the voluntary exercise of his or her will (*Report of the commission of inquiry into the responsibility of mentally deranged persons and related matters* (RP69/1967) "Rumpff Commission" para 9.7). In addition the Rumpff Commission noted that these mental functions of an individual can break down, or stated differently, there may be a disintegration of the personality of an accused (Louw in Kaliski 40-41). Whenever a total disintegration of personality occurs, the individual cannot be held criminally responsible (*idem* 40-41, Rumpff Commission para 9.25). The latter disintegration of the personality of an accused can result in either the disintegration of the cognitive or the conative functions of the human personality.

The threshold requirement for the defence of pathological criminal incapacity denotes the existence of a mental illness or mental defect at the time of the commission of the act. The latter requirement is also referred to as the pathological leg of the test for criminal responsibility. However, the fact remains that the mere existence of a mental illness or mental defect does not necessarily warrant a finding of criminal non-responsibility. The particular mental illness or mental defect must in addition render the accused incapable of appreciating the wrongfulness of his or her act, and of acting in accordance with such an appreciation (Snyman 172; Burchell and Milton 377; Van Oosten 1990 *SACJ* 2). The latter two defences apply in the alternative. Snyman as well as Burchell and Milton state that "wrongfulness" for purposes of the appreciation of the wrongfulness of an act should denote either legal wrongfulness or moral wrongfulness (Snyman; Burchell and Milton 380-381; Du Toit *et al* 13-14; Kaliski 103). In respect of the concept of appreciation, Burchell and Milton note:

"The notion of appreciation postulates not only a knowledge of the nature of an act, but also the capacity to evaluate the act, its implications, and its effects upon the accused himself and others who may be involved. 'Appreciation' implies

something in the nature of ‘deliberate judgment’ or ‘perception’. Where a person is deprived of the capacity, it would follow that he lacks the insight into the true moral nature of his act, of the implications of the act or its consequences for himself or others” (381).

In respect of a defence of pathological criminal incapacity, it is important to note that certain mental illnesses may not necessarily affect an accused’s capacity to appreciate the wrongfulness of his or her action, but may nevertheless deprive the accused of the ability to control conduct or to act in accordance with the appreciation of wrongfulness (*ibid*; Snyman 173; Hiemstra 13-19).

Section 78(1)(b) of the Act accordingly provides that even though an accused was capable of appreciating the wrongfulness of his or her act, he or she will still not be criminally responsible if at the time of the commission of the act, he or she suffered from a mental illness which rendered him or her incapable of acting in accordance with such appreciation. Africa notes that in order to successfully rely on this defence, it has to be proved that the symptoms of the disorder resulted in a significant impairment of psychological functioning (“Psychological evaluations of mental state in criminal cases” in Tredoux *et al Psychology and law* (2005) 395; see also *S v Kavin* 1978 2 SA 731 (W) where reliance on s 78(1)(b) was successful and the accused was held not criminally responsible for his acts; *S v McBride* 1979 4 SA 313 (W)).

Constructing a defence of pathological criminal incapacity due to postpartum psychosis will therefore entail the following: firstly, establishing postpartum psychosis as a mental illness for purposes of section 78(1) as threshold requirement; secondly, establishing that such postpartum psychosis either resulted in the inability of the accused to appreciate the wrongfulness of his or her actions (cognitive capacity) or the inability of acting in accordance with that appreciation (conative capacity). If the cognitive or conative capacity of the accused was sufficiently impaired as a result of a mental illness or mental defect, the accused is said to have lacked criminal capacity (Snyman 171; Burchell and Milton 374; Du Toit *et al* in Kaliski 46).

Currently the test for pathological criminal incapacity entails that a mental illness which affects the accused’s cognitive or conative capacity in such a manner that he or she is deprived of the capacity to appreciate the wrongfulness of his or her conduct or the capacity to act in accordance with such appreciation, which constitutes insanity (Burchell and Milton 374).

The test for pathological criminal incapacity does not define the terms “mental illness” or “mental defect”, nor does it specify the particular mental disorders that constitute “mental illness” or “mental defect”. What becomes evident is that the test only identifies the effects which should result from a particular “mental illness” or “mental defect”. The pivotal role of the mental health professional in the definition and assessment of the mental illness becomes evident. A question which frequently arises is whether the definition of mental illness should be a medical or a legal prerogative. Slovenko “The meaning of mental illness in criminal responsibility” 1984 *J of legal Medicine* 4 pertinently encapsulates the dilemma as follows:

“During the past two centuries the courts have often said that the term ‘disease of the mind’ or ‘mental disease or defect’ in the test of criminal responsibility is not a medical but a legal term. At the same time, however, since medical or psychiatric opinion is necessary to give meaning to the term, it becomes a fusion of legal and medical components. To be sure, no rule of law can be reliable when absolutely dependent on another discipline, but without input from other areas, the law would be arid verbal agonising.”

It is submitted that the definition of mental illness should neither be solely a medical prerogative, nor exclusively a legal prerogative, but that the professions of law and medicine with specific reference to forensic psychiatry should meet one another halfway in the assessment of mental illness for purposes of the defence of pathological criminal incapacity. The fact remains – the law needs medicine to provide meaning to the defence of insanity and accordingly medical input in the assessment of insanity is pivotal if not essential. The latter inadvertently also applies to postpartum psychosis. The presence or absence of postpartum psychosis can only be assessed by adequately trained mental health professionals. In respect of expert evidence by mental health professionals, a court is obliged in terms of section 78(2) of the Act to refer an accused for observation if it is alleged at criminal proceedings that an accused is by reason of mental illness or mental defect not criminally responsible or if it appears to the court that an accused is for such a reason not criminally responsible. The matter is then enquired into and reported on in accordance with section 79 of the Act which provides for a panel of experts who are required to conduct the assessment and comply with the procedural aspects associated therewith. The latter sections will accordingly inadvertently also apply to a woman alleging that she murdered her new-born as a result of suffering from postpartum psychosis. An in-depth analysis of the terms “mental illness” and “mental defect” falls beyond the scope of this note and accordingly the author will address the specific diagnostic entities of postpartum psychosis in order to indicate that postpartum psychosis can very well satisfy the test for pathological criminal incapacity.

### 3 Diagnostic features of postpartum psychosis

Kaplan and Sadock note that postpartum psychosis is an example of a psychotic disorder not otherwise accounted for that predominantly occurs in women who recently gave birth and the syndrome is marked by the mother’s depression, delusions or thoughts of harming herself or her infant (526–527; Hammen and Watkins 21).

Symptoms of postpartum psychosis features within days of delivery with initial complaints of fatigue, insomnia and restlessness. Individuals later develop emotions of not wanting to care for the infant or not loving the infant or the desire to harm the baby, themselves or both. Typical delusions include the belief that the baby is dead or defective (Kaplan and Sadock 526). Macfarlane “Criminal defence in cases of infanticide and neonaticide” in Spinelli *Infanticide – Psychosocial and legal perspectives on mothers who kill* (2003) 133–134 illustrates the problematic scenario of postpartum psychosis in the following manner:

“The killing of an infant by its own mother is an act that at once captivates and repels popular attention. Flying in the face of ‘mother love’, infanticide both shocks common notions of decency and calls out for punishment at law. Yet, many infanticides are committed not by women intent on callously ridding themselves of their children but rather by women who are experiencing a psychosis precipitate by gross postpartum mental illness. That a woman suffered some form of mental illness at the time of the killing calls into question her criminal culpability.”

Postpartum psychosis develops within a few days or at most a few months after childbirth, in which event the woman starts displaying signs of losing touch with reality by, for example, having delusional thoughts, hallucinations, extreme anxiety, confusion, agitation, insomnia and suicidal and homicidal thoughts (Comer 349; Wisner *et al* “Postpartum disorders” in Spinelli *et al* (2003) 36).

Women with a history of bipolar disorder, schizophrenia, are generally more susceptible to this form of psychosis (Comer 349; Hammen and Watkins 21).

Hammen and Watkins note (*ibid*) that women who have experienced one episode of postpartum psychosis have a higher risk for subsequent postpartum episodes with psychotic features and such episodes are more likely to occur in women with histories of bipolar depression but it may also occur in women with unipolar depression.

Wisner *et al* 41 note that postpartum psychosis differs from other psychotic episodes due to variations in cognition and confusion and consequently the confused, delirium-like and disorganised profile of postpartum psychosis has been reported repeatedly. They also note that “the childbearing psychotic woman had a high score on the factor we named ‘cognitive disorganisation/psychosis’ which contained the following symptoms: thought disorganisation, bizarre behaviour, lack of insight, delusions of reference, persecution, jealousy, grandiosity, suspiciousness, impaired sensorium/orientation, and self-neglect. These women displayed prominent symptoms of cognitive impairment and bizarre behaviour”.

Typical delusional thoughts in these cases relate to the woman’s belief that she is being controlled by external forces, that her thoughts are not her own and are placed into her mind by other human beings, that the infant is the devil incarnated, or that there is a possibility that the child will be kidnapped (Macfarlane 136). Hallucinations range from auditory, visual, tactile and command hallucinations directing the woman to kill herself or the infant. A major obstacle for a mental health professional diagnosing a woman with postpartum psychosis is the fact that postpartum psychosis has not yet been fully acknowledged by the American Psychiatric Association’s DSM-IV as a discrete mental illness, but rather as a mental disorder with postpartum onset (*idem* 136 147). It is interesting to note that the DSM-IV-TR (2000) 422 states the following in respect of the psychotic feature of postpartum episodes: “Postpartum onset mood episodes can present either with or without psychotic features. Infanticide is most often associated with postpartum psychotic episodes that are characterised by command hallucinations to kill the infant or delusions that the infant is possessed, but it can also occur in severe postpartum mood episodes without such specific delusions or hallucinations.”

Due to the fact that postpartum psychosis does not exist as an officially-acknowledged mental disorder, it cannot be used to pass the test for insanity. It is submitted that the inclusion of this form of psychosis in future diagnostic systems of classification is pivotal as this rare form of mental illness is a growing phenomenon and does not always satisfy the diagnostic requirements for differential diagnoses such as major depressive disorder, bipolar disorder or schizophrenia.

Macfarlane 163 confirms the latter by stating:

“A woman is left to support her defenses with a recognised disorder, such as schizophreniform disorder, even though that disorder lends on incomplete and imperfect description of the actual mental state she possessed at the time of the homicide. It is absolutely imperative, therefore, that the psychiatric profession formalises the aggregated symptoms apparent in the various puerperal mental illnesses so that a woman accused of killing her child in the puerperium may adequately defend herself by way of using a recognised postpartum mental disorder as the basis of her defense.”

It is clear that the diagnostic features of postpartum psychosis could give rise to a mental illness sufficient to meet the criteria for the defence of pathological criminal incapacity. The advancements in psychiatric knowledge with regards to this illness call for a revision the current DSM-IV-TR to create a distinct diagnostic framework for postpartum psychosis which will assist mental health professionals in assessing and detecting this disease in future (Comer 349).

Meyer and Spinelli encapsulate the severity of postpartum psychosis by stating:

“Postpartum psychosis presents as a psychiatric emergency. Whether mood changeability is associated with bipolar disorder or organic delirium, or both, this presentation may disarm even the psychiatric professional. Because moments of complete lucidity are followed by frightening psychosis for the new mother, the illness may go unrecognised and untreated. Out of shame, guilt, or a paranoid delusional system, the new mother may not share her bizarre thoughts and fears” (“Medical and legal dilemmas of postpartum psychiatric disorders” in Spinelli *et al* (2003) 169).

#### 4 Andrea Yates – Mad or bad?

Andrea Pia Yates was a registered nurse who later became a stay-at-home mother who also home-schooled her children. Whilst being almost consistently pregnant, she provided care to her bedridden father as well as her family which included Noah 7, John 5, Paul 3, Luke 2 and Mary who was 6 months old. Yates had a history of psychiatric illness. After the birth of Noah she constantly blocked her thoughts when she felt Satan’s presence and when she believed to hear Satan tell her to pick up a knife and stab the children. She did not reveal these thoughts to anyone out of fear that Satan would harm her children. She also believed that some of her doctors were Satan or were influenced by Satan. Six months after the birth of the fifth child, Yates began to behave very strangely and her family described her behaviour as “catatonic”. Even after two psychiatric hospitalisations Yates’ condition worsened. When her psychiatrist discontinued her antipsychotic medication two weeks prior to the tragedy she became more psychotic. On 20 June 2001 Yates drowned all five of her children in the bathtub whereafter she laid them on a double bed in the master bedroom. She told police officers, without emotion, what had happened. Yates was charged with capital murder after confessing to the murder of her five children. One psychiatrist, Dr Puryear, stated that she was “the sickest person I had ever seen in my life”. Yates told another psychiatrist that she believed God would take her children “up”. She was eventually found competent to stand trial and pleaded not guilty by reason of insanity and that due to a mental disease or defect she did not understand that what she was doing was wrong. It was contended that she was suffering from postpartum depression with psychotic features. However, the psychiatrist called for the state, Dr Dietz, stated that she did not act like a mother who believed she was saving her children from Satan and that she had known that what she was doing was wrong. Dietz further believed that an episode of a famous television show, *Law and order*, in which a mother drowned her children, inspired Yates and the latter led to an inference of premeditation. Yates was a clear victim of postpartum psychosis, but unfortunately her doctors, her husband and other people close to her failed to appreciate the severity of the disorder. She was initially found guilty of murdering her children and sentenced to life in prison. The Texas Appeal Court later reversed the conviction as it was found that the television episode upon which Dietz had based his expert opinion



had never been broadcast and accordingly his testimony which played a cardinal role in the outcome of the case was inaccurate. Mental health experts testifying for Yates stated: "She did what she thought was right in the world she perceived through her psychotic eyes at the time . . . which meant that even if she did understand the difference between right and wrong, she was unaware of what she was doing". Yates was accordingly found not guilty by reason of insanity and was sent to a mental health institution for treatment. (See also Ramsland "Andrea Yates: Ill or evil" <http://bit.ly/sUOh5q> (accessed 2009-09-23.) The Yates case illustrates the detrimental effect that inaccurate expert testimony can have on the outcome of a case.

Meyer and Spinelli 177 illustrate the problematic nature of postpartum psychosis and the need for diagnostic recognition by stating: "Clear-cut diagnostic and legal guidelines for psychiatric illness associated with infanticide could likely assist our legal system with those cases . . . reluctance to distinguish postpartum disorders may lead to tragic outcomes for women in the family and society."

## 5 Diminished criminal capacity

South African criminal law does not, as yet, have a specific defence of diminished criminal capacity. The principle of diminished criminal capacity or responsibility is, however, enshrined in section 78(7) of the Act. Section 78(7) in essence provides that if a court finds that an accused was criminally responsible, but his or her capacity to appreciate the wrongfulness of the act or to act in accordance with such appreciation was diminished as a result of the mental illness or mental defect, the court shall have regard to such diminished responsibility during sentencing (Burchell and Milton 400–402; Snyman 176; Kaliski 105; Van der Merwe "Die begrip verminderde toerekeningsvatbaarheid en die implementering daarvan" 1983 *TRW* 172–181).

A person may very well suffer from a mental illness or mental defect but may still be able to appreciate the wrongfulness of his or her act or to act in accordance with such appreciation, albeit that one of these capacities was severely diminished at the time of the commission of the crime. Diminished criminal capacity does not exonerate an accused, but will serve in mitigation of sentence. In determining whether a finding of diminished criminal capacity should be rendered, a court will inadvertently turn to specialist psychiatric evidence in conjunction with all the other relevant information (see Zabow "Psychiatric evidence in extenuation: assessment and testimony in homicide defendants" 1989 *Medicine and Law* 631–639).

Within the framework of postpartum psychosis, mothers who kill their infants whilst suffering from postpartum psychosis could also rely on section 78(7) in mitigation of sentence, provided that it is established that the woman's capacity to appreciate the wrongfulness of the act or to act in accordance with such appreciation was diminished as a result of suffering from postpartum psychosis.

## 6 Conclusion

At the outset of this contribution it was indicated that the aim is to illustrate that postpartum psychosis as a mental disorder is still fairly novel and, as such, often misdiagnosed despite the severity thereof. The lack of diagnostic classification of this disorder further exacerbates the problem. The diagnostic features of postpartum psychosis clearly illustrates that this disorder could classify as a mental

disorder or mental illness for purposes of section 78(1) of the Act. In addition it is clear that postpartum psychosis could affect the cognitive or conative mental faculties of an accused to such an extent that, it is submitted, criminal capacity is excluded. In the alternative, postpartum psychosis could severely diminish these faculties. However, the effect that postpartum psychosis had on an accused at the time of the commission of the act can only be assessed by trained psychiatrists. The latter fact inadvertently exacerbates the need for diagnostic recognition of this disorder in order to assist the mental health professional requested to perform the assessment of the accused and render the ultimate diagnosis.

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