Guest Editorial

The Perils of Dual Political Madness: the Lindsay Clancy Case

Jane M. Orient, M.D.

Introduction

Three decades ago, social critic Martin L. Gross published *The End of Sanity: Social and Cultural Madness in America* (1997).[1] He argued that a new establishment of left-aligned "experts" was replacing traditional American norms of *individual responsibility, fairness, and common sense* with senseless leftist doctrines. He predicted that as a result, a previously sane American society would start slouching toward madness. Ultimately, the end of sanity would blind Americans to the existential threats such as moral decay, opening the borders to hostile aliens, rejection of merit-based systems, etc.

Most of Gross's dire predictions were accurate. The calamities he foresaw are familiar, widely discussed, and of grave concern. Yet, what he overlooked is even more important. He failed to recognize that ideological insanity is highly contagious and can infect even the sanest minds. Though a brilliant visionary, Gross did not anticipate that in response to the insane leftward cultural shifts, some perfectly sane right-wingers would abandon their traditional skepticism. This was not a descent of a sane person into total madness. It was a targeted infection. Under immense political and cultural pressure, they started to harbor certain irrational ideas, while remaining reasonable otherwise.

The American right-wing reaction to the pervasive leftist follies was not a uniform effort to restore sanity. Prudent calls to stop the madness coexisted with deployments of some right-wing campaigns that were as unmoored as any leftist craze. For instance, when the Left politicized science by capturing academia, some on the Right decided to blindly dismiss any usefulness of science. Instead of working to reclaim universities, they prefer to demolish them. They dismiss academia and science as "unnecessary and wasteful," ignoring the past lessons. Shockingly, some otherwise sane people on the Right can no longer differentiate perverted science that endangers society from objective science that strengthens it. Historically, arrogant disdain towards valuable scientists is not a new phenomenon—as Figure 1 shows.[2,3] However, it always backfired, and it was never a policy of the American right-wing. The U.S. sheltered persecuted scientists, and in exchange, they enriched our nation. This was a quintessential sane approach. Yet, it has been irrationally rejected by the people who remain logical and correct about other things.

Why Rational People Accept Irrationality

The rise of the purely insane Woke ideology showed that leftist efforts to become the antithesis of common sense had succeeded. Unfortunately, growing segments of the right-wing started to answer left-wing absurdities with sensational, poorly evidenced assertions, rather than with efforts to restore empirical restraint. Strikingly, many rational right-wingers who had accurately identified all the left-wing insanities were unable to criticize the similarly irrational theories circulating in right-wing circles.[4] Instead, they started to embrace them, while remaining fully rational about virtually everything else. It is tempting to dismiss those tendencies as isolated harmless eccentricities. However, the chronic embrace of pathological reasoning is profoundly dangerous, both to the individual mind and to the civic fabric of society. The devastating social consequences of normalizing insanity by the Left should serve as a warning for the right-wing to not make similar errors.



Figure 1. Death of Archimedes by Thomas Degeorge (1815). During the 212-B.C. fall of Syracuse, Roman General Marcellus ordered his troops to summon Archimedes to be honored for his mathematical brilliance. Tragically, a brute, incompetent soldier murdered the preoccupied mathematician when Archimedes dismissed him saying: *"Noli turbare circulos meos!" ("Do not disturb my circles!")*. An early historical precedent of trying to make something great that kills it instead [Wikimedia Commons].[2,3]

To prevent the proliferation of this dangerous tendency one must first understand its causes. Under the right conditions, even the most rational among us can succumb to a localized, partial insanity. No one is entirely immune, and because of its compartmentalized nature, it is notoriously difficult to self-diagnose. Moreover, collective denial and tribal solidarity keep ideas that are popular among right-wingers from being correctly identified as wrong and harmful. This affliction arose from prolonged pressures and maladaptive coping mechanisms formed by the Right in response to a constant barrage of irrational and despotic leftist policies. Gross could not have foreseen the uncanny developments that followed his book. Those include the extreme ideological polarization, the politicization of every aspect of life, and a long era of power asymmetry favoring the Left. Those initial insults were augmented by the COVID-19 pandemic with its follies, the collapse of institutional credibility, and the enthusiastic but often counter-productive efforts of recently elected populist right-leaning politicians to undo leftist supremacy. The epistemological

crisis produced by the rise of social media-based echo chambers has completed the vicious circle.

Another issue contributing to confusion about the right-wing's attitudes towards irrationality is terminology. Not every movement that self-identifies as "right-wing" can be classified as such. The MAGA ("Make America Great Again") coalition initially emerged as a right-wing response to the anti-American leftist ideology. However, with time it has changed to the extent that many question whether it is still synonymous with "right-wing." Several clearly right-wing former supporters of MAGA claim that they did not leave that movement, but that it has left them. Currently MAGA frequently departs from the evidentiary rigor and institutional skepticism characteristic of the classical right-wing world view. The movement tends to abandon traditional right-wing pragmatism by endorsing unsubstantiated claims, appealing to dubious authorities without consulting primary evidence. The part known as MAHA ("Make America Healthy Again") is amplifying epidemiologically minor risks—such as emotional but irrational focus on food colorants. This modus operandi is reminiscent of passionate but unjustified leftist concerns about the alleged dangers of plastic straws. Furthermore, its uncritical acceptance of shifting executive narratives on foreign military action directly contradicts historical right-wing skepticism of state power and state narratives. Moreover, certain MAGA politicians imitate the Left's tactics of guilt by association. They demand to abandon former European allies because the current European governments push Woke agendas. They ignore the large anti-Woke right-wing movements in Europe. In the past, the U.S. provided substantial support to Soviet dissidents that led to the fall of our major enemy. Just as political scholars distinguish neoconservatism from traditional right-wing ideology, the analytic task is to ***measure self-description against the actual content of the expressed positions***.

The classical right-wing presents its projects as "a defense of individual liberty and the American constitutional order." Its methods involve common sense and meticulous verification of claims. Groups that self-identify as "the Right" while deviating substantially from these principles are either confused (or disingenuous) about their own identity or they are unwittingly adopting positions that can be described as heretical.

The Right's reluctance to confront such heresies is understandable. The Woke Cult has been injured, but it is not dead. In the presence of a still strong enemy, it is unwise to alienate good friends by brutally criticizing their wrong but sincere beliefs. However, this status quo cannot be ignored any longer. Many new solutions proposed by the real or self-identified Right rely on replacing leftist follies with the right-wing version of the madness. This is extremely dangerous since **two insanities will not restore sanity**. Instead, they will create a phenomenon of self-destructive **dual political insanity**. A civilization under its spell oscillates between two poles of psychosis. It merely changes the theme of its hallucinations. A society that replaces sanity with cycles of ideology-driven delusions is bound to perish.

To avert the impending disaster, the crisis of partial irrationality must be resolved wisely. This duty falls to those who still retain their capacity for proportion, especially to right-wing-aligned physicians, scientists, and honest political leaders. They must address this social contagion with both empathy and uncompromising candor. To do so they should possess a deep understanding of the nature of dual political madness.

Remaining neutral on the verdict, this editorial uses the partisan furor over the court case of Lindsay Clancy to illustrate the perils of dual political madness and to provide a blueprint for taming that dangerous trend. While thematically different from most popular right-wing irrationalities, the case reveals the pathological mechanisms that lead otherwise rational minds astray.

Background of the Case: Filicide

In January 2023 a Massachusetts labor-and-delivery nurse, Lindsay Clancy, strangled her three minor children (Cora, five; Dawson, three; and Callan, eight months) with exercise bands in the basement of the family home.[5,6] During that time her husband was on an errand. She then jumped from a second-story window and survived with paraplegia. She has not disputed those facts. At trial in the summer of 2026, her counsel argued that postpartum psychosis, bipolar vulnerability, and a cascade of poorly coordinated psychiatric medications rendered her not criminally responsible. Prosecutors answered that treating clinicians had not observed psychosis, that the sequence of events showed planning, and that the law does not dissolve responsibility merely because a mother was depressed, anxious, or overmedicated.[6] A jury deadlocked. A mistrial was declared in early Sep 2026.[7] The charges remain at the time of writing this editorial.

None of that, standing alone, would require a guest editorial in a medical journal. Filicide is an ancient crime that has existed since time immemorial.[8] Annually, approximately 500 filicide arrests occur in the U.S., representing roughly 2.5% of all national homicide arrests.[9] Postpartum psychiatric disorders while controversial are well-documented in medical literature.[10] Insanity defenses are a common part of the court proceedings; they involve defense attorneys and forensic psychiatry experts.[11] Yet, what makes this case crucial for understanding dual political insanity is the unprecedented public fallout. History is full of notorious filicide cases, yet none generated such intense political acrimony, because none took place at the height of ongoing dual political insanity.

The national discourse surrounding the trial of Lindsay Clancy quickly transcended the question of crime and punishment posed so provocatively by Fyodor Dostoyevsky.[12] It became a stark cultural flashpoint reflecting America's severe political polarization and, above all, illustrating how easily the extreme factions on both sides can descend into madness.

The moderate voices of reason existed on both sides of the debate. However, they were drowned out by the rhetoric from a small number of highly vocal and extremely popular partisan pundits. Lacking formal expertise, these commentators still felt entitled to issue "authoritative" opinions simply because of their large internet followings and similar types of vainglorious notoriety. More alarmingly, some well-credentialed experts lent their authority to express irrational but politically favored conclusions. They have seemingly been blinded by ideological bias or entirely captured by partisan agendas.

The Left-Wing Perspective: Systemic Failure, Privilege, and Concocted Excuses

The Clancy case has been framed as an indictment of the "failing" maternal mental health system, simultaneously using it to highlight the racial disparities in criminal justice alleged by social justice warriors. A segment of the left-wing demographic went as far as misinterpreting the medical term ***"altruistic suicide,"*** twisting it into a blanket excuse for Lindsay Clancy's actions.[13]

A Broken Health System: Left-wing-aligned voices point to Clancy as a *victim* of a severely inadequate medical system rather than a *perpetrator*. They argue that postpartum psychosis is a

medical emergency that is under-researched, misunderstood, and improperly treated in the U.S.[6] From this viewpoint, the tragedy was preventable if Clancy had received the appropriate level of psychiatric care.[6]

White Privilege and Intersectionality: While mainstream leftists united to portray Clancy as a victim of a broken maternal health system, the most radical factions criticized their own comrades for granting Clancy "white privilege." Operating through the lens of intersectionality—which argues that overlapping social identities compound to create more severe degrees of victimhood—they accused white supporters of Clancy of a double standard. White liberal women immediately championed Clancy yet offered no such empathy to Black women in similar circumstances. There was no such outcry for Latarsha Sanders, a Black mother who was sentenced to two life terms and condemned as a "monster" after her mental illness was entirely excluded from evidence by the court.[14]

The "Pink Mob": The large group of women dressed in pink who gathered outside the courthouse to support Clancy has been praised as "stunning and brave" feminist warriors.[15] They framed the children as victims of institutional failure rather than of a mother's choices. Some online communities went further, recasting the husband as the real villain through neglect or worse.[16,17] Other leftists criticized this "Pink Liturgy" as an expression of "racial solidarity" that would never materialize for "a woman of color."[18]

Altruistic Filicide: Altruistic filicide is a recognized term within forensic psychiatry, but it is not a clinical diagnosis listed in the DSM.[19] Coined by P. Resnick in 1969, it belongs to a six-category typology of filicide based on motive, which also includes acutely psychotic, unwanted child, accidental, spouse revenge, and neonaticide.[20,21] It describes a parent killing a child under the belief that it is in the child's best interest—such as sparing them from wartime atrocities. While this framework helps psychiatrists categorize motives, altruistic filicide is not a mental illness, nor does it serve as a total legal/moral excuse for the act. While Clancy's prosecutors used this term to demonstrate calculated intent rather than psychosis, some left-wing commentators twisted the concept to completely absolve Clancy of murder.[13]

The Essence of Madness: The claim that only the Right believes conspiracy theories does not survive this case. The obviously insane conspiracy theory that Lindsay Clancy's husband was the killer and had framed her spread widely among left-leaning audiences. So did a zealous campaign, cast in social-justice terms, to defend a woman who had killed her own children. Both are symptoms of the obvious loss of sanity.

The Right-Wing Perspective: Accountability, Skepticism, Absolutism, Disregard for Science

Numerous right-wing-aligned commenters tend to view the case reasonably, through the lenses of personal responsibility, justice for the victims, and skepticism toward leftist excuses for horrific crimes. However, as noted earlier, such sensible opinions are buried by the avalanche of absolutist, bombastic, and proudly unscientific proclamations issued by notorious right-wing influencers.

Demand for Accountability: Some right-wing pundits criticized logically the progressive defense of Clancy, emphasizing that regardless of mental health struggles, there must be accountability for the murder of children.[22] They argued that the focus should remain on the victims—Cora, Dawson, and Callan—rather than on the perpetrator or on some esoteric and unrelated ideas of "social justice."[23]

Skepticism of the Defense: Unlike the Left, many right-wingers agree with prosecutors' arguments that Clancy's actions (such as sending her husband on errands before the killings) showed deliberate planning and control, rather than a total psychotic state.[24] Some right-wing commenters expressed serious doubt specifically about the "command hallucinations" defense used by Clancy's team.[25]

Critique of Liberal Hypocrisy: The Right's accusation of "performative empathy" in the Clancy case is certainly justified. Left-wing supporters of Clancy centered the narrative on the killer and themselves, claiming they were "one step away" from committing the same crime. This conflated ordinary maternal exhaustion with a rare psychiatric crisis, effectively erasing the three murdered children to spotlight the sympathizers' own medical grievances. This empathy is blatantly gender-selective: Mentally ill fathers who commit filicide do not receive rallies, million-dollar GoFundMe funds, or ideological defense. True compassion acknowledges tragedy without turning a killer into a relatable symbol. Empathy that ignores the victims to serve a political narrative about gender and medicine is not compassion. It is a performance of tribal loyalty.

Unnuanced Approach: The defining feature of the loudest heretical right-wing "shock-jocks" is their complete lack of nuance regarding this tragedy.[26] Their pontificating commentaries are aggressively dogmatic. They adhere obsessively to absolutist principles, leaving no room for mitigating factors or extenuating circumstances. Ultimately, they are a Dark Mirror reflection of the left-wing provocateurs: where the extreme Left sees only excuses, these right-wing voices refuse to see any context and reject any empathy. There is profound irony here. While such right-wing rabble-rousers claim to be Christians, their merciless approach is the absolute antithesis of Christian philosophy.

Disregard for Science: As previously noted, an exaggerated backlash against the Left's capture of academia has led some right-wing influencers to develop an irrational aversion to science itself. Unable to distinguish between maliciously politicized science and indispensable objective science, this vocal minority showcased their scientific illiteracy during the Clancy debate. Commentators eager to "own the liberals" made audacious assertions contradicting indisputable scientific facts. With the unearned overconfidence typical of the Dunning-Kruger effect, some arrogantly dismissed the existence of postpartum depression and psychosis, framing these well-documented diagnoses as left-wing hoaxes akin to transgenderism. Fortunately, prominent conservative personalities took these commentators to task for their ludicrous denialism. Nonetheless, this kind of irresponsible rhetoric has inflicted lasting damage on the Right's credibility.

The Essence of Madness: It is painful for sensible conservatives to admit that madness has taken hold of a significant part of their community. It is equally disheartening to realize that the Right can no longer universally claim the mantle of "common sense." Yet this is our irrefutable reality. Succumbing to rigid dogmatism, claiming Christian values while practicing their exact opposite, and failing to distinguish perverted science from real science are all symptoms of a profound political insanity. The sooner we abandon our denial about it, the sooner the healing can begin.

Lessons from Clancy Case Dispute

Like many critics of decadence, Gross assumed that the alternative to an illiberal left-wing order would be a return to old

common-sense: individual responsibility, color-blind justice, and traditional American virtues. The partisan dispute over the Clancy case proves otherwise. Instead of a return to reason, dual political madness has emerged. Through a Dark-Mirror phenomenon, some on the Right have become a distorted reflection of the Left.

Nietzsche warned: *"He who fights with monsters might take care lest he thereby become a monster. And if you gaze for long into an abyss, the abyss gazes also into you."* Clearly, the left-wing abyss has gazed back into the Right. Segments of the American conservative movement—especially its online, performative factions—are, like their opponents, acting as if institutions are enemy territory, every tragedy is a weapon, cruelty is a mark of seriousness, and nuance is treason.

Where the Left dissolves personal agency into "systemic forces," this new Right dissolves the patient into the crime. The Left cannot mourn a dead child without blaming the patriarchy; the Right cannot look at a possibly psychotic mother without asking which feminist to punish. Both refuse the burden of dispassionate analysis: to see that the woman may be ill, but the children are certainly murdered—and to let both facts stand—without concocting a false, cause-and-effect relationship to explain it all away.

The dual political insanity dominating the partisan quarrel over the Clancy case has generated several bizarre sociocultural phenomena:

- **The Inversion of Feminism:** By relying so heavily on Clancy's emotional and biological state, her defenders inadvertently resurrect 19th-century patriarchal tropes—framing women as fragile creatures governed by reproductive biology rather than independent moral agents.
- **The Collapse of Shared Reality:** The most alarming aspect of this tragedy is how two sides can observe the exact same event but make entirely incompatible conclusions. For the Left, it is a story of systemic healthcare failure and racial bias; for the Right, it is a tale of decadent moral failing that demands swift and merciless punitive deterrence.
- **Race as the Undercurrent:** Ironically, both sides weaponize the tragedy to accuse the other side—and even their own comrades—of racism. Clancy confuses both sides by being white. The Left asserts collectively that the Right invokes "law and order" to disproportionately punish women of color. Leftist purists chastise liberal white women for disregarding intersectionality. The Right contends that the Left offers only conditional empathy centered on racial identities entirely divorced from objective reality and fairness.
- **Bifurcated Moral Anthropology:** Both extremes weaponize moral anthropology.[27] The Left's moral anthropology is centered only on the mother as a "systemic victim," not a killer—dismissing the suffering of the murdered children as collateral damage. Their chosen communal response is radical identification: *"I am a woman, I can be pregnant—therefore, I am Lindsay."* The Right's version of moral anthropology is centered on the children. Dismissing not only leftist unmitigated excuses but the very concept of potential mitigating factors and demanding a communal response of merciless retribution "unburdened" by due process.

The Official Modern Science of Postpartum Psychopathology

Neither side cared to ask the most essential questions: What are the scientifically demonstrated facts of peripartum psychopathology, what is obscured by ideological and commercial bias, and what is fundamentally beyond the reach of science?

Status of Modern Psychiatry

It is conventional knowledge among right-wing-aligned physicians and the public that major medical organizations dealing with psychiatric diagnoses and treatment have been compromised by left-wing ideology and commercial influence of the pharmaceutical industry. However, this compromise is neither universal nor absolute.

Certain areas of psychiatry that are of special interest for leftist ideologues and pharmaceutical executives have been deliberately altered, violating the principle of scientific objectivity. However, other parts of psychiatry have remained free of undue influences. Experienced academic psychiatrists can identify those biases easily, even though they cannot speak about them freely within academia that is still controlled by external forces. However, distinguishing objective recommendations from the those polluted by bias may be very difficult for the lay public and even for physicians who are not psychiatrists by training.

It is therefore equally unwise for nonspecialists to automatically consider all the official standards of psychiatric care as an "absolute truth" or to reject psychiatry altogether as a "total lie" motivated by ideology and commerce. Biases aside, one must keep in mind that science is also ever changing. Theories respected today may be rejected tomorrow. Information presented below is a simple summary of the current official position on perinatal psychopathologies, not its endorsement. It is always wise to seek the input of a trusted knowledgeable expert for a given case.

Confusing Spectrum of Peripartum Psychopathologies

Postpartum psychiatric disturbances span a wide spectrum along three poorly demarcated focal points: from **maternity blues** through **perinatal depression** to **postpartum psychosis**. The public and even a part of medical community are unaware that perinatal mental disorders are a continuum. Much is firmly established about their prevalence and risk stratification. Far less is settled about underlying biology, nosological boundaries, and long-term course. Management is susceptible to commercial and other biases and is frequently questioned by clinicians not affiliated with orthodoxy.

The confusion about those disorders is amplified by fragmentation of care. Psychiatrists manage these patients along with other specialists. Obstetricians provide direct perinatal care, and pediatricians are expected to recognize those disorders in their patients' mothers. Those three specialties sometimes use different diagnostic criteria.

The condition called **postpartum ("maternity") blues** does not meet DSM-5 criteria for a mood disorder and is not recognized as "a true" mental disorder.[28,29] It represents a transient state of heightened emotional reactivity (tearfulness, irritability, lability) affecting 50–80% of mothers, peaking 3–5 days after delivery, often coinciding with lactation onset, lasting days to weeks and resolving with supportive care.[28] Psychiatrists, obstetricians, and pediatricians all use this term, but the two latter groups sometimes miss signs of postpartum depression by mislabeling them as "just the blues."[30]

Perinatal (postpartum) depression, as defined by psychiatrists, is a major depressive episode (2 weeks or longer of depressed mood plus neurovegetative symptoms) occurring during pregnancy or after delivery. The DSM-5 "with peripartum onset" specifier replaced the older antenatal/postpartum distinction because about 50% of major depression identified as postpartum begins before delivery. The DSM-5 limits onset to within 4 weeks of delivery. Obstetricians, however, use the ACOG

criteria, which extend the window up to 12 months postpartum, reflecting ongoing psychosocial stressors of infant care.[31] Pediatricians follow AAP guidelines that frame "postpartum mood and psychotic illness" as a spectrum of distinct entities under the broader umbrella of perinatal depression, and emphasize early recognition in pediatric practice because the pediatrician has frequent contact with mothers during well-infant visits.[28]

Postpartum psychosis is a rare (estimated two per 1,000 deliveries) and serious disorder distinctly different from postpartum depression. It is a **psychiatric emergency** because of the risk of infanticide and an up to 70-fold increased risk of suicide.[28] It begins within the first 1–4 weeks with agitation, irritability, mood lability, delusions, and disorganized behavior. All perinatal specialists use similar diagnostic criteria; however, the AAP notes that although it is often conceptualized as being on a spectrum with perinatal depression, the preponderance of data implies it is an overt presentation of bipolar disorder.[28]

What Is Established but Still Prone to Bias or Confusion

The potential biases do not seem to interfere with the proven fact that the perinatal period is a time of substantially elevated risk for new-onset or relapsing psychiatric illness. The perinatal mental health conditions are now recognized as a leading cause of preventable maternal mortality.[32-34]

Perinatal depression that begins during pregnancy or within 12 months after delivery affects about 1 in 7 women (14%) in the U.S.[32] Among women who have it, depression began before pregnancy in about 27%, during pregnancy in about 33%, and after delivery in about 40%. Because so many cases start before birth, "perinatal" is more accurate term than "postpartum" depression.[32,35]

Estimated prevalence varies with setting and method. Postpartum depression affects about 10–15% of women worldwide, ranging from about 13% in high-income countries to as high as 19% in some low- and middle-income countries (LMICs).[36] Studies from LMICs that relied mostly on screening questionnaires report higher rates, about 1 in 4 (24.7%).[37] Screening tools overestimate depression compared with diagnostic interviews. When estimates count only interview-confirmed major depression, about 6–7% of women worldwide have it at any time during pregnancy or the postpartum year.[38]

In a Swedish national cohort, new diagnoses of most psychiatric disorders became less common during pregnancy, then returned toward pre-pregnancy levels after delivery.[39] There were two exceptions. New depression diagnoses were elevated at weeks 5–15 postpartum.[39] New psychosis diagnoses were six to seven times more common in the first 5 postpartum weeks than before pregnancy.[39]

Two-thirds of patients with perinatal depression have a comorbid condition, most often anxiety. Critically, up to one in five who screen positive for depression have bipolar rather than unipolar disorder. Since treating bipolar depression with antidepressant monotherapy can precipitate mania, mixed states, or psychosis, screening for bipolar disorder before starting pharmacotherapy is recommended, e.g., with the Mood Disorder Questionnaire (MDQ) and the 3-question Composite International Diagnostic Interview (CIDI).[32,40] ACOG and the USPSTF (United States Preventive Services Task Force) recommend universal screening at the initial prenatal visit, in the third trimester, and postpartum, using the Edinburgh Postnatal Depression Scale (EPDS) or PHQ-9 (Patient Health Questionnaire-9), with mandatory separate reviews of the self-harm item. These are screening, not diagnostic tools, and medical mimics (thyroid dysfunction, anemia, substance use) should be excluded.[32,34]

Official recommendations about the **management of perinatal depression** may be very susceptible to commercial biases. The recommendations including the generous use of selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are met with skepticism by physicians who do not operate within the official academic milieu. Current standards of care include the following: Psychotherapy (cognitive behavioral therapy, interpersonal therapy) is first line for mild illness. Officially recommended first-line pharmacotherapy is SSRIs. Sertraline is said to be preferred in lactation given minimal breast milk passage and officially endorsed safety data. SNRIs are considered as "a reasonable second-line choice." Most antidepressants are also designated as compatible with breastfeeding, and official observational data overall show no or low risk of major adverse pregnancy outcomes. Neurosteroids (brexanolone, zuranolone) are newer options; brexanolone (intravenous for inpatients) is being sunset commercially, while oral zuranolone (Zurzuvae) is FDA approved specifically for postpartum depression.[34,36,40-42]

Postpartum Psychosis is generally managed as a true emergency requiring inpatient (ideally mother-infant unit) admission, medical workup (thyroid, infection, and consideration of anti- N-methyl-D-aspartate (NMDAR) receptors encephalitis). The officially recommended "stepwise treatment" with benzodiazepines, antipsychotics, and lithium is not free of controversy. One large cohort reported a 98% remission rate, with lithium protective against relapses. High-dose lithium immediately postpartum has the strongest evidence for prevention in high-risk women. Prognosis is generally favorable, with most women returning to premorbid functioning.[31,43-46]

What Remains Uncertain

Postpartum psychosis is not a distinct DSM-5 diagnosis, and whether it should be classified as a discrete entity, a bipolar episode, or part of a psychotic disorder remains debated. It should be noted that even many academic scientists remain skeptical about the value of the recently revised DSM-5 manual.

The **clinical course** is difficult to predict. Not all affected women develop recurrent illness. One longitudinal study found that about two-thirds had no recurrent symptoms within four years, creating a genuine clinical dilemma about who needs long-term maintenance treatment.[43,44,46] Individual clinical risk factors each confer only small increases in risk. The impact of the treatment on clinical course remains controversial. The mechanisms of action and highly variable efficacy of existing drugs are often unclear, and treatment of postpartum psychosis rests largely on naturalistic cohorts and expert consensus rather than randomized controlled trials.[34,43,47] Despite the existence of effective treatments, more than 75% of those screening positive receive no treatment, reflecting systemic and patient barriers. There are few specialists, and patients fear stigma. Proposed solutions to remedy those issues include virtual care, task-sharing, and collaborative care.[34,41]

Etiologic factors implicated in postpartum psychiatric disorders (PPDs), comprising both postpartum depression and postpartum psychosis, include both psychosocial and biological factors that are specific for pregnancy and the postpartum period, such as drastic alterations in gonadal sex steroids and impaired mother-infant interactions. Those mechanisms are complex and still poorly understood. Leading specific hypotheses invoke the rapid postpartum drop in estrogen, progesterone, and allopregnanolone, plus neuroimmune dysregulation (IL-

6, cytokines, autoimmune mechanisms), HPA-axis changes, circadian/sleep disruption, and genetic vulnerability (loci at 16p13 and 8q24, serotonergic genes). Epigenetic factors such as DNA methylation, hormone-mediated chromatin remodeling, and non-coding RNAs (miRNAs) have also been implicated, but no single pathway is established, and why childbirth triggers illness in vulnerable women is still being worked out.[43,45,47,48] Moreover, further research is needed to determine whether psychiatric disorders have different underlying causes depending on whether they arise during or after pregnancy. **Figure 2** summarizes the conceptual framework of multifactorial etiology of all PPDs. **Figure 3** presents the unified model of peripartum depression, which explains how reproductive hormones, inflammation, stress, and oxytocin converge on tryptophan/kynurenine metabolism and the serotonin-NMDA axis.[49]

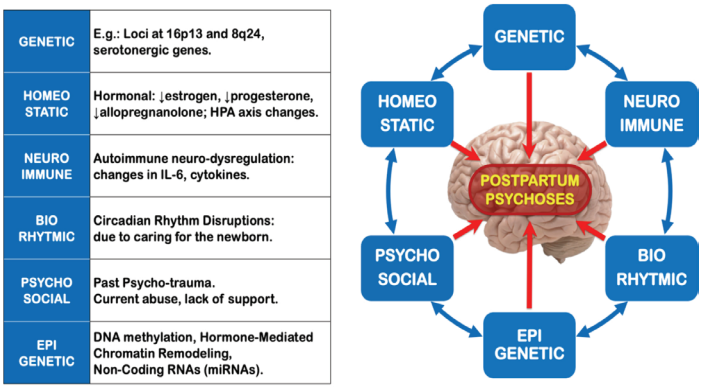


Figure 2. Pathomechanisms of postpartum psychiatric disorders (PPDs). *Abbreviations used*: ACTH (adrenocorticotropic hormone); PUFA (polyunsaturated fatty acid); IL-6 (interleukin 6); miRNA (microRNA)

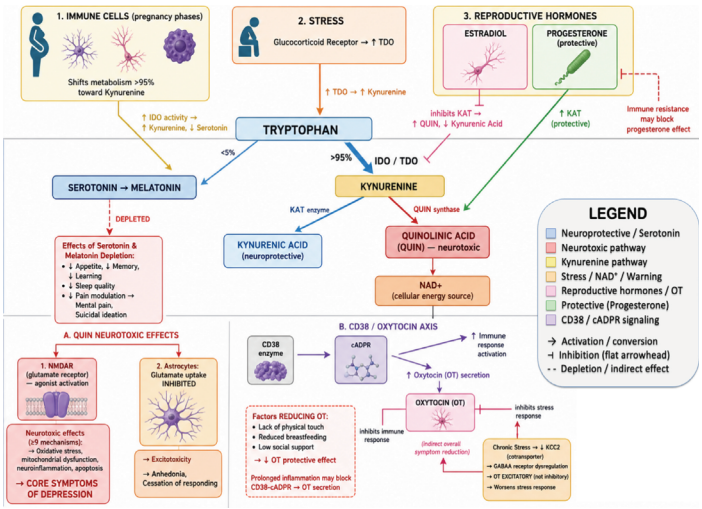


Figure 3. Unified model of peripartum depression
Tryptophan/kynurenine metabolism and the serotonin-NMDA axis are affected by pregnancy-induced changes in reproductive hormones, inflammation, stress, and oxytocin level.
IDO (indoleamine 2,3-dioxygenase); TDO (tryptophan dioxygenase); KAT (kynurenine aminotransferase); QUIN (quinolinic acid); NAD^+ (nicotinamide adenine dinucleotide); NMDAR (N-methyl-D-aspartate receptor); cADPR (cyclic ADP-ribose); OT (oxytocin); KCC2 (potassium–chloride cotransporter 2); GABA A, (gamma-aminobutyric acid type A receptor).
Figure was made using SciSpace AI.[49]

Inaccuracy of Forensic Psychiatry

The inherent uncertainty of retrospective diagnosis of those disorders is a fundamental problem for forensic psychiatry. Contrary to conventional wisdom, no expert can definitively prove a defendant was psychotic at a precise moment in the past. While investigators routinely reconstruct a suspect's mental state using records, texts, and witness accounts, this process is highly subjective. It never yields "settled science" capable of compelling universal consensus. The disagreement between Clancy's treating clinicians and later forensic experts is not a medical scandal. It is the inevitable reality of retrospective evidence and reflection of fact that science is never fully settled. The consensus of "official" experts does not signify eternal truth.[50] Science is uncertain, tentative, and probabilistic.[51]

Limits of Science in General

It is tempting, for all physicians, to believe that if the public simply understood the scientific data, the partisan bickering would cease. The right-wing-aligned doctors may hope that if only academia would free itself from left-wing control it could serve as the trusted arbiter in this case. This is unfortunately wishful thinking. The combatants in the Clancy culture war were not waiting for an updated and no longer politically biased American Psychiatric Association consensus statement. They were arguing over imponderable matters far beyond the scope of medical science. Moreover, the science itself has been contaminated by political and commercial agendas.

The Clancy case is not a puzzle solvable by the scientific method that powers clinical and forensic psychiatry. It is a diagnostic specimen of a civilization that has lost the **capacity to hold two truths at once:** ***that postpartum psychopathology is a real, potentially catastrophic illness and that the deliberate killing of children is a moral enormity that no diagnosis can erase***. Unbiased medical science can testify about the first truth. It cannot and should not pretend to settle the second. This public dispute was never a scientific controversy. It was a profound moral conflict over what society still holds sacred, who is permitted to receive pity, and whether empathy should outrun justice. Nevertheless, because scientific expertise was weaponized by both sides, unbiased physicians and scientists have a duty to inform. Scientists owe the public an unvarnished account of the current scientific knowledge and especially explanations of its limits and persistent biases.

Guidance for Physicians

The Clancy case proves that public tragedies are no longer judged objectively; they are immediately absorbed into ideological warfare. To navigate these partisan disputes and properly inform the public, physicians should consider the following:

- **Embrace relevant facts from both competing perspectives**. Postpartum psychosis is a severe psychiatric emergency. Killing children is a moral enormity. Diagnosis helps to explain an act, but it does not erase it, nor does it automatically determine criminal responsibility.
- **Do not conflate distinct illnesses.** ***Postpartum depression*** is typically a mild and common condition affecting up to one in five new mothers, the vast majority of whom never harm anyone. Its official treatment is prone to commercial biases and hence controversial. ***Postpartum psychosis*** is an exceptionally rare psychiatric emergency, affecting only one or two women per thousand births. It hits abruptly, bringing hallucinations

and a severe risk of infanticide. It requires emergency hospitalization and responds to judicious treatment with lithium or electroconvulsive therapy. Conflating those two diagnoses creates dangerous public misunderstandings.

- **Admit the limits of hindsight**. No one can definitively reconstruct a defendant's mental state at the hour of a crime. Dueling expert testimonies are the expected reality of forensic psychiatry, not incompetence or machinations.
- **Reject avatars**. Lindsay Clancy does not represent "All Women," just as her critics do not represent "All Men." Treating a single defendant as a demographic symbol guarantees that every trial becomes a culture war. Physicians treat individuals in the clinic—not "populations." They must assert the same in public.
- **Name both distortions**. The Left turned a killer into a martyr of systemic failure and baselessly villainized her husband. The Right dismissed severe illness as mere selfishness. Both sides weaponized science.
- **Expose ideological delusional theories**. The Left cannot claim immunity to conspiracy thinking. The evidence-free theory that Patrick Clancy committed the murders spread rapidly online under the guise of "empathy" in left-wing circles.
- **Separate explanation from excuse**. Biological stressors and severe illness are real, but criminal responsibility is a separate test. A mother can be genuinely ill and still not commit an unspeakable act.
- **Reject the Dark Mirror**. The Left's loss of proportion does not justify the Right's reactionary contempt for evidence and pity. Two competing insanities do not make sanity.
- **State the non-negotiables**. Children must not be murdered. Untreated postpartum psychosis is a lethal emergency. There is no tension between these facts, and any politics that forces you to choose one is fundamentally broken.

How One Insanity Replaces Another

Why does a whole society—not just individuals—when confronting an ideology it rightly recognizes as distorted so often answer with a distortion of the opposite extreme rather than with proportion? The mechanisms are the ordinary pathologies of polarized groups, now industrially amplified:

- **Reactive Identity**: Factions under cultural siege do not ask what is true; they ask what most painfully contradicts their enemy. If the Left says the mother is a victim of the system, the Right says she is a monster and the system is a fiction. Truth becomes whatever the other side hates to hear.
- **The Collapse of Mediating Institutions**: Churches, guilds, and local papers once forced people to practice the small compromises that make society possible. Today, they are replaced by online echo chambers that reward ideological purity. The Clancy case was tried twice: once in a courtroom, and once in the attention market. Only the second trial had an infinite jury and no standard of proof.
- **The Prestige Economy of Extremity**: In a crowded public square, moderate speech is inaudible. Status accrues to the person willing to say the unsayable. On one side, the unsayable became, "I see myself in a woman who killed her children." On the other, it became, "Postpartum illness is an excuse, and she should die." Both statements are optimized for viral circulation. Neither is optimized for a mother in an emergency department at three in the morning, or for a jury tasked with distinguishing illness from intent.
- **The Confusion of Explanation with Excuse**: The Left treats every causal story as an acquittal: if hormones and exhaustion contributed, punishment is violence. The extreme Right treats moral judgment as a duty to withhold care: if the act was evil, the diagnosis is propaganda. Polarized speech cannot bear the reality that a person can be both a patient and a perpetrator.
- **The Earned Distrust of Expertise**: When medical institutions spent a decade acting as political activists, they spent the credibility they needed for when a rare psychiatric crisis emerged. The Right now treats psychiatric categories as inventions, while the Left treats all skepticism as bigotry. To be believed, medicine must stop acting as a factional asset.
- **Religious Vacancy**: Politics has inherited religion's job: naming the innocent and the damned. The Left is the church of the oppressed; the Right is the church of the unapologetic avenger. Neither can process a woman who is both gravely ill and a murderer, because neither retains the true teaching that a soul can require both restraint and mercy. Divine law was replaced by capricious anarchy of human emotions.

Dual Political Insanity is Perilous for Medicine, the Country, and Civilization

Physicians should not flatter themselves that this is merely a media problem adjacent to their work. Polarization inevitably enters their clinic. A resident trained to view every postpartum woman as a political subject will miss the patient. A zealous pundit who teaches his audience that psychiatric diagnosis is a scam will drive the next desperate mother away from life-saving treatment. Officialdom will cause similar harm by endorsing ineffective treatment due to commercial bias. A public that cannot distinguish postpartum depression from postpartum psychosis will either panic at ordinary sadness or sleep through a lethal emergency.

But the ultimate cost is civic. A republic cannot survive a populace that treats every hard case as proof of the other half's wickedness. The rule of law demands a shared moral language: that children are not props, that illness explains without automatically excusing, that courthouse mobs do not dictate justice, and that a hung jury is a legal fact, not a political sacrament. When that shared language evaporates, only force and fashion remain. That is how civilizations end—not with a bang, but with the quiet inability to perform basic functions: trying a murder, treating a psychosis, and telling the truth about both.

It is therefore unacceptable to combat the irrational Left by mirroring its methods. A Right that counters institutional capture with a contempt for science, toxic empathy with total apathy, and the cult of the victim with a cult of punishment has not restored sanity. It has simply accepted the premise that public life is a permanent war and put on a different uniform. Such wars do not save nations. They lead to exhaustion, cruelty, and cynicism, and culminate in self-destruction.

How to Restore Lost Sanity

Sanity, which Gross desired and we physicians must demand, is not a centrist compromise between two frenzies. It is the reclamation of normalcy. Strategies listed below to restore sanity are not partisan platforms. They are the holding pillars without which medicine and civic life cannot endure:

- **Recover the boundary between description and verdict**. Medical journals and clinical consensus can explain the rarity, treatment, and retrospective uncertainty of postpartum psychosis. They cannot dictate whether a defendant should

be freed or executed. Physicians who refuse to accept this limit will be weaponized. They must refuse to be used.

- **Tell the truth in both directions**. Reject the Left's collapse of all maternal distress into filicide and reject the Right's dismissal of postpartum psychosis as a hoax. Quote the data accurately. Describe the emergencies. Disclose the unknowns. A public armed with objective facts is immune to political liturgies.
- **Reclaim the medical guild for the craft**. Old institutions like academia and medical societies existed to protect medicine from ideological capture. Since they have been captured themselves, the answer is to reclaim them for science—prioritizing evidence, standards, and the humility to say "I don't know." Subjecting the guild to a rival right-wing capture might feel like justice, but it is simply a change of commissar.
- **Demand adult moral psychology**. Cause is not excuse, and judgment is not cruelty. A mother can be gravely ill and still commit an unspeakable act deliberately. A husband can be imperfect and still not be a killer. A system can fail, and a defendant can still meet—or fail to meet—the legal test of responsibility. Children can be the primary victims even when their killer is deeply pitiable. Politics that forbids holding these truths together fundamentally rejects human nature.
- **Starve the attention market**. Scientific institutions must stop rewarding the most viral, inflammatory interpretations of a tragedy. Medical journals must reject purely denunciatory essays. Clinical professionals must refuse to turn real human tragedy into "content." This alone will not save the republic, but it is the basic hygiene without which all else fails.
- **State the non-negotiables clearly**. A society that cannot condemn the murder of children without a qualifying clause about "the system" has turned against its own future. A society that cannot acknowledge lethal postpartum psychosis without a qualifying clause about "excuses" has chosen willful ignorance. These facts do not contradict one another. Pretending what they do is the exact madness we must cure.

Conclusions

Martin Gross foresaw the victory of leftist delusional dogmas but missed that intense political pressure would drive many who oppose them into the trap of partial madness. The Clancy case embodies this dual insanity: science weaponized, victims sidelined, and severe illness treated as either blanket absolution or a hoax. The unglamorous but effective remedy is to hold two truths at once—acknowledging both the clinical reality of the illness and the tragedy of the murdered children—while rejecting any faction that demands a choice between them. If we continue trading one insanity for another, we will lose the capacity for ordinary judgment needed to sustain our civilization.

Jane M. Orient, M.D., is a practicing general internist and serves as executive director of AAPS and managing editor of the Journal. Contact: jane@aapsonline.org.

Acknowledgement: This text was created by a human author with limited support from advanced AI tools: licensed versions of OpenEvidence, Gemini, SciSpace and SuperGrok. Those tools were used only for purposes of reference management, data visualization, and spelling and grammar refinement. All analyses, conclusions, and recommendations are solely those of the human author, who verified all sources.

REFERENCES

1. Gross ML. *The End of Sanity: Social and Cultural Madness in America*. Avon Books; 1997. Accessed Sep 29, 2026. Available at: https://archive.org/details/endofsanitysocia0000unse
2. Death of Archimedes (1815) by Thomas Degeorge. Wikimedia Commons. Accessed Sep 29, 2026. Available at: https://commons.wikimedia.org/wiki/File:Death_of_Archimedes_(1815)_by_Thomas_Degeorge.png
3. Clough A. *Plutarch's Lives*. Vol 5. Little Brown and Co.; 1806. Accessed Sep 29, 2026. Available at: https://archive.org/details/bwb_T3-CBS-573_5/page/n9/mode/2up
4. Orient JM. Negative evidence: examining the concept of chemtrails. *J Am Phys Surg* 2025;30(3):66-73. Accessed Nov 3, 2025. Available at: https://jpands.org/vol30no3/orient.pdf
5. Zangari J. Commentary—Postpartum psychosis on trial: a preview of *Commonwealth v. Clancy*. Suffolk Univ Law Rev. Published online Jun 15, 2026. Accessed Sep 29, 2026. Available at: https://sites.suffolk.edu/lawreview/2026/06/15/commentary-postpartum-psychosis-on-trial-a-preview-of-commonwealth-v-clancy/
6. Lindsay Clancy was inside the mental health system the whole time. *Forefront Group*. Published online Sep 18, 2026. doi:10.1377/FOREFRONT.20260917.810330
7. Harris A. Beyond the juror box: what caused the Lindsay Clancy mistrial. *Univ Miami Law Rev*. 2026;81. Accessed Sep 29, 2026. Available at: https://lawreview.law.miami.edu/beyond-the-juror-box-what-caused-the-lindsay-clancy-mistrial/
8. West SG. An overview of filicide. *Psychiatry (Edgmont)*. 2007;4(2):48. Accessed Sep 29, 2026. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC2922347/
9. Frederique A, Stolberg R, Estrellado J, Kellum C. Motherhood's dark dance: casting light on the shadows of maternal filicide. Palo Alto University. 2026. Accessed Oct 6, 2026. Available at: https://paloaltou.edu/resources/translating-research-into-practice-blog/motherhoods-dark-dance-casting-light-on-the-shadows-of-maternal-filicide
10. Meltzer-Brody S, Howard LM, Bergink V, et al. Postpartum psychiatric disorders. *Nat Rev Dis Primers*. 2018;4:18022. doi:10.1038/nrdp.2018.22
11. Frierson RL, Joshi KG. Mental health criminal defenses in persons with neuropsychiatric disorders. *Behav Sci Law*. 2024;42(1):1-10. doi:10.1002/BSL.2635
12. Dostoyevsky F. *Crime and Punishment*. Random House; 1950. Accessed Sep 29, 2026. Available at: https://archive.org/details/crimepunishmentf0000cons
13. Strom D. Do the women excusing murder because of 'hormones' know what they are saying? . Townhall Media: HotAir. Sep 18, 2026. Accessed Sep 29, 2026. Available at: https://hotair.com/david-strom/2026/09/18/do-the-women-excusing-murder-because-of-hormones-know-what-they-are-saying-n3819139
14. Porter-Gore J. Two moms killed their kids. Did race play a role in their cases? Word In Black. Sep 15, 2026. Accessed Sep 30, 2026. Available at: https://wordinblack.com/2026/09/new-trial-ordered-for-latarsha-sanders-as-spotlight-on-race-mental-illness-widens-in-child-death-cases/
15. Bruening E. The meaning of the Lindsay Clancy mistrial. *Atlantic*. Published online Sep 4, 2026. Accessed Sep 30, 2026. Available at: https://www.theatlantic.com/ideas/2026/09/clancy-mistrial-debate-conspiracy/688483/
16. Riess R. Lindsay Clancy admits to killing their children. So why is there an online groundswell blaming her ex-husband? CNN. Sep 4, 2026. Accessed Sep 30, 2026. Available at: https://www.cnn.com/2026/08/22/us/patrick-clancy-conspiracy-theories
17. Winter J. Why people want to believe the Lindsay Clancy conspiracy theories. *The New Yorker*. Aug 4, 2026. Accessed Sep 30, 2026. Available at: https://www.newyorker.com/news/the-lede/why-people-want-to-believe-the-lindsay-clancy-conspiracy-theories
18. Emerald Pages Staff. The right & left call each other racist: how the Clancy case proves both right. Emerald Book Publication. Sep 3, 2026. Accessed Sep 30, 2026. Available at: https://emeraldbook.org/news/sep-0326-5/
19. Milia G, Noonan M. Experiences and perspectives of women who have committed neonaticide, infanticide and filicide: A systematic review and qualitative evidence synthesis. *J Psychiatr Ment Health Nurs*. 2022;29(6):813. doi:10.1111/JPM.12828
20. Resnick PJ. Child murder by parents: a psychiatric review of filicide. *Am J Psychiatry*. 1969;126(3):325-334. doi:10.1176/AJP.126.3.325
21. Resnick PJ. Murder of the newborn: a psychiatric review of neonaticide. *Am J Psychiatry*. 1970;126(10):1414-1420. doi:10.1176/AJP.126.10.1414
22. Sainez B. Megyn Kelly rips Lindsay Clancy jurors as 'too clueless to understand' after they call holdout 'arrogant' following mistrial. Yahoo Style Canada. Sep 9, 2026. Accessed Sep 30, 2026. Available at: https://ca.style.yahoo.com/megyn-kelly-rips-lindsay-clancy-222247621.html

23. Downey C. No, not all women identify with Lindsay Clancy. *National Review*. Aug 21, 2026. Accessed Sep 30, 2026. Available at: https://www.nationalreview.com/2026/08/no-all-women-do-not-identify-with-lindsay-clancy/
24. Associated Press. Lindsay Clancy didn't have acute psychosis when she killed her 3 children, psychologist says. Courthouse News Service. Aug 24, 2026. Accessed Sep 30, 2026. Available at: https://www.courthousenews.com/lindsay-clancy-didnt-have-acute-psychosis-when-she-killed-her-3-children-psychologist-says/
25. Prestigiacomo A. The major hole In Lindsay Clancy's defense. *Daily Wire*. Aug 25, 2026. Accessed Sep 30, 2026. Available at: https://www.dailywire.com/news/the-major-hole-in-lindsay-clancys-defense
26. McShane J. 'Feminism is a death cult': How culture wars infiltrated the Lindsay Clancy case. MSNOW. Sep 5, 2026. Accessed Sep 30, 2026. Available at: https://www.ms.now/news/news-analysis/lindsay-clancy-murder-trial-feminism-culture-wars
27. Caduff C. Anthropology's ethics: Moral positionalism, cultural relativism, and critical analysis. *Anthropological Theory*. 2011;11(4):465-480. doi:10.1177/1463499611428921
28. Rafferty J, Mattson G, Earls MF, Yogman MW. Incorporating recognition and management of perinatal depression into pediatric practice. *Pediatrics*. 2019;143(1). doi:10.1542/PEDS.2018-3260/37306
29. Stewart DE, Vigod S. Postpartum depression. Solomon CG, ed. *N Engl J Med*. 2016;375(22):2177-2186. doi:10.1056/NEJMCP1607649
30. Dagher RK, Bruckheim HE, Colpe LJ, Edwards E, White DB. perinatal depression: challenges and opportunities. *J Womens Health*. 2021;30(2):154-159. doi:10.1089/JWH.2020.8862
31. Miller E, Metz T. ACOG Clinical Practice Guideline No. 5: treatment and management of mental health conditions during pregnancy and postpartum. *Obstetrics & Gynecology*. 2023;141(6):1262–1288. doi: 10.1097/AOG.0000000000005202
32. Moore Simas TA, Whelan A, Byatt N. Postpartum depression—new screening recommendations and treatments. *JAMA*. 2023;330(23):2295-2296. doi:10.1001/JAMA.2023.21311
33. Wisner KL, Murphy C, Thomas MM. Prioritizing maternal mental health in addressing morbidity and mortality. *JAMA Psychiatry*. 2024;81(5):521-526. doi:10.1001/JAMAPSYCHIATRY.2023.5648
34. Miller ES, Cunningham KK, Osborne LM. Pharmacologic treatment of perinatal depression. *JAMA*. 2025;334(24):2223-2224. doi:10.1001/JAMA.2025.17250
35. ACOG Committee on Clinical Practice Guidelines–Obstetrics. ACOG Clinical Practice Guideline No. 4: Screening and diagnosis of mental health conditions during pregnancy and postpartum. *Obstet Gynecol*. 2023;141(6):1232-1261. doi:10.1097/AOG.0000000000005200
36. Li C, Yang H, Bi J, et al. Caregivers' knowledge, attitudes, and practices regarding postpartum depression: a cross-sectional study. *Sci Rep*. 2026;16:24252. doi:10.1038/s41598-026-54922-1
37. Roddy Mitchell A, Gordon H, Lindquist A, et al. Prevalence of perinatal depression in low- and middle-income countries: a systematic review and meta-analysis. *JAMA Psychiatry*. 2023;80(5):425-431. doi:10.1001/JAMAPSYCHIATRY.2023.0069
38. Ferrari AJ, Miller PA, Shadid J, et al. The global prevalence of major depressive disorder during the peripartum period: a systematic review and meta-regression. *Lancet Psychiatry*. 2026;13(6):461-471. doi:10.1016/S2215-0366(26)00085-4
39. Bränn E, Guintivano J, Yang Y, et al. Maternal psychiatric disorders before, during, and after pregnancy: a national cohort study in Sweden. *Mol Psychiatry*. 2025;31(1):309-317. doi:10.1038/s41380-025-03212-9
40. Miller DC, Chawla D, Johansen Taber K, Payne JL, Del Tredici AL. Real-world pharmacotherapy treatment patterns among patients diagnosed with postpartum depression in the United States. *BMC Psychiatry*. 2025;25:572. doi:10.1186/S12888-025-06977-Z/FIGURES/5
41. Dennis CL, Singla DR, Brown HK, et al. Postpartum depression: a clinical review of impact and current treatment solutions. *Drugs*. 2024;84(6):645-659. doi:10.1007/S40265-024-02038-Z
42. Approved Drug Products with Therapeutic Equivalence Evaluations. Orange Book. FDA. Accessed Oct 1, 2026. Available at: https://www.fda.gov/drugs/drug-approvals-and-databases/approved-drug-products-therapeutic-equivalence-evaluations-orange-book
43. Bergink V, Akbarian S, Byatt N, et al. Postpartum psychosis and bipolar disorder: Review of Neurobiology and Expert Consensus Statement on Classification. *Biol Psychiatry*. 2025;99(9):740. doi:10.1016/J.BIOPSYCH.2025.10.016
44. Cohen LS, Vanderkruik R, Arakelian M, Church TR, Dunk MM, Freeman MP. Establishment of the MGH Postpartum Psychosis Project: MGHP3. *PLoS One*. 2023;18(2):e0281133. doi:10.1371/JOURNAL.PONE.0281133
45. Bergink V, Rasgon N, Wisner KL. Postpartum psychosis: madness, mania, and melancholia in motherhood. *Am J Psychiatry*. 2016;173(12):1179-1188. doi:10.1176/APPI.AJP.2016.16040454
46. Cohen LS, Arakelian M, Church TR, et al. The phenomenology of postpartum psychosis: preliminary findings from the Massachusetts General Hospital Postpartum Psychosis Project. *Mol Psychiatry*. 2024;30(6):2537-2544. doi:10.1038/s41380-024-02856-3
47. Davies W. Does hypothalamic CCN3 hypersecretion confer postpartum mood disorder risk? *Transl Psychiatry*. 2026;16(1):195-. doi:10.1038/s41398-026-03969-9
48. Meltzer-Brody S, Howard LM, Bergink V, et al. Postpartum psychiatric disorders. *Nat Rev Dis Primers*. 2018;4(1):18022. doi:10.1038/nrdp.2018.22
49. Levin G, Ein-Dor T. A unified model of the biology of peripartum depression. *Transl Psychiatry*. 2023;13(1):138. doi:10.1038/s41398-023-02439-w
50. Michael Crichton explains why there is 'no such thing as consensus science.' American Enterprise Institute—AEI. Accessed May 6, 2024. Available at: https://www.aei.org/carpe-diem/michael-crichton-explains-why-there-is-no-such-thing-as-consensus-science/
51. Baron J. If I were dean: a challenge to new medical students. *Mt Sinai J Med*. 2004;71(2):134-138. Accessed Nov 8, 2026. Available at: https://pubmed.ncbi.nlm.nih.gov/15029406/

WILL YOUR GRANDCHILDREN BE ABLE TO SEE A PRIVATE PHYSICIAN?

The answer to that question probably depends on this one:

Will AAPS, the voice for private physicians, remain strong?

AAPS has defended private medicine for 83 years–since 1943.
AAPS relies on the generosity of its members to survive and thrive.
Please remember AAPS in your will or charitable annuity.
This is your opportunity to send a Final Message in support of freedom and private medicine.
Every gift helps, no matter how small.

For information on making a bequest, call or write:

Andrew Schlafly
AAPS General Counsel
939 Old Chester Rd.
Far Hills, NJ 07931
(908) 719-8608
aschlafly@aol.com