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Article

*25 GENDER-SPECIFIC CLINICAL SYNDROMES AND THEIR ADMISSIBILITY UNDER THE FEDERAL RULES OF EVIDENCE

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Abstract

The authors examine the use of syndrome evidence in the context of the requirements for scientific evidence under Daubert, discussing the historical context beginning with the venerable Frye doctrine and tracing the requirements through the promulgation of the Federal Rules of Evidence and the elaboration of the requirements in the Daubert trilogy.

Introduction

Since the 1980s, the introduction of expert testimony that a defendant or witness suffers from a psychological "syndrome" has increased. [FN1] Often *26 such evidence [FN2] is proffered by criminal defendants to excuse their alleged criminal conduct, negate an element of the crime, establish diminished capacity, or establish mitigating factors to reduce the severity of the punishment. [FN3] Prosecutors may offer expert testimony to prove that the alleged victim suffers a syndrome consistent with the type of victimization at issue. Use of such evidence may range from educating the fact finder to establishing a complete defense. In essence, syndrome evidence suggests that a person with a psychological syndrome belongs to a readily identifiable group, those who suffer from the syndrome, and thus is tantamount to group character evidence. [FN4] Admission of psychological syndrome evidence may give special status to a criminal defendant, or it may be offered to prove a crime occurred. Therefore, such evidence requires special scrutiny by the court. [FN5] Factors that must be considered by the court before admitting syndrome evidence include a scientific basis for the assertion the syndrome truly exists; evidence regarding the error rates in making such a clinical diagnosis; evidence regarding etiology of the syndrome; and evidence of the consistency of effects of the syndrome across individuals. [FN6]

*27 Recent attempts to use syndrome evidence include claims as far-ranging and esoteric as drug courier syndrome, television intoxication syndrome, love fear syndrome, detail phobia, and urban survival syndrome. [FN7] These novel syndromes have not been successful for criminal defendants; they lack a sufficient scientific basis for their existence and reliability in "diagnosis." [FN8]

Another set of syndromes, however, has begun to gain currency in the courts, though the procedures for their admission may not have assured that they have a sufficient scientific basis. These syndromes include Battered Woman Syndrome, Rape Trauma Syndrome, Premenstrual Syndrome, and Postpartum Depression. [FN9] In questioning the basis for

admitting such syndromes, this Article does not question that battering and rape occur, that they affect people in gender-specific ways, that the effects of such traumatic events can be devastating to an individual's mental health, or that such effects may be relevant to issues that arise in court. Rather, this Article discusses the need for courts to assure that psychological syndrome evidence is admitted pursuant to rigorous standards that assure its reliability and validity. It demonstrates that legally relevant mental health effects from trauma or childbirth can be admitted in court pursuant to rigorously defined and scientifically supported diagnostic criteria, and that vague, undefined, and scientifically unsupported "syndromes" should not be accepted as substitutes.
This Article examines these four syndromes in the context of the requirements for scientific evidence under Daubert, [FN10] discussing the historical context beginning with the venerable Frye doctrine [FN11] and tracing the requirements through the promulgation of the Federal Rules of Evidence and the elaboration of the Daubert requirements in the Daubert ***28** trilogy. [FN12] Each of the four syndromes is discussed in turn; for each, the clinical and scientific literature are first presented, and then court cases considering the syndrome are reviewed to determine whether their procedures in reviewing the proffered evidence are consistent with the actual findings from the literature. This Article posits that three of the four syndromes, as presented, do not meet the requirements of Frye or Daubert. Regarding Battered Woman Syndrome and Rape Trauma Syndrome, an approach based on established diagnostic criteria for Post-Traumatic Stress Disorder is suggested as a viable alternative. Regarding Premenstrual Syndrome, the alternative diagnosis of Premenstrual Dysphoric Disorder (PMDD) is discussed. PMDD is in its experimental stage in the psychiatric community, and this Article concludes it has not yet received sufficient scientific verification to be received as evidence in court, though developments in the future may raise it to a level of sufficient validity. Regarding Postpartum Depression, this Article emphasizes the distinctions between separate classifications for the disorder, including the possibility of psychosis, and concludes that the range of disorders do have sufficient scientific backing, but that only a rare subset may rise to the level of mental health effects that would be relevant in a court of law.

This Article returns to the discussion of Post-Traumatic Stress Disorder to demonstrate that even this scientifically valid clinical diagnosis may suffer the pitfalls of the less valid event-based syndromes if rigorous scrutiny is not also applied to the forensic training of the expert offering testimony that a particular individual suffers from the syndrome. The differences between clinical diagnosis and forensic evaluation are discussed, and it is recommended that only forensically trained doctors be permitted to present evidence of psychological syndromes. [FN13] Finally, this Article posits that, at least for psychological syndrome evidence, standards from the Daubert trilogy are more likely to result in the admission of good science than the Frye doctrine. Guidelines are suggested for the admissibility of this type of evidence.

***29** I. From Frye to the Daubert Trilogy: The Evolution of "Good Science"
Since the 1923 decision in Frye v. United States, [FN14] legal scholars have debated what is, and what is not, good science. [FN15] Initially, Frye was a little-noticed opinion involving an appeal by a convicted murderer who asserted that readings from a systolic blood pressure measurement device would prove deception or truth telling. The court rejected the evidence, stating that, "while courts will go a long way in admitting expert testimony deduced from a well-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." [FN16] Conceptually, the Frye doctrine was aimed at novel scientific evidence, in other words, evidence that had not yet been accepted by the federal courts but had been accepted by certain members of the scientific community. The Frye doctrine deferred responsibility for judging the scientific validity of a novel theory to members of the community from which it came.

In 1975, the Federal Rules of Evidence were adopted, adding its definition of expert testimony. [FN17] A split then arose in the federal courts [FN18] over whether the Frye doctrine, emphasizing general acceptance in the field, or Federal Rule of Evidence 702, allowing expert testimony so long as the expert witness is "qualified," was controlling. [FN19] In the renowned ***30** Daubert decision, the United States Supreme Court addressed the split directly and unanimously held that the Federal Rules of Evidence superceded the venerable Frye doctrine and would control the admissibility of scientific evidence in federal courts. [FN20] The Court described the Frye doctrine as an "austere standard" that was incompatible with the liberal thrust of the Federal Rules. [FN21] Justice Harry Blackmun, who authored the Daubert opinion, noted that Rule 702 required that an expert's testimony be based on "scientific . . . knowledge." [FN22] He interpreted the modifier "scientific" to imply a "grounding in the methods and procedures of science," and "knowledge" to mean a body of facts or ideas "'accepted as truths on good grounds."' [FN23] Thus, the "scientific knowledge" requirement established a standard of scientific validity for admissibility of expert testimony. Additionally, the case held that the expert's opinion must have "a reliable basis in the knowledge and experience of his discipline." [FN24] Justice Blackmun also pointed out that Federal Rules of Evidence 402 and 403 generally require that all testimony be relevant to the issues before the court. [FN25] Taken together, Rules 402, 403 and 702 require scientific evidence to be both relevant and reliable. The Daubert decision therefore placed the onus of responsibility upon the trial judge to ensure these bases for admissibility. [FN26] The move away from allowing the field or discipline to establish legal reliability represents a significant shift in emphasis and responsibility. Stated in terms of "truth seeking," the shift has been described as moving from a sociological view ("truth is what experts in the field believe") to a method-based view ("truth is what is discovered through the appropriate application of scientific research methods"). [FN27] ***31** This shift restores the role of the judge as gatekeeper for the admissibility of evidence. [FN28] To assist the federal judge in this role, the Supreme Court included guidelines or "general observations" for deciding whether proffered scientific evidence is valid in its field and, thus, legally reliable. [FN29]

Two additional decisions, specifically elaborating the application of Daubert, form the Daubert trilogy. In General Electric Co. v. Joiner, the Court solidified the shift in responsibility in Daubert, holding that the trial judge has authority under the Federal Rules of Evidence to exclude proffered expert scientific testimony. [FN30] The Court further underscored the importance of the trial judge's gate-keeping role, applying the most stringent abuse of discretion standard to appellate review of admissibility decisions. [FN31] The court actually held that the appellate review was overly stringent and rejected the respondent's argument that a more searching standard of review should be applied. [FN32] Under Joiner, the trial judge may consider the applicability of the scientific theory underlying the expert's role in the case, examine the methodology utilized by the expert, and decide whether the method and techniques were correctly chosen and applied to the facts in the instant case. [FN33] Thus, the Court concluded that it was within the judge's discretion to examine the evidence and decide whether the expert's opinions were derived from valid science. [FN34]

Within two years of deciding Joiner, the Court granted certiorari in Kumho Tire Co. v. Carmichael to decide if the trial judge's gate-keeping obligation applies only to scientific evidence per se or extends to "technical" or "other specialized evidence" as included in Rule 702. [FN35] A split in the circuits had developed over whether the standards and guidelines in Daubert and Joiner applied to disciplines, such as engineering. [FN36] Ultimately, the Court in Kumho Tire held that Daubert and Joiner apply equally to "'technical' and 'other specialized' knowledge" evidence. [FN37] ***32** As interpreted by the Daubert trilogy, [FN38] the Federal Rules of Evidence clearly apply to social science theories and methods including mental disorders and syndromes. [FN39] Essentially, social science and syndrome evidence now must meet the Federal Rules of Evidence

standards to be deemed admissible as "good science" in federal courts. Although the recent trend in state courts is to follow Daubert, some states continue to follow Frye.

II. Gender-Specific Clinical Conditions: Reliability and Validity

According to the National Institute of Mental Health, over twenty-two percent of American adults are diagnosed with a mental disorder in any given year. [FN40] Gender differences have been well-documented in both the rates and course of several forms of mental illness. For example, studies show that Schizophrenia, one of the more disabling mental disorders, tends to have an earlier onset in males, [FN41] but anxiety and depressive disorders are more prevalent in females, at about a two-to-one ratio overall. [FN42] Though the phenomenon is relatively rare, some disorders are wholly unique to one gender, such as Rett's Disorder, an onset of developmental ***33** delays that has only been reported in females. [FN43] Other syndromes were developed almost wholly to account for experiences that are largely unique to females, and the controversial bases for these syndromes are the subject of the next section of this Article.

A. Event Based Gender-Specific Syndromes: Battered Woman Syndrome and Rape Trauma Syndrome

Two gender-specific syndromes that are rather frequently utilized either by female defendants or prosecutors in criminal cases are Battered Woman Syndrome (BWS) and Rape Trauma Syndrome (RTS). [FN44] Both conditions are essentially anxiety-based and involve the assertion of a pattern of feelings or behaviors following victimization of the female. BWS also includes a factual description of the precipitating events, setting forth a patterned "cycle of abuse" as part of the understanding of the syndrome. Neither syndrome is included in the DSM-IV, the seminal guide to psychiatric diagnosis. [FN45] However, as discussed below, rape or other serious assault may be a causal factor in the development of Post-Traumatic Stress Disorder, which is included in DSM-IV. Several problems arise from the attempt to base gender-specific psychological syndromes on gender-specific experiences.

1. Battered Woman Syndrome

a. The Scientific Approach

The term "Battered Woman Syndrome" was coined by Dr. Lenore Walker who first described her observations of symptom presentations ***34** of battered women in 1978. [FN46] Walker originally depicted BWS as a syndrome occurring in adult women who were in an intimate relationship with a physically and psychologically abusive male from whom they could not escape. [FN47] The syndrome per se included a repeating cycle of violence between the male and female, marked by alternating periods of abuse, a contrite apologetic phase, and a period of relative calm, leading again to the buildup of an abusive phase. [FN48] The syndrome is proffered as an explanation for the continued pattern of abuse and the woman's inability or disinclination to leave it. This emphasis on the nature of the abusive relationship means that individuals afflicted with the syndrome are identified by the nature of these events, not by a consistent definition of the effects on mental health.

Walker's theory that battered women share a common psychological syndrome was based on two observational studies, describing the cycle of violence and psychological reasoning for why the woman remains in the relationship. [FN49] Since then, Walker has described BWS as a pattern of psychological and behavioral symptoms found in women living in battering relationships. [FN50] The four general characteristics of the syndrome have been summarized as follows:

1. The woman believes that the violence was her fault.
2. The woman has an inability to place the responsibility for the violence elsewhere.
3. The woman fears for her life and/or her children's lives.
4. The woman has an irrational belief that the abuser is omnipresent and omniscient. [FN51]

***35** Walker's observations of this clustering of beliefs has not been replicated by the scientific community. [FN52]

One research study, using controlled data and therefore taking an empirical approach, attempted to describe or define the actual existence of BWS. [FN53] In this study, a standardized interview protocol was used to assess pre-selected clinical symptoms in sixty-two women who were receiving state-funded services for battered women. [FN54] In general, the women expressed psychosexual dysfunction, major depression, post-traumatic stress, generalized anxiety, and obsessive-compulsive disorder. [FN55]

Although this study bolsters the view that long-term battering likely has negative effects on women's mental health functioning, it does little to promote the syndrome as a distinct clinical entity. All of these symptom clusters are specifically identified in DSM-IV, with clearly established diagnostic criteria. None of these disorders precludes domestic violence as a precipitating or contributing causal factor (though the connection may be less clear for Obsessive-Compulsive Disorder). Nor does this study support the use of the syndrome to prove that battering occurred; the women were selected for their battering history, and the symptoms were not used to separate those who had been battered from those who had not. [FN56]

Several risks follow from emphasis on the precipitating events as the definition of the syndrome, rather than a validated set of diagnostic criteria to define mental health symptoms. This risky approach leads to a process of circularity so that a "diagnosis" of Battered Woman Syndrome adds little information to the fact that the woman was in a battering relationship. This circularity is summarized by one court's reasoning: "It is clear that the trial court considered battered woman's syndrome . . . in addition to other corroborating evidence, for the limited purpose of determining whether the defendant was a battered woman." [FN57] Therefore, ***36** the basis for the syndrome is a pattern of battering, and the evidence for the fact of battering is the syndrome.

Mary Ann Dutton, writing in response to Walker's original publications, pointed out the lack of both an operational definition [FN58] and an accurate consensus on a victim profile for BWS. [FN59] There is neither scientific evidence that such a distinct syndrome truly exists nor consistency of effects across individuals. [FN60] In addition, as long as researchers only study pre-identified groups of women who all have a battering history, rates of accuracy and error in diagnosing the syndrome will remain unavailable. No evidence is available to compare the rates of the symptoms in battered women versus other categories of women or differences between battered women who develop the syndrome and those who do not.

The paucity of research establishing BWS as a bona fide reliable condition egregiously undercuts the claim that the condition exists as a distinct diagnostic entity. Though the battering of women is likely epidemic, experts nonetheless cannot reliably diagnose a related "syndrome."

b. The Legal Approach

In contrast to the paucity of research supporting BWS as a distinct, reliably diagnosed clinical condition, there is no shortage of court decisions admitting evidence of the syndrome. A recent review of thirty-six state court decisions found that thirty-one states had admitted proffered testimony on BWS, and only five had excluded such testimony. [FN61] A 1998 review of cases demonstrated that "(t)he vast majority of jurisdictions admit both expert and opinion evidence on the effects of domestic violence on victims of battering as part of a self-defense ***37** claim." [FN62] The discrepancy between the low level of scientific support and the high level of admissibility suggests that courts may be attending to factors other than a valid scientific basis in reaching their decisions to admit BWS testimony.

Another review suggests three factors that may be playing a role in the admissibility decisions: (1) the qualifications of the proffering expert, (2) the old Frye doctrine of general acceptance as evidenced by the ipse dixit testimony of the proffering expert, and (3) other courts ruling that testimony on BWS is admissible. [FN63] As a distinct example of the third possibility, in a recent decision allowing the testimony, the court did not cite any relevant scientific research, but held evidence of BWS should have been admitted based on a law review article that reported the growing number of courts admitting testimony on BWS. [FN64] The court quoted another court's opinion that "'the scientific principles underlying expert testimony relative to the battered woman's syndrome are now firmly established and widely accepted in the psychological community, (and) we conclude that the syndrome has now gained general acceptance in the relevant scientific community as a matter of law.'" [FN65] The fact that only one empirical study of BWS has been published since coining of the term in the 1970s supports the probability that other courts also are making admissibility decisions based on criteria other than the presence of a sound scientific foundation for this syndrome. This raises the question whether judges are upholding their gate-keeping responsibilities, as defined by the Daubert trilogy.

Other decisions have disallowed expert testimony regarding BWS or have put limitations on its use so as to protect the fact-finding function. [FN66] ***38** Most, however, do not reach the issue of whether BWS exists as a scientifically supported diagnostic entity. For example, in a state court appeal of a criminal case, the court held that experts on BWS could testify generally regarding behaviors of victims of domestic abuse, but could not opine that the defendant had told the truth about their particular abuse. [FN67] In a similar appeal, the court held that expert testimony that the defendant had been diagnosed with BWS was tantamount to testimony that the defendant told the truth about her history of abuse. The testimony should have been disallowed under this pretext because truthfulness is an issue reserved for the trier of fact, and the credibility of witnesses may be proved by reputation evidence but not expert testimony. [FN68]
In State v. Necaise, a defendant charged with the shooting death of her husband was not allowed to introduce expert testimony on BWS to prove her characteristics as a battered woman or her state of mind at the time of the shooting. [FN69] In this case, there had been no plea of insanity, and the court reasoned that such testimony would constitute an inadmissible diminished capacity or other partial responsibility plea, disallowed under state law. [FN70] Several courts have found BWS inadmissible when the defendant's pattern of behavior was inconsistent with the pattern of behavior associated with BWS. [FN71] For example, in Lentz v. State, the court held that, when the facts of the case are entirely inconsistent with the claim of a battered woman acting in self-defense, BWS testimony is irrelevant and inadmissible. [FN72] In Lentz, the defendant shot her former boyfriend twice, once while in the bedroom of her house and again after ***39** following him to a neighbor's house. [FN73] The court determined that no expert was needed to interpret the facts for the jury. [FN74]

Additionally, in Buhrle v. State, the court held that evidence of BWS was unreasonable when it was used to explain why the defendant had shot and killed her husband with a shotgun after having argued with him for one hour and forty-five minutes in the doorway of a hotel. [FN75] The court found this exclusion was necessitated by the fact that the BWS expert was unable to adequately explain how being chronically battered related to the defendant's hiding of the gun and gloves after the shooting. [FN76] The court concluded that BWS evidence may not always be inadmissible, but given the instant facts, the testimony would be confusing. [FN77]

2. Rape Trauma Syndrome

a. The Scientific Approach

Sexual violence toward women dates back to the beginning of recorded history and is currently of unmeasured epidemic proportions. This is particularly true given the fact that the majority of rapes go unreported. [FN78] According to the Bureau of Justice Statistics, over 132,000 completed rapes and 99,000 attempted rapes occurred in the last decade, and ninety-four percent of all completed rapes were perpetrated against females. [FN79] The term "Rape Trauma Syndrome" was coined in the 1970s to describe the abundance of psychological, emotional, and physical symptoms that were observed in women who visited emergency rooms after a sexual assault. [FN80] One data-based empirical study of RTS is located in psychological***40** literature. [FN81] The researchers in this study found that female rape victims presented a coherent variety of signs and symptoms that were consistent with physical and psychological trauma. [FN82] These signs and symptoms were further divided into two categories, according to how the women responded to the trauma. [FN83] As with the single empirical study for BWS, this study observed women pre-selected for having experienced rape. [FN84]

The development of RTS bears both similarities and differences to the development of BWS. Like BWS, RTS tends to be a gender-specific syndrome that was created to categorize extremely dramatic experiences that generally only affected women. [FN85] Also similar to BWS, RTS includes a specific, historical event as part of the "diagnostic" criteria. [FN86] Unlike BWS, however, observations of RTS in women are closely related to the psychological sequela of other forms of trauma. [FN87] Thus, the nexus between the event that caused RTS and its psychological effects can be better understood through a research of the vast literature on psychological trauma. [FN88]

The related term, "rape-induced Post-Traumatic Stress Disorder" (PTSD), has also appeared in the literature, combining the scientific evidence of human response to trauma and what is specifically known about women's responses to rape. [FN89] As discussed below, expert testimony on the type of PTSD that identifies rape as the precipitating factor is a viable, though not risk-free, alternative to expert testimony on RTS in situations where a woman's psychological response to rape is at issue in a trial. Allowing expert testimony on RTS, however, independent of the scientific basis for PTSD, is ill-advised for several reasons.

***41** As discussed above, a dearth of controlled scientific study supports RTS as a distinct diagnostic entity. One of the only studies that does exist is an observational study of women who have been pre-selected for having experienced rape, thus providing no basis for accuracy or error rates in diagnosis of the syndrome. As with BWS, no evidence exists to differentiate rape victims who develop the syndrome from those who do not develop it, or to differentiate the associated symptoms among women who have and have not experienced rape. This lack of specificity is of particular importance when evidence of the BWS is admitted to prove that a rape occurred. [FN90] Imagine, for example, a plaintiff suing an insurance company and offering expert testimony on soft tissue damage as

evidence that he was in a car accident. Or consider another possible scenario that consists of plaintiffs in a class action suit offering expert testimony of high rates of depression and anxiety as substantive evidence that gender discrimination has occurred in their workplace. In these cases, the possibility that the symptoms described by the plaintiffs were caused by other events would not be ignored by an introduction of consistent "syndrome" evidence, even if it were true that many (or all) people involved in such events suffered such symptoms. Neither of the observational studies that chronicle the symptoms that commonly follow a battering or a rape addressed either the need for specificity, or the need for accuracy and error rates, in setting forth a well-defined, scientifically validated set of diagnostic criteria. Without questioning the fact that rape occurs and can be horrifyingly devastating to its victims, some commentators have nevertheless called for a moratorium on use of the inherently problematic term "Rape Trauma Syndrome" by experts in courts of law. [FN91]

b. The Legal Approach

RTS has been accepted in a few courts as a valid syndrome, though as with BWS, the paucity of scientific evidence supporting it is not discussed. For example, in People v. Wheeler, the court held that evidence ***42** of RTS could be admitted as substantive evidence that a sexual assault occurred. [FN92] Yet it appears that, similar to BWS, some courts find evidence of RTS admissible based solely upon prior court decisions to admit the testimony, rather than by conducting an independent examination of the scientific basis for the proffered evidence. [FN93] For example, in State v. Marks, the court, after what appears to have been a review of the only case law on RTS, noted that RTS was "generally accepted to be a common reaction to sexual assault." [FN94] It appears that the Marks court relied upon the holding of other courts that had made admissibility decisions without evaluating the scientific reliability of RTS. [FN95]

Courts that have independently evaluated the scientific basis have concluded that evidence of RTS is inadmissible. For example, in State v. Black, the court held that RTS lacks scientific credibility. [FN96] In Black, a rape crisis counselor was permitted to testify that the alleged victim's symptoms fit the specific profile of a rape victim. The trial court, in considering the counselor's testimony, reached a verdict of guilty. [FN97] The counselor testified "that (the victim)'s symptoms fit a specific profile for rape victims." [FN98] On appeal, the primary issue was whether the admission of expert testimony stating that the victim exhibited signs and symptoms of RTS was in error. [FN99] The appellate court held that, under its state analogue to Rule 702, the record failed to establish RTS as sufficiently reliable and accepted within the scientific community to permit the counselor's testimony that the victim fit the syndrome. [FN100] Similarly, the ***43** court in State v. Taylor held that a doctor's testimony concerning RTS was "not sufficiently based on a scientific technique, which is either parochially accepted or rationally sound." [FN101] In People v. Bledsoe, the court noted that, when used to establish whether a rape had indeed occurred, RTS testimony intruded on an issue ultimately reserved for the jury and was, therefore, unduly prejudicial. [FN102] The court correctly pointed out that RTS was developed as a "therapeutic tool," but should not be used to verify whether the historical event of rape had occurred. [FN103]

B. Biology Based Gender-Specific Syndromes and Disorders: Premenstrual Syndrome and Postpartum Depression

Along with BWS and RTS, two additional gender-specific syndromes, Postpartum Depression (PPD) and Premenstrual Syndrome (PMS), have received clinical attention and found their way into legal proceedings, usually to explain or excuse a woman's criminal conduct. [FN104] Both of these conditions are often misnamed and confused with related

but distinguishable classifications in DSM-IV. Frequently, the confusion results in misunderstanding of the proper descriptive characteristics of these disorders.

1. Postpartum Depression

PPD is technically not a diagnosis at all; rather, it is a specifier for the primary DSM-IV diagnosis of Major Depressive Disorder (MDD). [FN105] Thus, the correct manner of expressing a diagnosis for a woman suffering with PPD is "Major Depressive Disorder with Post-Partum Onset." [FN106] ***44*** To aid in clarity of diagnosis, three levels of severity have been associated with PPD: (1) postpartum blues or baby blues, (2) postpartum depression, and (3) postpartum psychosis. [FN107] Postpartum blues and depression both involve disruptions in mood and related functioning, but entail no loss of contact with reality. In other words, new mothers with these depressive features are not expected to misperceive their environments or suffer hallucinations and delusions. [FN108] In contrast, postpartum psychosis does include deficits in perceiving reality, including hallucinations and delusions. Though it shares precipitating factors, postpartum psychosis is distinguishable from blues and depression; it represents a major psychotic mental illness. [FN109] Research on the prevalence and course of postpartum disturbances shows that only a small minority of affected women experience postpartum psychosis. [FN110] When postpartum psychosis occurs, it may be due to a pre-existing mental disorder that has been exacerbated by hormonal changes secondary to the pregnancy and subsequent childbirth. [FN111] The DSM-IV provides for diagnosis of PPD if the symptoms become present within the first four weeks after delivery. [FN112] On the rare occasion when postpartum psychosis occurs in PPD, a woman may experience delusions or auditory hallucinations so severe as to require hospitalization. [FN113] The DSM-IV classification system for Major Depressive Disorder, providing further for classification of postpartum type, and associated research delineating prevalence and course of different manifestations of postpartum disturbances, present a good basis for comparison with the approach to BWS and RTS. An expert testifying that a criminal defendant suffered postpartum psychosis at the time she committed a crime ***45*** would have a scientific basis for discussing accuracy and error rates in assigning the diagnosis to new mothers. The overall incidence rate of a postpartum disturbance of any type is known to be small, from one-in-500 to one-in-1000 deliveries. [FN114] Systematic research has grouped women who engage in infanticide according to whether they do or do not develop psychosis, and the sub-portion of women who develop postpartum psychosis can be further compared by whether they do or do not engage in violence. For example, a study examining 106 years of data on infanticide in England found that fewer women kill their infants in the first twenty-four hours after delivery than kill after this twenty-four-hour period and that women who killed their infants after the twenty-four-hour period were far more likely to be diagnosed with psychosis. [FN115] Those who killed their infants immediately after their births were more likely to have engaged in rational (i.e., non-psychotic) attempts to conceal the pregnancy and childbirth. [FN116] Thus, it is incorrect to assume that all women who commit infanticide are suffering (as a result of childbirth) from a mental illness that is sufficient to justify a legal conclusion of diminished capacity or insanity . . . . (I)t is incorrect to assume that childbirth itself produces a mental state so altered that most women in the postpartum period are incapable of understanding the act of murder. [FN117]

In contrast to BWS and RTS, where women are diagnostically grouped because they suffered battering or rape, new mothers are not diagnostically grouped because of the event of childbirth; rather their diagnoses are based on a comparison of their symptomatology with well-defined and scientifically validated criteria sets.

Despite the rarity of postpartum psychosis, it has been raised as a defense to murder in recent years. A trend may be developing in which trial judges properly admit evidence of postpartum psychosis, but juries do not accept the diagnosis as an excuse for criminal

conduct, especially ***46*** where mothers have killed their own children. In People v. Massip, a mother was charged with the murder of her newborn son after running him over with her car. [FN118] She entered a plea of insanity, based upon an assertion of postpartum depression with psychosis. [FN119] Nonetheless, the jury decided she was sane and convicted her of second-degree murder. [FN120] The trial judge set aside the jury verdict, deciding that the defendant was insane as a matter of law, and entered a finding of not guilty by reason of insanity. [FN121] Although the admissibility of the expert testimony was supported by relevant scientific research, the records in the Massip case are unclear regarding the extent to which the court made inquiries into its clinical validity. In a more recent high-profile case, Andrea Yates, a Texas mother, was convicted of murdering her five children, despite essentially undisputed factual and expert testimony that she suffered from mental illness. [FN122] Similarly to the Massip case, the trial judge properly admitted the scientifically valid testimony for the jury's consideration, but the jury rejected it as an excuse for the mother's criminal conduct; Yates was convicted and sentenced to life in prison.

In sum, postpartum psychosis has a valid scientific basis as a distinct clinical entity, and has been proven to severely affect women's mental health functioning, including their ability to perceive their environments accurately. However, it has not been accepted by juries as relevant evidence in cases where women killed their children. [FN123] Conversely, BWS ***47*** and RTS lack scientific bases as distinct clinical syndromes, but have gained some acceptance as relevant evidence to prove factual events or relevant mental state at trial.

2. Premenstrual Syndrome and Premenstrual Dysphoric Disorder

PMS apparently represents both a description of and reason for certain undesirable feelings and behaviors observed in women about once a month. PMS, in its popular and broad formulation, is not a recognized psychiatric diagnostic entity and is not found in the DSM-IV. A related syndrome, Premenstrual Dysphoric Disorder (PMDD), is found in the DSM-IV, not as an established diagnosis, but as a constellation of observed symptoms that warrants further investigation. [FN124] In its suggested form, a diagnosis of PMDD requires the presence of five symptoms out of a list of eleven to have occurred in most menstrual cycles during the past year, "began to remit within a few days after the onset of the follicular phase, and were absent in the week post-menses, with at least one of the symptoms being either" a markedly depressed mood, marked anxiety, sudden sadness, or persistent irritability. [FN125] The list of symptoms includes: markedly depressed mood, marked anxiety, marked affective lability, persistent or marked anger or irritability, decreased interest in activities, difficulty concentrating, lethargy, changes in appetite, insomnia, a feeling of being overwhelmed, and physical symptoms such as breast tenderness. [FN126] Although this symptom cluster remains in its "warrants further investigation" stage, women meeting these suggested criteria may receive a diagnosis of "Depressive Disorder, Not Otherwise Specified," with features of PMDD. [FN127]

Many issues require further investigation before PMDD can be considered an established diagnostic entity. For example, some researchers suggest that PMS may not be a unique process that occurs only in women; rather, men and women alike experience cyclical changes in ***48*** mood. [FN128] Thus, the cyclical changes in mood experienced by women may not be uniquely linked to their menstrual cycle. It is also difficult to differentiate PMDD from other disorders. [FN129] For example, fluctuations in hormones during the menstrual cycle can exacerbate underlying psychological disorders. Similar symptoms can also occur with various endocrine disorders. [FN130] Several attempts to develop and refine a psychometric measure of PMDD have resulted in high sensitivity and low specificity. This produces a risk of high false positives in diagnosing this disorder and problems of reliably distinguishing it from other disorders with similar signs and

symptoms. [FN131] Additionally, if PMDD is accepted as a DSM-IV diagnostic criteria set, care must be taken not to confuse this mental disorder with the popular PMS, which describes a milder constellation of subjective physical and psychological symptoms and does not address impairments in functioning. [FN132]

Based on the nature of the symptoms suggested for diagnosis of PMDD, it is unlikely that this disorder will become relevant to explain or justify a woman's conduct in a criminal trial, even if future developments in diagnostic clarity and reliability render it a valid clinical entity. [FN133] A recent search of the caselaw revealed no appellate cases reporting use of PMDD in conjunction with the key terms "murder" or "self-defense" in the past ten years. PMS, in contrast, has been raised in at least two criminal cases. In one case, a defendant intended to argue that PMS ***49** caused "blackouts," thereby negating an element of intent. [FN134] In another case, the defendant argued successfully that PMS caused her to respond to alcohol differently, so that a breathalyzer was inaccurate. [FN135] It is not clear how either of these findings relates to the research criteria set forth for PMDD. Consistent with the lack of diagnostic reliability for PMS, the experimental nature of the criteria for PMDD, and the nature of the symptoms (which do not involve thought disorder or other major impairments in cognitive functioning), PMS and PMDD should not frequently appear as substantive evidence in criminal trials.

C. PTSD and the DSM-IV Non-Gender Based Approach to Trauma-Related Symptoms

Overwhelming evidence indicates that women suffer at the hands of their sexual perpetrators and abusive domestic partners. In some portion of cases, the suffering undoubtedly rises to the level of a mental disorder. In other words, the impact on the woman's mental health functioning after a battering or rape is sufficiently severe that she cannot be expected to function the way she functioned before the incident or the way women function who have not had these traumatic experiences. It is imperative to approach these cases with a reliable set of signs and symptoms that can lead to a reliable diagnosis. Researchers seeking a syndrome to capture the impact on mental health functioning of traumatic events do not need to start from scratch. The DSM-IV includes a scientifically accepted diagnostic condition specifically for this purpose, namely Post-Traumatic Stress Disorder (PTSD).

PTSD is an anxiety-related mental disorder that results from trauma. [FN136] Like BWS and RTS, a diagnosis of PTSD requires the clinician to find ***50** that the individual experienced a qualifying traumatic event. In order to be a precipitating factor in PTSD, the event must involve actual or threatened death, serious injury or a threat to one's physical integrity, and the individual's response must have included intense fear, helplessness, or horror. [FN137] Unlike BWS and RTS, PTSD does not begin with the identification of a specific event. PTSD has been found in individuals who have experienced military combat, violent personal assault, kidnapping, torture, disasters, severe automobile accidents, and diagnosis of life-threatening illnesses. [FN138] Rather than categorize individuals by the facts of the events, as in BWS and RTS, a diagnosis of PTSD groups people by the nature of their psychological functioning following the traumatic event. These features of psychological functioning include re-experiencing the trauma through vivid recall or nightmares, avoiding situations associated with the trauma, and symptoms of increased physical and emotional arousal, especially when reminded of the traumatic event. [FN139] Subsequently, patients experience "recurrent and intrusive recollections of the event," feeling of detachment or estrangement, "hypervigilance," "exaggerated startle response," and "feeling as if the traumatic event were recurring." [FN140]

Studies examining both the sensitivity and specificity of PTSD diagnoses have produced acceptable accuracy levels. [FN141] In contrast to the two observational studies in pre-selected groups of battering and rape victims for BWS and RTS, research into the etiology, development, incidence, and course of PTSD provides expert witnesses with bases for comparing trauma sufferers who develop the syndrome from those who do not and for comparing trauma sufferers from non-trauma sufferers. Even among groups of individuals who have shared similar traumatic events, such as military combat, it is understood in the research base that some individuals will develop the potentially disabling mental disorder and some will not. The diagnostic criteria emphasize the known and expected psychological sequela of trauma over the facts of the traumatic event so that a ***51** man involved in a death-defying automobile accident may be more similar to a female rape victim than two women who lived for several years in abusive relationships. The observed similarities and differences should be based on findings about psychological functioning from the social sciences literature. This approach is preferable in the legal context, both to avoid circularity in reasoning when determining if the events that caused the "syndrome" occurred, and to avoid undue prejudice to the trier of fact where the syndrome is alleged.

In recent years, some commentators have suggested that BWS and RTS are actually subsets or sub-categories of the DSM-IV diagnosis of PTSD. [FN142] This reasoning may or may not be scientifically valid, depending on what is meant by it. Nothing in the DSM-IV approach to PTSD prevents the clinician from considering both common and unique responses of women who have been battered or raped in formulating their clinical understanding of the diagnosis and an effective treatment plan. In fact, the polythetic approach to the diagnostic criteria sets in the DSM-IV encourages clinicians to consider the richness of information that is found in individual differences. [FN143] However, it should not be acceptable to label syndromes that lack systematic study as "sub-categories" of the PTSD diagnosis to bolster their admission in court, if the general, less-well defined features of the syndromes will be substituted for a rigorous examination of whether the diagnostic criteria for PTSD apply.

Lastly, wrapping a "syndrome" around all women who have experienced a battering or rape and including the legally significant terms in the names of the syndromes, may suggest unnecessary pathology in women who are actually responding in a normative and adaptive way, and where a woman's functioning is more severely impaired, may inaccurately suggest that she is vulnerable to trauma in a manner that men are not. Overuse of the syndrome to explain a woman's response to these events may also lead to cynicism and skepticism about the known sequela of trauma, such as happens when all such syndromes are lumped together ***52** as "the abuse excuse." This, of course, would be detrimental to the best interests of any woman who has been battered or raped. [FN144]

III. The Need for Reliable Methods of Assessment and Diagnosis in Court Cases

Thus far, this Article has identified major gender-specific disorders and discussed whether they are likely to meet the admissibility guidelines set out in Daubert. However, before a disorder is even considered for admissibility, it must first be accurately assessed and diagnosed. In addition to the need for accurate classification that exists in any mental health context, when the existence of mental disorder constitutes substantive evidence in criminal or civil cases, the method of classification also receives scrutiny. Questions of the legal relevance of the clinical impairments also arise. This section compares unique aspects of psychological assessment within a forensic context to the traditional therapeutic assessment approach.

A. The DSM-IV Approach

Given the complexity and inherent heterogeneity among individuals suffering with any given mental disorder, the DSM-IV uses a polythetic, criteria-based approach to classify mental disorders. [FN145] Clusters of signs and symptoms are used to categorize mental illness into one of seventeen classifications. [FN146] Within the broader classifications, specific mental disorders are described by way of a list of key features that have been found to commonly appear together in individuals afflicted with the disorder. Typically, a "cut-off" number of symptoms from a longer list is required in order to assign the diagnosis. For example, the first criterion for diagnosis of Major Depressive Episode requires that five of nine listed symptoms be present and that one of those be either a depressed ***53** mood or a loss of interest or pleasure. Two or three individuals who receive the diagnosis may have somewhat different manifestations of the disorder, all within the criteria set. The presence of the "cut-off" number of signs and symptoms is not sufficient, however, to identify the cluster as a mental disorder. The symptoms must also interfere with social, occupational, or other significant areas of functioning and must not be better explained by other known phenomena, such as substance intoxication, in the case of Major Depressive Episode. Even with this level of specification, the diagnostic criteria ultimately serve as guidelines only. [FN147] Though DSM-IV generally captures a high level of consensus, particularly among its developers, controversy persists and the validity, as well as the meaning, of any given diagnosis may remain in dispute. It is also not uncommon for doctors who agree to the clinical utility of a diagnosis in general and who use similar methods of assessment to nevertheless disagree as to whether it should be applied in any given case.

B. The Clinical Approach

Accurate diagnosis of psychopathology requires a series of steps, including collection of objective and subjective data, evaluation of the reliability of data, identification of psychopathology, identification of distinctive features of signs and symptoms, conclusion of a diagnosis by checking diagnostic criteria, and ultimately, the resolution of diagnostic uncertainty. [FN148] Most clinicians begin any assessment with a comprehensive patient interview. Clinical interviews typically include a review of symptoms and history furnished by the patient. Depending on the need, the evaluation may entail review of relevant records, such as school records for diagnosis of learning disability, and information from reliable third party sources such as hospitals and treating physicians. [FN149] For many types of problems, family members will be interviewed for their observations and understanding of the patient's presentation. For example, when considering a diagnosis of dementia, the clinician may need to consult ***54** family members for information about the pace and course of the patient's decline in functioning.

Based on all available information, and guided by her own observations, as well as the patient's complaints and subjective descriptions, the evaluator searches for the presence of symptoms that provide the best fit in explaining the patient's functioning. Most clinical evaluations involve at least an initial screen for signs and symptoms related to anxiety, depression, suicide risk, odd or unusual thinking or beliefs, peculiar mannerisms, oddities of speech, and other manifestations consistent with known psychiatric disorders. [FN150] Hypotheses regarding diagnoses are formulated throughout the process and those that begin to show a good fit are followed up with more specific examination of relevant signs and symptoms. For example, when response to trauma becomes a viable hypothesis, more specific questions about flashback experiences, avoidance of stimuli, and startle response will be evaluated. These symptoms may not receive much attention for other patients. Typically, several hypotheses will be considered, compared with the evidence, and rejected until only one or a few hypotheses that best explain the observations remain. Then, the information supporting the final hypothesis is compared to the

diagnostic criteria published in the DSM-IV. These diagnostic criteria, based upon widely accepted operational definitions in peer-reviewed literature, are applied to the data until, finally, one or more are selected.

In a treatment context, the evaluation may not entail such detailed and systematic steps, especially in the early phases, because response to the treatment itself may help to clarify the diagnostic picture, and other therapeutic goals, such as relief from suffering and restoration of functioning, may take precedence over precision in the steps toward diagnosis. Non-specificity of both medications and therapy modalities may also render diagnostic clarity less important in this context. Many patients have received benefits from treatment on the basis of "provisional" and "rule out" diagnoses, indicating a potentially appropriate set of priorities ***55*** when patient and clinician meet over their respective help-seeking and help-providing roles in the treatment context.

C. The Forensic Approach

The clinician's approach in the treatment context will rarely be appropriate for the truth-seeking function of expert testimony in court cases where the nature of an individual's psychiatric diagnosis constitutes substantive evidence regarding a fact in issue. Moreover, an expert offering to testify about mental disorder for purposes of a dispute in court not only will need to present a level of certainty and specificity sufficient to the task, but also will need to consider the legal relevance of the diagnosis. DSM-IV specifically limits the usefulness of the diagnostic criteria sets for this purpose:

It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category . . . does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved . . . may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency. [FN151]

Clinicians called upon to assist attorneys and the courts with such determinations are commonly called "forensic" experts. Both psychology and psychiatry have forensic specializations, including specialized training, within their general fields of expertise. Forensic training emphasizes the differences in roles, purposes, and methods between treatment-providing clinicians and testimony-providing forensic experts. Depending on the specific context, these emphases may include issues of neutrality, heightened skepticism of self-report symptoms where secondary gain is at issue, the legal relevance of psychological hypotheses, and the expert's unique role in the truth-seeking function and its attendant responsibilities. For example, a clinician treating a patient for depressed mood and excessive fatigue following an accident at work may be much less concerned ***56*** with the potential for exaggeration of symptoms than a psychologist appointed by a worker's compensation commission to determine whether the symptoms rise to the level of psychological injury meriting a compensatory award. Similarly, a clinician addressing a woman's fear of leaving her home at night six months after a sexual assault will have different concerns than the forensic expert called to testify in a case where a jury must determine whether the assault occurred, whether it legally constituted rape, and whether the defendant being charged committed it.

Although both the clinical method and the forensic method involve a deductive reasoning process, the forensic method necessarily requires a higher level of scrutiny of the individual's recollection of relevant events and self-report of related symptoms. [FN152] Additional and comparative sources of information, including thorough records review and collateral interviews, are essential in forensic evaluations to address potentially relevant issues ranging from alternative causes of the individual's current functioning to outright malingering. For example, in the context of a forensic evaluation of a criminal defendant

who asserts that a history of being battered should provide mitigation for killing her husband, the forensic evaluator will need to gather independent information about her marital relationship as well as evidence of her functioning before, during, and after the periods of alleged battering. The defendant's self-report will be compared with the information gathered from other sources, and both consistencies and inconsistencies followed up until coherent and reasonable explanations emerge. A thorough forensic evaluation will consider several alternative hypotheses; discrepancies in the defendant's self-report may represent distortions related to the mental health impairment itself or may be intentional and motivated by secondary gain. Psychological test instruments are frequently employed to gain additional information and understanding of the psychological functioning of the individual, and many such instruments have scales especially designed to assist in gaining an understanding of an individual's tendency toward honest effort or feigning of symptoms.

***57** D. Useful Assessment Instruments

Numerous psychological test instruments aid in the assessment of mental health functioning by permitting comparison of the individual at issue with large groups of individuals, based on objectively defined and empirically validated criteria. As an illustration of their potential usefulness in a forensic context, this section briefly discusses instruments that have been developed to assess psychological response to trauma and may, therefore, assist in forensic evaluation of women who assert that their experience of battering or rape has affected their mental health functioning in a legally relevant manner.

Karen Calhoun and Patricia Resick, well-known researchers in the area of psychological trauma following rape, describe several helpful instruments widely used to assess PTSD following rape for which they apply the term, "rape-induced PTSD." [FN153] These researchers suggest that a PTSD assessment might include a structured clinical interview such as the Structured Clinical Interview (SCID) for the DSM-III-R, [FN154] which has recently been replaced by a newer, psychometrically-sound version updated for the DSM-IV. [FN155] Structured interview information is often supplemented with one or more self- report scales such as The Impact of Events Scale, [FN156] The Rape Aftermath Symptom Test, [FN157] or The PTSD Symptom Scale. [FN158] Similarly, there are solid measures of the sequela of domestic violence such as the Abusive Behavior Observation Checklist [FN159] ***58** or Richard Tolman's Psychological Maltreatment of Women Inventory. [FN160] Additionally, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) is a well-regarded personality inventory that measures the presence of specific clusters of psychological symptoms that may occur at pathological levels. [FN161] Results from these or other objective and validated assessment instruments should always be seriously considered in assessments of trauma for legal purposes.

One hypothesis that is always present until excluded in a forensic evaluation is malingering or faking mental illness. [FN162] Thus, doctors performing forensic assessments must be attuned to the possibility of a conscious or unconscious desire on the part of parties to appear less or more psychologically stable than they actually are. [FN163] The need for direct assessment of tainted efforts is nearly always present in both criminal and civil cases where a party has much to gain by demonstrating psychological or neurological impairment. [FN164] Therefore, psychological tests of malingering and genuine effort have been developed and validated in the last few years. [FN165] Specifically, these tests permit assessment of an individual's tendency toward honest disclosure versus exaggeration or outright fabrication of psychiatric symptoms. [FN166] Although no single test directly measures malingering completely, these psychological test instruments can greatly assist in fair and balanced evaluation in a forensic context. [FN167]

*59 IV. Selecting a Qualified Forensic Expert

As discussed above, procedures employed as part of the "helping ethic" of doctors are unsuitable for conducting forensic assessments. [FN168] Without specialized training, the vast majority of treating doctors will not be prepared to shift roles for the purpose of testifying in court. [FN169] Empathic therapists are taught to accept what the patient relates, especially in the exploratory stages, with perhaps only gentle confrontation of any inconsistencies, in order to encourage disclosure. Thus, the method used in a therapeutic assessment requires the examiner to maintain an attitude and demeanor that will help the patient feel comfortable, safe, and free to disclose intimate details normally censored from others. [FN170] Experienced forensic examiners, however, are keenly aware that their role requires them to critically analyze the information. [FN171] Of course, non-forensically trained doctors can-and should-be utilized as fact witnesses, or in an educative role for the court. However, if a doctor is expected to serve as an independent, non-biased expert examiner and proffer testimony, then a forensically trained expert should be employed.

In several studies designed to determine rates of concordance on psycho-legal issues among non-forensically trained doctors on the one hand and forensically trained examiners on the other, rates of agreement were higher for the forensically trained examiners, ranging from 88% to 93%. [FN172] Perhaps one of the reasons for these results is that doctors who *60 lack formal forensic training have a strong tendency to equate mental illness per se to trial incompetence or insanity, and this tendency is not true in a majority of cases. [FN173] Formal forensic training on the legal issues prepares doctors to understand better the subtle legal distinctions that must be made when conducting evaluations in a forensic context. Thus, doctors who desire to perform evaluations for courts as expert witnesses, arguably, should undergo specialized forensic training. This training primarily serves to inform doctors of the pitfalls of the helping ethic, the shortcomings of traditional clinical methods of assessment, and the legal issues involved, so that the doctors may contribute to the process of truth finding in an unbiased manner. [FN174]

The consensus of the clinical forensic community is that doctors who conduct evaluations for the courts should, at a minimum, hold either a Ph.D. or Psy.D in clinical psychology or an M.D. with a residency in psychiatry. [FN175] Attorneys who select mental health experts for cases such as those discussed herein should keep these forensic training distinctions in mind. These credentials alone, however, should not be considered sufficient. [FN176] The doctorate-level witness must show the court that she or he is qualified in the clinical subject matter at issue. For example, if *61 a defendant alleges she was psychotic secondary to postpartum depression during the time of the criminal conduct, the doctor must have sufficient training and experience with women who suffer postpartum disorders. Hence, psychologists who work as college counselors, or psychiatrists who work exclusively with children, may lack the necessary clinical expertise to proffer testimony, even if they also had specific forensic certification. [FN177] Judges acting as gatekeepers of evidence should be prepared to question proffered experts regarding their orientation, forensic training, and experience in order to arrive at a proper ruling of admissibility.

The above discussion, comparing the approaches to BWS and RTS to the approach of the DSM-IV diagnosis of PTSD, may particularly illuminate the importance of forensic expertise among doctors who offer to testify as experts at trial. Although PTSD is not rooted in any particular, legally relevant type of trauma, a diagnosis will require the assessing clinician to find that a qualifying traumatic event occurred. In cases where a woman likely suffers from PTSD as a result of battering or rape, even for treatment purposes, the clinician will work from the understanding that either battering or rape actually occurred. If care is not taken in the application of this "diagnostic criteria" to

potentially legally relevant events, then for purposes of evidence at trial, the more carefully constructed diagnostic criteria set for PTSD may suffer the same pitfalls as the less well-defined "syndromes" of BWS and RTS. Specifically, clinicians who recognize signs and symptoms of trauma, such as self-report of flashbacks and avoidance of situations, may assume that these symptoms support the actual occurrence of the battering or rape without consideration of alternative hypotheses.

Though the risk of such circular reasoning may cause little harm in treatment cases, where relief may be provided though the woman's trauma derived from other causes, the risk of misleading, prejudicial inferences is higher in court cases, where the circular reasoning may result in a finding of fact that historical events occurred without sufficient independent evidence of them. Specially trained forensic experts, and judges well-informed about the comparative methods and procedures, will be more likely to view the traumatic event as a condition precedent to a diagnosis of PTSD. By this approach, independent evidence, of the type that police ***62** can amass and juries can understand without assistance, should be required to support the factual assertion that rape or battering occurred, before a forensic expert is permitted to testify to its effects on the victim.

V. Suggested Admissibility Standards Under the Rules of Evidence for Psychological Syndrome Evidence

The requirements for support by scientific method, derived from the Daubert trilogy, are preferable to the Frye doctrine of general acceptance for admissibility decisions regarding psychological syndrome evidence. The Frye doctrine is not sufficiently rigorous for evaluating this type of scientific evidence because there is no court-guided inquiry into the clinical reliability and validity of the diagnosis or syndrome under consideration. [FN178] Under Frye, the judge must rely on the opinion of the proffering expert, or sometimes dueling experts, to determine whether the relevant discipline sufficiently accepts the theory for it to be deemed of general acceptance. [FN179] Through this process, admissibility decisions under Frye are left largely in the hands of the professional discipline and not the courts. [FN180] The inquiry fails to establish the scientific reliability of the syndrome evidence [FN181] or whether a sufficiently validated method was used to apply it in the individual case.

At least with regard to psychological syndrome evidence, the Daubert trilogy provides assurance that judges will maintain their appropriate gate-keeping role by only allowing scientifically sound psychological or psychiatric theory into courtrooms and will guard against a snow-balling effect, in which admissibility decisions are based on the "popularity" of a syndrome in other court decisions and observers' commentary that do not address the issue of grounding in scientific support. Toward that end, ***63** the following guidelines are suggested to aid attorneys and judges in evaluating proffered psychological syndrome evidence. They are based on the Federal Rules of Evidence and the Daubert trilogy.

1. Is the theory or technique testable? [FN182] Have published studies been conducted on the theory? [FN183]
2. Has the theory or technique been tested? [FN184] With what results?
3. Has the theory or technique been subjected to peer review? [FN185] With what results?
4. Has the theory or technique been published in professional journals? [FN186] With what response?
5. For a given technique, what is the error rate? [FN187] That is, what is the false positive and false negative rate? If not known, can one be determined?
6. To what extent is the theory, or technique, accepted in the scientific community?

[FN188] How does the expert demonstrate this general acceptance, e.g., are there published surveys regarding acceptance, or is this allegation merely ipse dixit?
7. Does the method or technique employed logically flow from the underlying theory? Does it make sense and is it logically connected to the underlying theory? [FN189] What is the empirical research demonstrating this critical link?
8. Was the method or technique properly adhered to in accord with published guidelines? [FN190]
***64** 9. Are the expert's results and findings tied to the facts in the instant case? [FN191] Or are they only generalizations? That is, do the results fit this case?
10. Do the conclusions of the expert logically flow from the test or interview findings? [FN192]
11. Do the conclusions require a "leap of faith?" Are the conclusions grounded in the facts of the instant case? [FN193]
12. Can the trier of fact understand and follow the expert's testimony, or will it confuse either the judge or the jury? [FN194] That is, considering the facts and complexity of the litigation, will the expert's testimony be probative or prejudicial? [FN195]

Conclusion

The days of ipse dixit are gone. Today, psychological and psychiatric testimony must be based upon good science. In particular, gender-specific syndromes must meet the rigorous admissibility standards set forth in the Federal Rules of Evidence as elucidated by Daubert, Joiner, and Kumho Tire. Arguably, these same standards should also be employed in Frye doctrine states if "junk science" is to be kept out of their courts. Battered Woman Syndrome and Rape Trauma Syndrome lack the necessary empirical research and acceptance in the clinical community to satisfy the admissibility guidelines for scientific and technical evidence. Instead, women who have suffered battering or rape may more correctly be clinically assessed for the presence of Post-Traumatic Stress Disorder, which most closely matches the signs and symptoms associated with battered and raped women. Further, PTSD is a diagnostic condition that meets the requirements for "good science." The reader is reminded, however, that meeting clinical diagnostic criteria alone is insufficient to show legal relevance in a particular criminal case. A nexus must be shown between the clinical condition and one or more elements of the crime charged.

***65** The syndrome called Postpartum Depression with psychotic features (correctly identified as Major Depressive Disorder with Postpartum Onset) meets admissibility criteria, but the reader is cautioned that postpartum psychosis, which would be required for a successful mental state defense, is a rare condition. For example, PMS fails to meet admissibility standards because it is not a bona fide diagnostic disorder. [FN196]
In order best to ascertain whether or not a client suffers with any clinical condition that may have a legal bearing on a case, attorneys should utilize the services of a doctor with specific training and experience in forensic psychology or psychiatry. Forensically-trained doctors are aware of the psycho-legal issues involved and are better attuned to the needs of the court. Moreover, those doctors are more aware of their proper role in a legal setting. Finally, guidelines are provided, in the form of a list of questions, which may be used to assist in determining whether or not the client's apparent mental condition will meet admissibility guidelines set out in the Federal Rules of Evidence.

Undoubtedly, women experience unique psychological experiences related to the trauma of battering and rape. However, well-intentioned coining of new syndromes to explain away the criminal conduct of women is ill-advised. Ultimately, these syndromes open the evidence door to bad science and, thus, detrimentally affect the plight of women who legitimately suffer. The naming of new syndromes, which include legalistic terminology, is

especially egregious because well-meaning doctors are placed in the awkward situation of having to make legalistic determinations for which they have no special training, experience, or qualifications. [FN197] Verification of battering and rape is best left to the police and the courts. Further, use of legal terminology in clinical diagnoses is conclusionary and introduces a bias for both the doctor conducting a clinical examination and the trier of fact should the case go to trial.

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[FN1]. See Jerrold S. Maxmen & Nicholas G. Ward, Essential Psychopathology and its Treatment 6 (2d ed. 1995). "Syndrome" is defined as a cluster of signs and symptoms involving affect, cognition, and behavior. "Signs" are directly observable clinical conditions, such as stuttering or weak muscles, and "symptoms" are reported to the doctor by the patient and cannot be directly observed. Id. at 7. "Affect" is defined as an outward expression of a current emotion. Alan Stoudemire, Clinical Psychiatry for Medical Students 30 (3d ed. 1998). The term "syndrome" is frequently used to refer to an observed constellation of symptoms that is new and has not been sufficiently researched in the relevant literature. However, the mere presence of a particular cluster of symptoms is insufficient to diagnose a mental disorder. In order for a diagnosis to be rendered, the individual must also experience significant psychological distress as well as impairment in one or more areas of functioning such as academics, employment, or interpersonal relationships. In the mental health field, only those syndromes that meet the threshold for a mental disorder and have been sufficiently researched are included as diagnoses in DSM-IV, the seminal guide to psychiatric diagnosis. American Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) 7 (4th ed. 1994). In common parlance, however, an established diagnosis is sometimes still referred to as a syndrome, and this misnomer can be confusing.

[FN2]. See Ned Miltenberg, Out of the Fire and Into the Frying Pan or Back to the Future, Trial, Mar. 2001, at 19; Phyllis T. Bookspan & Maxine Kline, On Mirrors and Gavels: A Chronicle of How Menopause Was Used as a Legal Defense Against Women, 32 Ind. L. Rev. 1267, 1270-79 (1999) (recording the use of menopause from the early 1900s through the 1980s as a defense against female plaintiffs in civil actions, often in an attempt to reduce damage awards by claiming plaintiff's injuries were due to menopause); Neil J. Vidmar & Regina A. Schuller, Juries and Expert Evidence: Social Framework Testimony, 52 Law & Contemp. Probs. 133, 148-55 (discussing the trial effects of a Battered Woman Syndrome claim); Laurens Walker & John Monahan, Social Facts: Scientific Methodology as Legal Precedent, 76 Cal. L. Rev. 877, 880-85 (1988) (analyzing the effects of social science research on trials); see also Laurens Walker & John Monahan, Social Frameworks: A New Use of Social Science in Law, 73 Va. L. Rev. 559, 563-68 (1987) (noting "anomalous uses" of social science evidence in cases concerning battered women and "sexual victimization").

[FN3]. These various criminal defenses fall outside the scope of this Article. For a good review of various defense and prosecution strategies utilizing syndrome and other scientific evidence, see Joshua Dressler, Understanding Criminal Law 1995 (1998 reprint), and Robert J. Goodwin, Criminal and Scientific Evidence (1997).

[FN4]. 3 Christopher B. Mueller & Laird C. Kirkpatrick, Federal Evidence § 351 (2d ed.

2002).

[FN5]. R.P. Mosteller, Syndromes and Politics in Criminal Trials and Evidence Law, 46 Duke L.J. 461, 463 (1996).

[FN6]. Id. at 463-69.

[FN7]. See, e.g., Goodwin, supra note 3, at 454.

[FN8]. See, e.g., id. at 448-55.

[FN9]. See Bechtel v. State, 840 P.2d 1, 7 (Okla. Crim. App. 1992) (citing survey results that thirty-one states allowed expert testimony on Battered Woman Syndrome); L.E. Boeschen et al., Rape Trauma Experts in the Courtroom, 4 Psychol., Pub. Pol'y & L. 414, 428 (1998) (discussing the poor reliability and validity of Rape Trauma Syndrome); see also Mosteller, supra note 5, at 485-86 (discussing the effects of societal politics on the admission of syndrome evidence).

[FN10]. Daubert v. Merrell Dow Pharms., Inc. 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993).

[FN11]. Frye v. United States, 54 App. D.C. 46, 293 F. 1013 (D.C. Cir. 1923).

[FN12]. Daubert, 509 U.S. at 589-90; Gen. Elec. Co. v. Joiner, 522 U.S. 136, 118 S. Ct. 512, 139 L. Ed. 2d 508 (1997); Kumho Tire Co. v. Carmichael, 526 U.S. 137, 119 S. Ct. 1167, 143 L. Ed. 2d 238 (1999).

[FN13]. This Article uses the term "doctors" to refer to Ph.D. or Psy.D. doctors of psychology as well as M.D. doctors of medicine specializing in psychiatry, all of whom are licensed for independent practice in their jurisdictions.

[FN14]. 54 App. D.C. 46, 293 F. 1013 (D.C. Cir. 1923).

[FN15]. See, e.g., Edward J. Imwinkelried, Evaluating the Reliability of Nonscientific Expert Testimony: A Partial Answer to the Questions Left Unresolved by Kumho Tire Co. v. Carmichael, 52 Me. L. Rev. 19, 30-38 (2000); Daniel W. Shuman & Bruce D. Sales, The Impact of Daubert and Its Progeny on the Admissibility of Behavioral and Social Science Evidence, 5 Psych., Pub. Pol'y & L. 3, 6-8 (1999).

[FN16]. Frye, 293 F. at 1014.

[FN17]. Fed. R. Evid. 703.

[FN18]. Daubert, 509 U.S. at 585 (stating that certiorari was granted "in light of sharp divisions among the courts regarding the proper standard for the admission of expert testimony"). The split in the courts included United States v. Shorter, 257 U.S. App. D.C. 358, cert. denied, 484 U.S. 817 (1987) (applying Frye's general acceptance standard), and DeLuca v. Merrell Dow Pharms., Inc., 911 F.2d 941 (3d Cir. 1990) (rejecting the Frye general acceptance standard).

[FN19]. Daubert, 509 U.S. at 587 (emphasizing that Rule 401 provides a liberal standard of relevance).

[FN20]. Id. at 589.

[FN21]. Id.

[FN22]. Id. at 590.

[FN23]. Id. (quoting Webster's Third New International Dictionary 1252 (1986)).

[FN24]. Daubert, 509 U.S. at 592.

[FN25]. Id. at 587, 595.

[FN26]. Id. at 589. Previously, under Frye, the onus was placed upon the discipline or scientific community to establish the scientific validity of a theory or technique, and thereafter, all that was required by an offer of proof was that the theory or technique be generally accepted by the discipline. Frye, 293 F. at 1014.

[FN27]. Robert M. Galatzer-Levy & Eric Ostrov, From Empirical Findings to Custody Decisions, in The Scientific Basis of Child Custody Decisions 33 (Robert M. Galatzer-Levy & Louis Kraus eds., 1999).

[FN28]. Daubert, 509 U.S. at 594-95.

[FN29]. Id. at 592-93.

[FN30]. 522 U.S. 136, 146, 118 S. Ct. 512, 519, 139 L. Ed. 2d 508, 519 (1997).

[FN31]. Joiner, 522 U.S. at 141-42.

[FN32]. See id. at 142-43.

[FN33]. Id. at 146-47.

[FN34]. Id.

[FN35]. 526 U.S. 137, 141, 119 S. Ct. 1167, 1171, 143 L. Ed. 2d 238, 246 (1999).

[FN36]. Kumho Tire, 526 U.S. at 138, 139.

[FN37]. Id. (quoting Fed. R. Evid. 702).

[FN38]. Miltenberg, supra note 2, at 20.

[FN39]. See Mueller & Kirkpatrick, supra note 4. For further analysis of these three cases, see Margaret A. Berger, The Supreme Court's Trilogy on the Admissibility of Expert Testimony, in Reference Manual on Scientific Evidence (Fed. Jud. Center 2000); Edward J. Imwinkelried, The Taxonomy of Testimony Post Kumho: Refocusing on the Bottom Lines of Reliability and Necessity, 30 Cumb. L. Rev. 185 (2000); C. Robert Showalter, Essay, Distinguishing Science from Pseudo-Science in Psychiatry: Expert Testimony in the Post-Daubert Era, 2 Va. J. Soc. Pol'y & L. 211 (1995) (offering a doctor's perspective on the evidentiary issues).

[FN40]. Nat'l Institute of Mental Health, The Numbers Count, at http://www.nimh.nih.gov/publicat/numbers.cfm (last updated Jan. 1, 2001). This percentage represents approximately 44 million adults in the United States. Id.

[FN41]. DSM-IV, supra note 1, at 281-82.

[FN42]. Id. at 393, 341. Generalized Anxiety Disorder prevalence rates indicate that fifty-

five percent to two-thirds of those diagnosed are female. Id. at 434. On average, other specific anxiety disorders appear at a rate two to three times higher in females. For example, Panic Disorder with Agoraphobia is three times higher in females than in males. Id. at 399. Major Depressive Disorder is twice as prevalent in females as in males. Id. at 341.

[FN43]. Id. at 72.

[FN44]. Mueller & Kirkpatrick, supra note 4, at 3-4.

[FN45]. The DSM-IV was developed from the efforts of over 1000 mental health professionals and various professional organizations. Extensive empirical testing and review of diagnostic criteria was completed by thirteen work groups with contributions and assistance from numerous individuals and professional organizations. DSM-IV, supra note 1, at viii-xx.

[FN46]. Lenore E. Walker, Battered Women and Learned Helplessness, 2 Victimology: An Int'l J. 525 (1977-78) (hereinafter Learned Helplessness); Lenore E. Walker, The Battered Woman Syndrome 95-97 (1984) (hereinafter The Battered Woman Syndrome).

[FN47]. The Battered Woman Syndrome, supra note 46, at 100.

[FN48]. Learned Helplessness, supra note 46, at 531-32.

[FN49]. Marilyn McMahon, Battered Women and Bad Science: The Limited Validity and Utility of Battered Woman Syndrome, 6 Psychiatry, Psychol. & L. 23, 26 (1999).

[FN50]. The Battered Woman Syndrome, supra note 46, at 95-97.

[FN51]. Lori S. Rubenstein, What is Battered Woman's Syndrome?, Fam. L. Advisor (1999), at http://www.divorcenet.com/or/or"art02.html.

[FN52]. McMahon, supra note 49, at 29.

[FN53]. Walter J. Gleason, Mental Disorders in Battered Women: An Empirical Study, 8 Violence & Victims 53 (1993).

[FN54]. Id. at 55-56.

[FN55]. Id. at 78-79.

[FN56]. See id. at 53.

[FN57]. Knock v. Knock, 621 A.2d 267, 274, 224 Conn. 776, 782 (1993).

[FN58]. In science, operational definitions are critical to isolating and studying a phenomenon of interest. The operational definition needs to be highly specific and clearly communicated in the published literature so other scientists can also isolate and study the same phenomena. Absent an operational definition, a particular researcher's observation often is unclear.

[FN59]. Mary Ann Dutton, Critique of the "Battered Woman Syndrome" Model (Sept. 1996), at http://www.vaw.umn.edu/finaldocuments/Vawnet/bws.htm.

[FN60]. See Mosteller, supra note 5, at 463-64.

[FN61]. Bechtel v. State, 840 P.2d 1, 7 (Okla. Crim. App. 1992).

[FN62]. Erin M. Masson, Annotation, Admissibility of Expert or Opinion Evidence of Battered-Woman Syndrome on Issue of Self-Defense, 58 A.L.R.5th 749 (1998).

[FN63]. See Christopher Slobogin, The Admissibility of Behavioral Science Information in Criminal Trials: From Primitivism to Daubert to Voice, 5 Psychol., Pub. Pol'y. & L. 100, 106-07 (1999) (offering an excellent discussion of issues surrounding admissibility of behavioral science information in criminal trials since Daubert).

[FN64]. Bonner v. State, 740 So. 2d 439, 442 (Ala. Crim. App. 1998), cert. denied, (Ala. July 16, 1999).

[FN65]. Bonner, 740 So. 2d at 440 (emphasis added) (quoting Rogers v. State, 616 So. 2d 1098, 1100 (Fla. Dist. Ct. App. 1993)).

[FN66]. Hill v. State, 507 So. 2d 554, 555 (Ala. Crim. App. 1986) (stating BWS lacks scientific validity and reliability).

[FN67]. State v. Niemeyer, 740 A.2d 416, 420, 55 Conn. App. 447, 453 (1999), rev'd on other grounds, 782 A.2d 658 (2001).

[FN68]. State v. Carter, 762 So. 2d 662, 677-78 (La. Ct. App. 2000). However, the appeals court held the trial court correctly allowed the expert to give the definition of a battered woman, and that the defendant's history was consistent with that of a battered woman. Id.

[FN69]. 466 So. 2d 660, 664 (La. Ct. App. 1985) (noting that the testimony would be inadmissible due to lack of notice).

[FN70]. Necaise, 466 So. 2d at 665.

[FN71]. See, e.g., Adams v. State, 534 S.E.2d 817, 820 (Ga. Ct. App. 2000); Thigpen v. State, 546 S.E.2d 60, 62 (Ga. Ct. App. 2001) (holding BWS inadmissible because the evidence did not support a history of chronic battering or "psychological paralysis that is the hallmark of the battered woman syndrome").

[FN72]. 604 So. 2d 243, 246-47 (Miss. 1992).

[FN73]. Lentz, 604 So. 2d at 245-47.

[FN74]. Id. at 247.

[FN75]. 627 P.2d 1374, 1377 (Wyo. 1981).

[FN76]. Buhrle, 627 P.2d at 1377.

[FN77]. Id. at 1378.

[FN78]. See Callie M. Rennison, Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000, in Bureau of Justice Statistics: Selected Findings 1, 2 (NCJ 194530) (2002).

[FN79]. Id.

[FN80]. Boeschen et al., supra note 9, at 416, 426 (1998) (stating that "RTS is a phrase

no longer used in the clinical setting and thus should no longer be used by a mental health expert").

[FN81]. Ann W. Burgess & Lynda L. Holmstrom, Rape Trauma Syndrome, 131 Am. J. Psychiatry 981, 981 (1974) (analyzing the results of interviews with ninety-two adult women admitted to a city emergency room with presenting complaint of having been raped).

[FN82]. Id.

[FN83]. Id.

[FN84]. Id.

[FN85]. See generally id.

[FN86]. Id.

[FN87]. Id.

[FN88]. Karen S. Calhoun & Patricia A. Resick, Clinical Handbook of Psychological Disorders 48, 54-58 (David H. Barlow ed., 2d ed. 1993).

[FN89]. Id.

[FN90]. Elizabeth Meadows & Edna B. Foa, Intrusion, Arousal, and Avoidance: Sexual Trauma Survivors, in Cognitive-Behavioral Therapies for Trauma 100-01 (Victoria M. Follette et al. eds., 1998) (giving a description of variety in clinical presentations and psychological symptoms in sexual assault victims).

[FN91]. Boeschen et al., supra note 9, at 426.

[FN92]. 602 N.E.2d 826, 831, 151 Ill. 2d 298, 308, 176 Ill. Dec. 880, 885 (1992) ("(E)vidence of rape trauma syndrome is substantive evidence that a sexual assault occurred. By showing that a complainant suffers from psychological symptoms common to most victims of sexual assault, this evidence tends to support the proposition that the complainant was also the victim of a sexual assault.").

[FN93]. Slobogin, supra note 63, at 106.

[FN94]. 647 P.2d 1292, 1299, 231 Kan. 645, 654 (1982).

[FN95]. Marks, 647 P.2d at 1300.

[FN96]. 730 P.2d 698, 701, 46 Wash. App. 259, 263 (1987).

[FN97]. Black, 730 P.2d at 700.

[FN98]. Id.

[FN99]. Id.

[FN100]. Id. at 701 (stating that the trial court abused its discretion when it admitted RTS testimony).

[FN101]. 663 S.W.2d 235, 240 (Mo. 1984).

[FN102]. 681 P.2d 291, 301, 36 Cal. 3d 236, 251, 203 Cal. Rptr. 450, 460 (1984) (stating that "expert testimony that a complaining witness suffers from rape trauma syndrome is not admissible to prove that the witness was raped").

[FN103]. Bledsoe, 681 P.2d at 300.

[FN104]. See Mueller & Kirkpatrick, supra note 4.

[FN105]. DSM-IV, supra note 1, at 386.

[FN106]. Id. The term "postpartum depression" is used throughout this Article because it is the term used, albeit incorrectly, in the vernacular.

[FN107]. Ian H. Gotlib, Post-Partum Depression, in Behavioral Medicine and Women: A Comprehensive Handbook 490 (Elaine A. Bleckman & Kelly D. Brownell eds., 1998).

[FN108]. Id. at 489.

[FN109]. DSM-IV, supra note 1, at 386.

[FN110]. Gotlib, supra note 107, at 490.

[FN111]. DSM-IV, supra note 1, at 386.

[FN112]. Id.

[FN113]. Velma Dobson & Bruce Sales, The Science of Infanticide and Mental Illness, 6 Psychol. Pub. Pol'y & L. 1098, 1106 (2000) (Auditory hallucinations are sometime referred to as "voices," and voices that command a person to perform an act are referred to as "command hallucinations.").

[FN114]. DSM-IV, supra note 1, at 386.

[FN115]. Dobson & Sales, supra note 113, at 1107.

[FN116]. Id. It should be noted that any of the mood disorders such as major depression, mania, or a mixed presentation of depression and mania, may be exacerbated by childbirth. See id.

[FN117]. Id.

[FN118]. 271 Cal. Rptr. 868, 869, 235 Cal. App. 3d 1884, 1899, review granted & opinion superseded by 798 P.2d 1212 (1990), vacated on other grounds, 824 P.2d 568 (Cal. 1992). This homicide occurred approximately one month after the birth of her son.

[FN119]. Massip, 271 Cal. Rptr. at 869.

[FN120]. Id.

[FN121]. Id.

[FN122]. Yates Sentenced to Life in Prison, CNN.com (Mar. 15, 2002) at http://www.cnn.com/2002/LAW/03/15/yates.sentence/index.html; see also Prosecution Psychiatrist Says Yates Was Sane, CNN.com (Mar. 8, 2002), at http://www.cnn.com/2002/LAW/03/08/yates.trial (psychiatrist stated that Yates knew

what she was doing wrong).

[FN123]. See Connie Huang, It's a Hormonal Thing: Premenstrual Syndrome and Postpartum Psychosis as Criminal Defenses, 11 S. Cal. Rev. L. & Women's Stud. 345 (2002) (suggesting Postpartum Psychosis may indeed have a role to play as grounds for insanity, and PMS may have a role to play in mitigation); Nicole R. Grose, Premenstrual Dysphoric Disorder as a Mitigating Factor in Sentencing: Following the Lead of English Criminal Courts, 33 Val. U. L. Rev. 201 (1998).

[FN124]. DSM-IV, supra note 1, at 715.

[FN125]. Id. at 717.

[FN126]. Id.

[FN127]. Id. at 716.

[FN128]. Jessica M. McFarlane, Premenstrual Disorders, in Behavioral Medicine and Women: A Comprehensive Handbook 457, 458 (Elaine A. Blechman & Kelly D. Brownell eds., 1998).

[FN129]. Shirley A. Hartlage & Sarah Gehlart, Differentiating Premenstrual Dysphoric Disorder From Premenstrual Exacerbations of Other Disorders, 8 Clinical Psychol.: Sci. & Prac. 242, 242 (2001).

[FN130]. Id.

[FN131]. Maria L. N. Pires & Helena Maria Calil, Clinical Utility of the Premenstrual Assessment Form as an Instrument Auxiliary to the Diagnosis of Premenstrual Dysphoric Disorder, 94 Psychiatry Res. 211, 212 (2000).

[FN132]. See Joseph F. Mortola et al., Premenstrual Syndrome: Cyclic Symptoms in Women of Reproductive Age, 32 Psychiatric Annals 452, 452 (2002) (reporting that "(m)ore than 150 symptoms have been attributed to PMS"); Meir Steiner, Premenstrual Syndrome and Premenstrual Dysphoric Disorder: Guidelines for Management, 25 J. Psychiatry & Neuroscience 459, 459 (2000).

[FN133]. See generally DSM-IV, supra note 1, at 717.

[FN134]. People v. Santos, No. IK046229 (N.Y. Crim. Ct. Nov. 3, 1982).

[FN135]. See Alan M. Dershowitz, The Abuse Excuse and Other Cop-Outs, Sob Stories, and Evasions of Responsibility 53-55 (1994); DeNeen L. Brown, PMS Defense Successful in Virginia Drunken Driving Case, Wash. Post, June 7, 1991, at A1.

[FN136]. Donald Meichenbaum, A Clinical Handbook/Practical Therapist Manual For Assessing and Treating Adults with Post-Traumatic Stress Disorder (PTSD) 34, 34-40 (1994); Mary Ann Dutton & Lisa A. Goodman, Posttraumatic Stress Disorder Among Battered Women: Analysis of Legal Implications, 12 Behav. Sci. & L. 215, 215 (1994).

[FN137]. DSM-IV, supra note 1, at 424.

[FN138]. Id.

[FN139]. Id. at 428-29.

[FN140]. Id.

[FN141]. Boeschen et al., supra note 9, at 423.

[FN142]. Lenore Walker, Terrifying Love: Why Battered Women Kill and How Society Responds 48 (1989).

[FN143]. The "polythetic" approach to DSM-IV diagnoses allows clinicians to base diagnoses on a cut-off number of criteria from a longer list of commonly appearing signs and symptoms. As a consequence, individuals receiving the same diagnosis may not display the exact same subset of symptoms.

[FN144]. Dutton, supra note 59, at subsection 5. "The term 'battered woman syndrome' creates an image of pathology." Id.

[FN145]. DSM-IV, supra note 1, at xxii.

[FN146]. Id. at 13-24.

[FN147]. Id. at 14.

[FN148]. Maxmen & Ward, supra note 1, at 45-48; see generally Stoudemire, supra note 1.

[FN149]. See Stoudemire, supra note 1, at 15-22.

[FN150]. The typical mental status examination covers the major areas of physical appearance, speech, mood and affect, thought and language, perceptions, cognitive function, and insight and judgment. Rarely, a physical examination may be required and sometimes laboratory studies may be ordered. See, e.g., Robert W. Baker & Paula T. Trzepacz, Mental Status Examination, in Psychologists' Desk Reference 6-11 (Gerald P. Koocher et al. eds., 1998).

[FN151]. DSM-IV, supra note 1, at xxvii.

[FN152]. See Gary B. Melton et al., Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers 235 (2d ed. 1997) (discussing the importance of collateral sources of information in forensic evaluations).

[FN153]. Calhoun & Resick, supra note 88, at 54-58.

[FN154]. See generally R.L. Spitzer et al., Structured Clinical Interview for the DSM-III-R: Non-Patient Version (1987).

[FN155]. M.B. First et al., Structured Clinical Interview for the DSM-IV Axis I Disorders, Doctor Version (1997). The Diagnostic Interview Schedule is another popular structured interview tool. See L.N. Robins et al., National Institute of Mental Health Diagnostic Interview Schedule: Its History, Characteristics, and Validity, 38 Archives Gen. Psychiatry 381 (1981).

[FN156]. Mardi Horowitz et al., Impact of Events Scale: A Measure of Subjective Stress, 41 Psychosomatic Med. 209, 209 (1979).

[FN157]. D.G. Kilpatrick, Rape Aftermath Symptom Test, in Dictionary of Behavioral Assessment Techniques 366 (M. Hersen & A. S. Bellack eds., 1988).

[FN158]. Edna B. Foa et al., Reliability and Validity of a Brief Instrument for Assessing Post-Traumatic Stress Disorder, 4 J. Traumatic Stress 459, 462 (1991).

[FN159]. Mary Ann Dutton, Empowering and Healing the Battered Woman: A Model for Assessment and Intervention 156-64 (1992).

[FN160]. Richard M. Tolman, The Validation of the Psychological Maltreatment of Women Inventory, in Psychological Abuse in Violent Domestic Relations 47 (K. Daniel O'Leary & Roland D. Maiuro eds., 2001).

[FN161]. James N. Butcher et al., MMPI-2: Manual for Administration and Scoring (1989).

[FN162]. Melton et al., supra note 152, at 54.

[FN163]. Id.

[FN164]. Id.

[FN165]. See, e.g., Richard Rogers et al., Structured Interview of Reported Symptoms (SIRS) (1992); Tom N. Tombaugh, Test of Memory Malingering (TOMM) (1996).

[FN166]. Richard Rogers, Current Status of Clinical Methods, in Clinical Assessment of Malingering and Deception 382 (Richard Rogers ed., 1997).

[FN167]. See generally Barbara Bolan et al., A Comparison of Three Tests to Detect Feigned Amnesia: The Effects of Feedback and the Measurement of Response Latency, 24 J. Clinical & Experimental Neuropsychology 154 (2002); Michaela C. Heinze & Arnold D. Purisch, Beneath the Mask: Use of Psychological Tests to Detect and Subtype Malingering in Criminal Defendants, 1 J. Forensic Psychol. Prac. 23 (2001); Laura M. Rees et al., Depression and the Test of Memory Malingering, 16 Archives Clinical Neuropsychology 501 (2001); Richard Rogers et al., The Detection of Feigned Mental Disorders on Specific Competency Measures, 14 Psychol. Assessment 177 (2002).

[FN168]. Melton et al., supra note 152, at 17-19 (discussing which mental health professionals should be expert witnesses).

[FN169]. Id. at 18-19.

[FN170]. Id. at 103 (stating that the goals of quality and ethics mandate "intensive legally and psychologically sophisticated training in forensic issues").

[FN171]. Id. at 50.

[FN172]. See Anasseril E. Daniel & Phillip W. Harris, Female Offenders Referred for Pre-Trial Psychiatric Evaluation, 9 Bull. Am. Acad. Psychiatry & L. 40, 44 (1981) (finding a concordance rate of 88% with 66 female criminal defendants); Kenneth K. Fukunaga et al., Insanity Plea: Interexaminer Agreement and Concordance of Psychiatric Opinion and Court Verdict, 5 L. & Hum. Behav. 325, 328 (1981) (finding a concordance rate of 93% with 315 criminal defendants); Richard Rogers et al., Legal Outcome and Clinical Findings: A Study of Insanity Evaluations, 14 Bull. Am. Acad. Psychiatry & L. 75, 78 (1984) (finding a concordance rate of 88% with 104 criminal defendants).

[FN173]. Melton et al., supra note 152, at 231 (comparing, from an unpublished 1982 study, a concordance rate of 93% in forensically trained doctors with a rate of 7% in doctors without forensic training).

[FN174]. Anecdotally, it is the first author's experience-based upon fifteen years of proffering expert testimony in state and federal courts-that doctors who lack, or have very little, forensic training are often at a great disadvantage in the legal arena and frequently offer testimony that is irrelevant to the issues before the court.

[FN175]. See Melton et al., supra note 152, at 17-19; see also 18 U.S.C. §§ 4241, 4243 (2000) (specifying that only psychologists and psychiatrists are qualified to conduct competency-to-stand-trial evaluations and insanity evaluations for the courts). Additionally, such professionals should demonstrate formal, didactic training in forensic evaluation and knowledge of the psycho-legal issues involved, the law for their jurisdiction, and the pitfalls of the helping ethic in forensic contexts.

[FN176]. Ralph Reisner et al., Law and the Mental Health System: Civil and Criminal Aspects 476 (3d ed. 1999) (finding that, in a court context, the training and experience related to specific issues at hand may be more important than an expert's degree).

[FN177]. Melton et al., supra note 152, at 17-19.

[FN178]. Sally Melnick, Aura of Reliability: An Argument in Favor of Daubert, 1 Fla. Coastal L.J. 489, 490 (2000) (stating that "Daubert is the better standard for determining admissibility of expert, scientific evidence").

[FN179]. Id. at 510.

[FN180]. Id.

[FN181]. Id.

[FN182]. Daubert v. Merrell Dow Pharms., Inc., 509 U.S. 579, 593, 113 S. Ct. 2786, 2796, 125 L. Ed. 2d 469, 483 (1993), remanded to 43 F.3d 1311 (9th Cir.), cert. denied, 516 U.S. 869 (1995).

[FN183]. Daubert, 509 U.S. at 593.

[FN184]. Id.

[FN185]. Id. at 593-94.

[FN186]. Id.

[FN187]. Id. at 594.

[FN188]. Id. This is the old Frye standard.

[FN189]. Id. at 591 (commenting on the fit of the proffered expert testimony and the facts in the case).

[FN190]. Gen. Elec. Co. v. Joiner, 522 U.S. 136, 146-47, 118 S. Ct. 512, 519, 139 L. Ed. 2d 508, 519 (1997), rev'd, 78 F.3d 524 (11th Cir. 1996), cert. granted, 520 U.S. 1114, rev'd, 522 U.S. 136 (1997).

[FN191]. Daubert, 509 U.S. at 592-93.

[FN192]. Joiner, 522 U.S. at 146-47.

[FN193]. Daubert, 509 U.S. at 592-93.

[FN194]. Fed. R. Evid. 403; Daubert, 509 U.S. at 595.

[FN195]. Fed. R. Evid. 403; Daubert, 509 U.S. at 595.

[FN196]. DSM-IV, supra note 1, at 716.

[FN197]. See Mosteller, supra note 5, at 463-64 (1996) (arguing that syndromes per se cannot identify or diagnose the cause of criminal conduct or determine if prior conduct, e.g., battering or rape, actually occurred).
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