An Infanticide Trial:
US Infanticide Laws Fall Well Short of International Standards

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I was discouraged when I left the Bronx Criminal Court in New York. The forensic psychologist for the prosecution had completed his testimony in the trial of a woman who had killed her 2 children during an episode of postpartum psychosis. I had testified as the psychiatric expert for the defense on the previous day. It went well, I thought.

Although I am not a forensic psychiatrist, I have testified as a perinatal psychiatry expert in cases of infanticide. I had not appeared in court for several years. But, in August 2012, I received a call from Jenny, who represented a group of parents from Public School 58 in Cobble Hill, Brooklyn. She described that Lisette Bamenga, their children's teacher, had killed her 6-month-old baby Violette and her 3-year-old son Kenny. The PS 58 parents wanted to finance Lisette Bamenga's defense. They asked me to take her case. According to Ms Bamenga's friends and students who knew her prior to this tragedy, Ms Bamenga was an exemplary mother and a brilliant teacher. She was loved in the school community.

What a testament to this woman! I thought. How can we make sense of such tragedy in a woman who exemplified herself as mother, teacher, and friend? I agreed to take her case.

One week after Jenny's call, I drove across the 59th Street Bridge to Riker's Island, Queens, where Ms Bamenga was incarcerated. Lisette Bamenga, an attractive 32-year-old African American woman dressed in an orange prison jumpsuit, appeared detached and quietly friendly. In an almost uneventful interview, I experienced a disconnect until she casually described the vision and voices that she experienced on the day that she killed her children and attempted to kill herself with poison.

Lisette described that every June since adolescence, she became extremely energetic, experienced rapid thoughts and speech, remained awake for nights, and made lots of plans. When her friend called from Paris and said, "I wish you were here," she flew to Paris that evening. Her family playfully gave her the nickname *la fille de soleil*. Shockingly, her symptoms of mental illness seemed to be treated as lighthearted family anecdotes. Over the following year, 2 additional evaluations with Lisette and family interviews convinced me that Ms Bamenga was bipolar and had been psychotic at the time she killed her children.

Her children were born in March. During the postpartum periods, she had profound depressions and sat on the couch day and night breastfeeding, crying, unable to dress or shower. As spring approached, subtle symptoms of hypomania signaled that depression was lifting. Ms Bamenga and her family never considered her mentally ill or sought treatment.

Women with bipolar disorder have a 30% chance of having a postpartum psychosis.[1] Ms Bamenga's paternal grandmother had a postpartum psychosis, threw her baby against the wall, was initially exorcised by the Catholic priest, and was later hospitalized in French Guiana. Ms Bamenga's aunt also suffered from postpartum psychosis and remained in a psychiatric hospital until her death. This family history increased Ms Bamenga's chances of postpartum psychosis to 74%.[1] She pled to the court "not guilty by reason of mental illness."

Now, 4 years later, Ms Bamenga was being tried for murder. We would have a bench trial; there would be no jury. I felt confident about my testimony. On that day, the courtroom became my classroom. I educated the judge about our biopsychosocial model of psychiatry and diagnostic formulation. Since our insanity defense is based on a cognitive standard of "right or wrong," I presented data that demonstrated impaired cognition in postpartum psychosis.[2]

The expert for the prosecution, a forensic psychologist, testified that he had appeared as an expert in almost 400 trials. His primary role as a psychologist was performing forensic evaluations and testifying in court. He did not have a clinical practice, although he said that he had seen over 200 cases of perinatal illness in the past years.

His initial testimony was a recitation of the insanity legislation. He attempted to normalize Ms Bamenga's bipolar diagnosis by labeling her summer hypomanic episodes as "seasonal mood disorder" despite classic symptoms of impulsive travel and spending, lack of sleep, goal-directed activity, and hypersexuality, all corroborated by Lisette's family and fiancé. He described her psychotic symptoms as dissociation, a simple disconnect of consciousness rather than the loss of contact with reality that she experienced.

I sat irate on the court bench while he misrepresented clinical facts. Did the judge believe him? Did he know that his authoritative testimony was filled with inaccuracies? Can a court trial be merely "he said, she said"?

The United Kingdom, Australia, Canada, and 21 European countries have infanticide laws for women who kill a child in the first year of life.[3] Based on the biological vulnerability of childbirth, women found mentally ill receive psychiatric hospitalization not punishment. In the United States, women are charged with homicide. Sentences may include life in prison or infrequently the death penalty. Nevertheless, our infanticide rates are higher!

I suggest that reasons for our contrasting views are the failings of both American psychiatry and US criminal law.

Although the field of perinatal psychiatry has made significant progress in this country in the past 20 years, a large gap in American medical education has created a shortage of knowledgeable practitioners. At the time of my medical school training, perinatal psychiatry was not part of the curriculum in American medical schools. If I wanted training in my desired

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field, I had to go abroad. In my fourth year of medical school, I went to the United Kingdom, where I had the pleasure and privilege to work with Dr Channi Kumar, Director of Perinatal Psychiatry and the Mother and Baby Unit at the Bethlem (AKA Bedlam) Royal Hospital just outside London.

The diagnosis of postpartum disorder (Psychosis with Childbirth) was included in the second edition of the 1968 *Diagnostic and Statistical Manual of Mental Disorders, Second Edition* (*DSM-II*).[4] It was not mentioned in the 1980 publication of the *DSM-III*[5] or the 1987 publication of the *DSM-III-R*.[6] The word *postpartum* was stricken from the official psychiatric nomenclature of the *DSM* for 14 years (1980–1994), creating a generation of American psychiatrists who disregarded the existence of perinatal mental illness. At the same time, the United Kingdom and other countries were making advances in research and clinical care in this field.

Recent editions of the *DSM* (*DSM-IV* and *DSM-5*)[7,8] continue to deny a formal diagnostic classification for postpartum disorders. The specifier "peripartum onset" may be added to other diagnoses if the onset occurs during pregnancy or within the first 4 weeks of childbirth.

The fact that postpartum psychosis is denied the status of "diagnosis" in psychiatry is an injustice that weakens its diagnostic credibility in the criminal court for mentally ill women. When the Bronx District Attorney used the fact that postpartum psychosis is not a formal *DSM-5* diagnosis to discredit my testimony, I realized the high cost of such error. Postpartum psychosis is a rare and serious illness that remains unsanctioned despite the complicated clinical presentation that distinguishes it from nonpostpartum psychosis.[9,10]

Furthermore, the absence of formal diagnostic criteria for psychosis flies in the face of biology. It disregards the neurohormonal triggering factors of childbirth. It discounts recent findings such as a dysregulation of the immune system[11] and genetic similarities[12] in bipolar women with postpartum psychosis.

Moreover, a discrepancy exists between psychiatry and the law for mentally ill defendants. More than 50% of US courts use a definition of insanity that was determined by the 1843 M'Naghten Rule,[13] which remains current in the courtrooms of most states in our nation. *Queen v M'Naghten* was arbitrarily decided in 1843 when Queen Victoria ordered the judges of the Central Criminal Court to come up with a definition for insanity. They wrote that "it must be clearly proved that, at the time of committing the act, the party accused was laboring under such a defect of reason…. that he did not know he was doing what was wrong."[13] Even today, that impromptu definition decides the fate of mentally ill defendants who seek to be found not guilty because of mental illness. This arbitrary decision determines the fate of mentally ill defendants in most of the United States. Keep in mind that in 1843, we in psychiatry used bloodletting to treat mental illness![14]

The M'Naghten Rule lacks the scientific foundations that we in psychiatry have achieved in over 170 years. How can a psychotic person whose illness alters the ability to reason be held to a cognitive standard of "right or wrong" when the person's ill mind cannot function at this level of reason?[15] How can justice be served by applying logic to the inherently illogical state of psychosis?

Can we, should we, use a 173-year-old M'Naghten test based on "cognition" if cognitive impairment is associated with psychosis?[2,15] Can 19th-century law meet the standards of 21st-century neuroscience?

The trial judge opined that Ms Bamenga did not fulfill criteria for insanity as described by M'Naghten. Ms Bamenga was found not guilty of murder in the first or second degree, but was found guilty of the lesser charge of manslaughter by reason of extreme emotional disturbance. The court was thoughtful and intelligent when it considered her mental illness.

On May 18, 2016, Lisette Bamenga was sentenced to 8 years in prison with the court's words, "Determining the appropriate sentence for you has been the most difficult sentencing decision that I have had to make in almost 24 years that I have served as a judge."

As perinatal mental illness takes its place in American psychiatry, new US federal mandates for screening pregnant and postpartum women have been put in place, laws that may have saved the lives of the Bamenga children.[16]

And while the outcome of Ms Bamenga's case was not perfect, this court's intelligent decision represents a shift toward progress and demonstrates that the expertise of clinicians and researchers is respected in the courtroom.

Perhaps it is time to invite psychiatrists as clinicians and scientists to partner with our legal representatives in the courtroom in order to determine laws based on psychiatric facts and not conjecture.

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