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Women and Crime: Premenstrual Issues

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This Trends and Issues is the first in a series that will focus specifically on women's issues in crime and criminal justice. The topic of premenstrual tension is a fitting, if controversial one with which to begin the series. It lacks credibility as a syndrome in certain sections of the community, and feminists fear that its use in the courts will revive biological deterministic theories of male superiority. It continues to be a cause of controversy and dissension in both the medical and legal professions.

This Trends and Issues examines the research that links PMS and deviant criminal behaviour. It also discusses possible ways that PMS could be used in the courts, and reviews its application to date as a defence strategy both in Australia and overseas.

The reality of this disorder and its consequences for a small minority of women should not be ignored. Women and Crime: Premenstrual Issues is an important contribution to the Australian literature on criminology.

Duncan Chappell
Director

In the early 1980s two court cases in England catapulted PMS (premenstrual syndrome) into front page headlines, talk shows, and medical and legal journals: it became a centre of controversy. The news of these two cases in which women were placed on probation for murder with PMS defences caused a heated debate in the press of many countries with captions such as 'raging hormones', 'premenstrual frenzy' and 'Dr Jekyll and Ms Hyde'. Although identified as a medical entity since 1953, it was not until this point in time that the media, legal practitioners and medical researchers began to really focus on PMS and its relationship to female criminality. Feminists, aghast at headlines such as appeared in *The Sun* - 'Monthly Miseries Save the Killer Mistress' - entered the journalistic and scholarly foray decrying the judicial use of a biological deterministic defence which could threaten the gains that women had made.

In part, the research which examined PMS and criminal behaviour undoubtedly reflected the growing interest in studying the female offender and aetiology since statistics during the 1970s were reflecting an increasing number of crimes committed by women (Horney 1978). And, certainly, as will be seen below, the idea of equating female anti-social or aggressive behaviour with the 'curse of Eve' was not new. This Trends and Issues will examine the history of such beliefs, describe the characteristics of PMS, canvass current medical and legal views, and give an account of PMS in the courts during the 1980s and the ensuing controversy it engendered.

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Historical Background

From Semonides, a Greek philosopher who warned of the moody nature of women:

> *One day she is all smiles and gladness. A stranger in the house seeing her will sing her praise . . . But the next day she is dangerous to look at or approach: She is in a wild frenzy . . . savage to all alike, friend or foe . . . (Trimble & Fay 1986, p. 183)*

to an ancient English poem cited by Simone de Beauvoir in *The Second Sex* (1969) which specifically refers to menstruation:

> *Oh menstruating woman, thou's a fiend*
> *From whom all nature should be screened!*

females have been portrayed as mercurial in temperament with the menstrual cycle either explicitly or implicitly being responsible.

Cross-culturally and throughout time, menstruation has been the object of fear and derision. In many tribal societies, social taboos were (and are presently for some) enacted at the menses with women kept secluded from the group and/or animals and with other living arrangement restrictions. Such attitudes do not occur only in so-called 'primitive' societies. Many of the ecclesiastical-level religions include similar perspective's in their doctrine or ritual. The Koran for example, refers to menstruation as an illness, and under Hindu law, menstruating women are required to retire apart from others for three days. The general impression in an ethnographic survey of menstruation is indeed one of a perception of a menstruating female as a pollutant - something to be avoided and feared.

Aside from this attitude about the menses, a view of women's persona emerged in the 19th century which contributed to the equation of female physiology and criminality. Females were regarded as innately angelical and by the natural order, incapable of violence. A violent woman was thus unnatural with insanity linked to the menstrual cycle since a woman's personality was believed to be directed by her hormones. Her temperament was a direct product of her female physiology, certainly a biological deterministic theoretical approach. Since females were the childbearers, they were perceived as passive, weak and highly vulnerable to stress, particularly during pregnancy, the post-partum and menstruation. Women offenders were sick or mad, but not bad! Court cases from the 1800s reflect this attitude. For example, in England a woman was acquitted of shoplifting in 1845; two women were found innocent of murder charges in 1851; all three were found to have acted with temporary insanity as a consequence of 'suppression of menstruation' (Spitz 1987). One of these women had murdered her lover who had rejected her. A doctor testified that her wild eyes indicated problems with her uterus (Meehan & MacRae 1986).

Even mothers who committed infanticide were seldom punished. They were simply not seen as responsible for their actions to the same degree as men (Sommer 1984). Thus the Canadian Criminal Code includes infanticide provisions that contain the scientifically unproven assumption that child birth trauma can cause mental derangement in the mother.

One of the parents of modern criminology, Lombroso (and Ferrero) contributed to this biological deterministic theory of female criminality in an 1894 study. They found that of 80 women arrested for 'resistance to public officials', 71 were menstruating (Abplanalp 1985). This research undoubtedly contributed to Krafft-Ebbing's view (an eminent sexologist at the turn of the century) that the courts should give special consideration to women whose menstrual problems are complicated by 'emotional influences beyond their control' (Riley 1986, p. 195).

Thus, these 19th century theoreticians, some ancient philosophers and cross-cultural menstrual taboos all supported a view of females as the victims of menstruation, and later, by the mid-1800s, more specifically their ovaries, and then in the 1920s, their hormones. It was not, however, until the early 1950s that the focus changed from menstruation to the menstrual cycle and the time period preceding the menses—the premenstrual era and its concomitant theories relating to deviant behaviour had arrived!

PMS: the Doctors' View

There is certainly no universally accepted medical consensus about the aetiology, symptomatology or treatment of PMS. In fact, the prosecutor in an American case in the early 1980s, *People v. Santos*, consulted many doctors and concluded that no well-defined condition called PMS exists (Holtzman & Newman 1984). Why is the medical profession indecisive about PMS? Pahl-Smith (1985) attributes it to a lack of research funding and states that since more research has been done on epilepsy and diabetic hypoglycaemia, these conditions have become better defined and thus more acceptable as components of criminal defences. Certainly the status of PMS within the medical community is important since doctors play an essential role in defining the legal significance of the syndrome within the criminal justice system. The medical literature is confusing in its diversity of opinion concerning the possible connection of PMS to criminal behaviour. Carney and Williams (1983, p. 258) in a law review state that 'medical experts do agree that the syndrome can cause marked psychological anomalies that affect behaviour patterns'. Another study reports that doctors who have worked with and studied PMS, have no doubt that many women are affected so severely that they may become incompetent to make decisions or even function (Riley 1986).

There does at least appear to be a trend in accepting PMS as a legitimate medical ailment or even disease. In the United States for instance, the

American Psychiatric Association Diagnosis and Statistical Manual of Mental Disorders (DSMIII) has now added 'Late Luteal (premenstrual) Dysphoric Mood Disorder'. Also in parts of America, the leading health insurance company, Blue Cross/Blue Shield has defined it as a disease, having a pre-existing condition clause that disallows cost reimbursement for premenstrual treatment if the claimant has sought medical attention for PMS before coverage.

There also appears to be fairly universal agreement about diagnosing PMS. The following criteria must be met:

- recurrent symptoms (described below);
- onset of symptoms at ovulation or shortly thereafter;
- disappearance of symptoms within five days after bleeding begins;
- severe enough symptoms to necessitate medical treatment and/or result in a decrease in level of functioning; and
- the absence of any other disease state or recurrent stress to account for the symptoms (Keye & Trunnell 1986). Monthly recurrence and complete relief of symptomatology following menses are the key denominators cited by all.

Aetiology, Treatment and Symptoms

The plethora of causation theories is evidence of the lack of medical consensus and perhaps indicative of several distinct syndromes that are currently lumped together as PMS (*see* T. Johnson 1987; Keye & Trunnell 1986; Reid & Yen 1981; Brunetti & Taff 1984). Treatment is also an area of debate among medical researchers and practitioners. A number of treatments are available but are often ineffective. This lack of a scientifically accepted remedy could present legal problems if the syndrome is used as a defence and court-ordered treatment is recommended and agreed upon by the defendant.

Over 150 symptoms have been defined as premenstrual. Table 1 outlines the primary categories and gives a few examples for each. The symptoms of course vary in intensity, not only from woman to woman, but also from month to month. It is theorised that stress plays a role in exacerbating the emotional symptoms. As stated earlier, only a small percentage of sufferers actually experience some of the more severe symptoms displayed in Table 1.

Table 1: *Common Symptoms of PMS*

Physical

Abdominal bloating; Leg cramps; Temporary hypoglycaemia; Headache; Acne; Constipation; Oedema; Breast swelling; Weight gain

Emotional

Depression; Anxiety; Anger; Guilt; Mood changes; Panic; Low self-esteem; Fatigue; Aggressiveness; Psychosis

Behavioural

Intolerance; Intense Irritability; Restlessness; Social isolation; Sugar and salt craving; Insomnia; Increased used of alcohol; Hysteria; Confusion; Physical Violence; Accident prone; Anorexia or Bulimia; Libido changes; Suicidal; Lack of self-control.

Source: Johnson 1987; Keye & Trunnell 1986; Reid & Yen 1981; Brunetti & Taff 1984

Dalton (1986), the physician who has been active in the United Kingdom as a defence expert witness on PMS, describes the three most common PMS symptoms she has found in women who have committed illegal acts:

- depression leading to feelings of hopelessness and uselessness with ideas of right and wrong becoming confused. This can lead some to shoplifting, suicide, smashing windows or arson;
- irritability leading to sudden mood swings with a complete loss of control 'as the irrepressible impulse takes over';
- psychosis induced by PMS which usually lasts only for a day or two and can involve hallucinations, paranoia and total amnesia of behaviour (Dalton 1986, p. 147).

Dalton's views, particularly her belief in temporary psychosis, are certainly not shared by all medical practitioners. But most medical experts do appear to agree that, in a small minority of women, some of the emotional and behavioural by-products of PMS can lead to criminal actions.

Incidence

There is marked variation in estimates of the incidence of premenstrual syndrome. This issue is relevant to feminists' concerns about the use of PMS as a defence and the risk of over-generalisation to a majority of women. However, it is important to differentiate between **severe** PMS which involves such symptoms as Dalton describes and the potential for criminal behaviour and a more **mild** form of PMS, also referred to as PMC (premenstrual changes). The latter's symptoms are not severe enough to debilitate or to cause a woman to lose time from work or seek treatment. Estimates of the percentage of menstrual-age females who experience any type of the syndrome varies from 90 per cent (Reid & Yen 1981) to 40 per cent (Brunetti & Taff 1984). One source of such disparity in research results may stem from the methodology employed. When women are informed of the purpose of the study, a higher rate of incidence is reported. Further, some of the studies involved women who were receiving psychotherapy and may not be reflective of women in general (Nicholson & Barltrop 1982).

Susan Johnson (1987) reviews five studies from different countries and finds that fewer than 10 per cent of respondents report symptoms of a severe nature.

Dalton (1986, p. 145) agrees that about 10 per cent of women do require treatment but stresses that the very severe form in which 'mood variations are so violent that they are no longer responsible for their actions or aware of what they're doing for a short time each month' is much less frequent, in fact 'very rare'. **Thus the general consensus and main point to remember is that although the syndrome is common, the incidence of its most serious facets which may**

manifest in antisocial actions is extremely uncommon.

Studies Linking PMS and Deviant Behaviour

Several researchers have found that a significant proportion of psychiatric hospital admissions and suicides occur during the paramenstruum. A 1968 report found that 45 per cent of attempted suicides occurred during the week preceding menstruation (Wallach & Rubin 1972). Other research has shown that 52 per cent of women admitted to hospital after serious accidents were paramenstrual (this term combines the four days prior to bleeding with the first three days of menstruation)(Horney 1978). These data could be related to alcohol abuse since a 1971 United States survey revealed that 67 per cent of female alcohol drinking binges occurred at this time of the cycle (Chait 1986). (It must be pointed out that the current consensus is that trauma from accidents or alcohol abuse would not induce menstruation prematurely. A woman's menses begins 14 days after ovulation. Stress and other psychological factors may impact on the date of ovulation but probably not on the luteal or post ovulatory stage of the cycle. More research needs to be conducted in this area.)

Another focus of research has been the examination of violent or aggressive behaviour of women in institutions. In 1971 Ellis and Austin looked at a North Carolina prison and found that 41 per cent of the female inmates who committed aggressive acts in the prison did so during the paramenstruum. This confirmed Dalton's 1961 findings that 43 per cent who broke prison rules were paramenstrual (D'Orban 1983).

The other type of study that has examined the possible link between criminality and PMS has employed either prison admission data or retrospective reports to ascertain the point in their menstrual cycle when female prisoners committed their offences. In a 1953 study Morton reviewed medical records of 42 New York state inmates and found that 62 per cent perpetrated their crime while premenstrual (Brunetti & Taff 1984). In 1961 Dalton looked at 156 British women imprisoned for theft, prostitution or public drunkenness. She showed that almost half of the offences had taken place during the paramenstruum (D'Orban 1983). D'Orban and Dalton (1980) interviewed 50 female prisoners convicted of violent crimes and found that 44 per cent of the violence occurred during the paramenstruum. All of these findings are significantly higher than one would expect to find for 7-8 days of a month. The researchers conclude that there is a definite relationship between the menstrual cycle and crime which is either attributable to hormonal changes that generate criminal behaviour, or to the greater chance of detection due to lethargy and slower reaction time, or both.

A number of articles have questioned the validity of the above results on methodological and theoretical grounds (Allen 1984; Horney 1978; Robinson 1986). The retrospective method has been queried since informants could be lying or guessing. Other criticisms include the failure to carefully define the syndrome; use of inadequate entry criteria; and failure to consider variation in length of menstrual cycle. It is also argued that although a relationship between time of cycle and crime has been shown, since the studies do not attempt to evaluate whether the women in the samples have severe PMS, they do not show that PMS sufferers are more likely to commit criminal acts.

PMS and the Judicial System

As early as 1953, an international medical journal (Oleck 1953 cited in Horney 1978) suggested that lawyers should examine the possible tie with PMS in every case with a female defendant and that laws be created that would allow PMS to be used as an insanity defence. This had little impact. However, in the early 1970s, the *UCLA Law Review* (Wallach & Rubin 1972) devoted over 100 pages to describing case studies that linked criminal behaviour to the paramenstruum and exploring the possible defences that the legal community could employ. Others have concurred and believe that for some women, PMS renders them incapable of possessing all of the criteria required to be criminally liable.

Consequently, throughout the 1980s, a number of legal journal articles have explored the various defences or bargaining uses of PMS: their limitations, strengths if any, and consequences. It should be noted that with any of the defences below, it is likely that the defence counsel would have to show, possibly in a pretrial or voir dire with expert witnesses, that there is general acceptance of PMS within the relevant medical communities. The major problem is that at present there is no general acceptance, at least concerning the aetiology and treatment. In addition, what type of scientific or medical expert would be acceptable to the court since PMS 'experts' include endocrinologists, psychiatrists, general practitioners, gynaecologists, sociologists and more?

PMS as an Insanity Defence

The general consensus of legal experts' opinion is that PMS would not be accepted as insanity. McArthur (1989, p. 852) states that although some premenstrual women have mood swings and may behave irrationally, 'they still comprehend the consequences of their actions'. Thus, under the *M'Naghten Rules* (rules that arose from an 1843 English court case that have acted as a precedent internationally in defining insanity) PMS would fail unless a psychotic state could be proven. M'Naghten refers to 'disease of the mind' and an inability to tell right from wrong (Pahl-Smith 1985). Osborne (1989) elaborates, stating that the only cognitive symptoms of PMS are decreased concentration,

indecisiveness, paranoia and others that do not indicate impaired intellect. However, it should be noted that some authors contend that contemporary French courts do allow a plea of temporary insanity due to PMS; that it is an 'unwritten law' (Riley 1986; D'Orban 1983).

It is doubtful that many would choose an insanity defence due to the stigma and the likelihood of lengthy incarceration in a psychiatric facility. However, Potas (1982) points out, on the latter point, that such detention may in fact be shorter in duration depending upon the particular jurisdiction.

PMS as an Automatism Defence

A defence of automatism, on the other hand, results in complete acquittal. It is broadly defined as a state in which the mind or the will does not accompany physical acts. Such states have been linked in court cases with hypoglycaemia, epileptic seizures, physical blows, spasms, reflex actions and sleep walking. It has been argued in a British trial that in certain women with PMS who go hours without eating, an excess amount of adrenalin is produced that causes a hypoglycaemic state of impaired consciousness. However, it could be argued that the PMS sufferer should be aware of this recurrent condition. Thus, Osborne (1989) believes that in Canada, the prosecution in such a case would say that the defendant's failure to eat was voluntary.

Diminished Responsibility

With a plea of diminished responsibility which includes both the concepts of mental disorder and culpability (Potas 1982), the defence must show that PMS prevented the accused from having the specific intent (*mens rea*) required by a crime. According to Wallach and Rubin (1972) hypoglycaemia, which, as mentioned above, can be a symptom of PMS, produces the hazy thinking, and impairment of self-control, judgment and willpower that could provide a substantial defence of diminished capacity. This has been used by defendants with PMS in the United Kingdom to decrease murder charges to manslaughter.

The jurisdictions in Australia where this plea is an option (only with a murder charge) are New South Wales, Queensland, the Northern Territory and the Australian Capital Territory. The statutes are similar, stating that at the time of the offence, an abnormality of mind impaired the capacity to control the action **or** the capacity to know that the act ought not to be done (Waller & Williams 1989; Fisse 1990). Scutt (1982) does not believe that a defendant has much to gain with this defence since she might end up with a longer sentence plus the stigma of mental illness.

Mitigation

The majority of lawyers who have written about PMS and its potential use as a defence, recommend that it would best be used in pre-trial hearings to reduce charges and in mitigation of sentence since the court has the discretion to consider a lot of factors including the various features of the crime that affect the 'extent of moral guilt of the offender' (Allen 1984, p. 26). In this manner it is put on the same terms as recent illness, lack of criminal record or a history of being battered. With mitigation, the court retains control of treatment but the defendant is still stigmatised as a criminal (Carney & Williams 1983). The primary arguments for restricting it to this type of evidence are the current lack of universal acceptance of PMS as a diagnostic entity; its failure to meet all criteria for an insanity plea; the fear of abuse as a defence by women offenders and the fear of sexism.

The Burden of Proof (Diagnosis for the Courtroom)

Much of the latter two fears could be allayed if the diagnosis of PMS is substantiated by rigid evidence requirements. The medical evidence must indicate that the woman has a clinically demonstrable physical disorder and a causal connection must be shown between the premenstrual symptom(s) and the criminal act (Chait 1986). Diagnosis is problematic for a number of reasons. There are known discrepancies between current and retrospective accounts of symptoms (D'Orban 1983). Additionally, according to Heggestad (1986, p. 161) any women could fake the syndrome for months before, even going to doctors or support groups. She could then walk into court, 'clutching her symptom charts and claim that the Devil, her hormones made her commit the crime'.

Dalton (1986) believes that through careful collecting of evidence, including employment, school, hospital, police and medical records, one can show a cyclical pattern of behavioural change. She believes that there are also other means of proving a premenstrual crime including:

- evaluating the accused with the nine risk factors for PMS (e.g. painless menses, varying tolerance to alcohol, weight swings);
- biochemical testing of the sex hormone binding globulin capacity;
- postponement of the trial for several months of close observation;
- looking for the traits of a PMS crime (e.g. spontaneous, irrational, no attempt to avoid detection).

She theorises that these steps should eliminate malingerers and restrict the defence 'to the few who suffer from severe clinically recognisable PMS' (Dalton 1986, p. 154).

Court Cases

United Kingdom

Probably due to the presence of Dalton, the most active medical practitioner/advocate of PMS as a disease entity with possible psychotic and/or anti-social behaviour, one finds that it has been used most frequently in British courts. Although the major headline cases occurred in the early 1980s, PMS resulted in acquittals

and/or successful pleading of diminished responsibility prior to the 1980s for offences ranging from shoplifting to manslaughter. For instance in 1977, a woman was acquitted of shoplifting. Her diary and testimony by her doctor (Dalton) and husband showed a cyclical pattern of such deviant activity. Another woman was found not guilty of dangerous driving based only on the evidence that she had had two accidents within 48 hours of menses.

The first case to generate some publicity was in 1978 when a woman appeared on a charge of attempted arson with a defence of PMS. The evidence, based on retrospective reports, was accepted by the judge who put the defendant on probation and ordered her to undergo medical treatment (Edwards 1982). Two other diminished responsibility pleas by reason of PMS were accepted in a manslaughter case and an assault. Analysis of police and prison records showed that both women had long histories of repeated misdemeanours related to the paramenstruum. In all three of these cases, since the women were recidivists, PMS was confirmed through delineation of a cyclical pattern in their criminal activities.

In 1982, Dr Dalton again provided testimony about PMS on a criminal case—infanticide. A 33-year-old woman drowned her baby in the bath tub and then attempted suicide. She was charged with the child's death but ultimately was freed on probation and progesterone therapy. Evidence of PMS consisted of a score of 100 per cent on the nine item risk factors mentioned earlier; the fact that she had not eaten since 8.00 am (the baby died at 5.00 pm) and was thus at least potentially in a hypoglycaemic state; and lastly, that she began to menstruate at the intensive care unit the day following the death of the baby.

However, none of these cases caused the same media coverage and reverberations as the following murder cases, two of which were heard within a couple of days of each other.

R v. Craddock (1980) and *R v. Smith* (1981): Craddock was a barmaid with a lengthy criminal record; 30 prior sentences for theft, arson and assault. Charged with murdering a co-worker, years of diaries and institutional records indicated a cyclical pattern to her violent behaviour. She was found guilty of manslaughter based on a plea of diminished responsibility; that PMS 'turned her into a raging animal each month and forced her to act out of character' (Benedek 1985, p. 24). Sentencing was delayed for three months to see if she would respond to progesterone. Subsequently, the judge also considered PMS as a mitigating factor. As a result, Craddock was placed on probation and the court ordered progesterone treatment.

Later that year, Craddock who never had clear recollections of her crimes, received no progesterone for four days. On the fourth day, having fasted, she threw a brick through a window and reported herself to the police. She was arrested, received progesterone and was released by the Magistrates' Court.

Then, in 1981, Craddock who had changed her surname to Smith, began to receive a lower dosage of progesterone. In April, she attempted suicide, wrote a threatening poison pen letter to a police sergeant and waited behind the police station with a knife. Charged with carrying an offensive weapon, Smith's defence was the claim of automatism. The judge directed the jury that there was no question of considering this plea because there was no evidence that she had acted unconsciously. Again, the sentence was reduced to probation due to Smith's PMS.

R v. English: This defendant differed significantly from Craddock/Smith since she had no prior criminal record. After a fight with her lover, a married man, English drove her car at him ramming him into a lamp post. Charged with murder, English ultimately was put on probation with the restrictions of abstinence from alcohol and a year's driving ban, plus a directive to eat regular meals.

Preceding the death, English had not eaten for nine hours. Dr Dalton testified that this fact coupled with the accused's severe PMS resulted in a raised glucose tolerance leading to a blood sugar level drop and the over-production of adrenalin. Several other physicians also testified that English had **extreme** PMS. Further, since she began to menstruate a few hours after the crime, there was no question concerning the premenstrual stage of her cycle at the time of the 'murder'. The court held that she had acted under 'wholly exceptional circumstances' and reduced the charge to manslaughter on the grounds of diminished responsibility due to PMS (T. Johnson 1987, p. 340).

Although these cases resulted in a great deal of controversy, PMS has continued to be raised in both United Kingdom civil and criminal courts. The latter has included an appeal case where a woman had beaten her mother to death with a hammer. PMS was one of several factors, including the fact that she had given up her baby shortly before the killing, that contributed to her release after the verdict of manslaughter was substituted for murder on the grounds of diminished responsibility. In two other cases, it has also been one of several mitigating factors. For example, the counsel for a young nanny with no criminal record, who had killed a child in her care, told the court that she was overtired, that her grandmother had died recently and that she 'might have some premenstrual tension' (Edwards 1988, p. 457). She received a two years' suspended sentence. Again in 1987, PMS and prior psychiatric treatment were considered in *R v. Morris* by the English Court of Appeal (Criminal Division). Morris had been sentenced to two and a half years for wounding with intent her de facto who had made advances to a neighbour. Her sentence was reduced to two years with six months suspension.

It is difficult to assess how influential premenstrual syndrome was in the latter cases since other mitigating factors were also presented. However, coupled with the strong

advocacy of Dr Dalton and the legal precedents that have been set in England, PMS will probably continue to be used by defence counsel as a partial defence and/or as mitigation for those diagnosed as the few severe sufferers.

Canada

The use of PMS as a defence or in sentencing appears to have increased over the past decade in Canada. Prior to the 1980s, menopause and postnatal psychosis had been instrumental in dismissal of criminal charges for minor offences. Then, in the early 1980s, shoplifting charges were dropped when it was shown through medical evidence that a woman had had PMS since her teenage years. Subsequently, it was also considered in two Toronto cases as grounds for mitigating sentences to probation and conditional discharge (D'Emilio 1985).

In an Alberta 1984 shoplifting trial, the defence argued lack of *mens rea*. It was rejected by the judge who refused to accept PMS as a disease. However, the judge did acquit the accused on the basis that evidence had established her irrationality at the time of the theft and her incapability of having the intent to steal (McArthur 1989). In another 1984 Calgary provincial court, a shoplifter, identified by testimony of medical witnesses as a PMS sufferer, was convicted but was placed on probation with a treatment clause. A similar disposition was handed down in London, Ontario, in 1986 to a woman who had seriously assaulted her husband. Osborne (1989) reports that proof of PMS and the necessity of 'proper treatment' mitigated her sentence. However in 1988, the judge in a Victoria, British Columbia trial turned PMS down as a defence for failing to provide a breath sample.

A defence of insanity on the grounds of PMS was given in a fairly recent (December 1988) murder trial in the Nova Scotia Supreme Court. Although the jury rejected PMS as a disease of the mind, McArthur (1989, p. 860) believes that the case was significant in a number of ways: the psychiatrist for the defence was willing to testify that the defendant was insane within the Canadian legal definition and secondly, the jury found the woman guilty of only manslaughter, so they apparently 'considered a diminished-responsibility-type defence with PMS negating the intent requisite for murder'.

United States

Although discussions of PMS as a defence or in mitigation have appeared in a number of American legal journals during the past 10 years, it has been used much less frequently than in the United Kingdom or Canada. This may be in part attributed to two facets of the American medico-legal context. Led by Dalton, the British medical community may accept PMS as a genuine medical disorder more than doctors in the United States. Secondly, as discussed earlier, in America, lawyers may be intimidated by the Frye standard of scientific acceptability and are reluctant to expose the disorder to that test until, or if, it has acquired medical legitimacy and acceptability.

It has however been used in shoplifting cases and other minor offences. For example, in *Reid v. Florida Real Estate Commission* (1966) the defendant successfully defended her real estate licence revocation that had been initiated as a consequence of her shoplifting prosecution. Her defence alleged 'change of life' and premenstrual symptoms that affected her intent to commit a crime. This was attested to by her physician and a psychiatrist.

In 1983, a PMS defence was used in a bankruptcy case, *Lovato v. Irwin*. It was rejected by the judge who did not believe that a cyclical pattern of violence had been shown. The defendant who had a lengthy psychiatric history had filed for bankruptcy and was asking the court to discharge a debt owed to her former lover for medical expenses which had been incurred as a result of the defendant's assault. However, the psychiatrist's testimony did not unequivocally support PMS as the defendant's primary problem. Thus the judge concluded that 'Given the present knowledge of PMS, it is not surprising that it has not yet been accepted in the United States as a defence to criminal conduct or intentional torts' (Benedek 1988, p. 499).

The only major criminal case cited in the literature in which PMS was used as a defence plea occurred in 1982, in *People v. Santos*, Brooklyn, New York. PMS was introduced as an exculpating factor in a motion to dismiss the charges of first degree assault against Shirley Santos who had allegedly beaten her four-year-old daughter. She claimed, 'I don't remember it, but I would never hit my baby. I just got my period' (Chait 1986, p. 269). Later, in criminal court the defendant abandoned that defence (and others) and a probationary plea bargain ended the case. Although PMS was not therefore actually tested as a defence, it was significant that a judge, at least at a pretrial hearing, was willing to allow PMS testimony (Oakes 1986). In fact, the judge in *Santos* stated that 'since psychological disturbances are admissible as evidence relating to criminal intent, physiological disturbances, such as PMS, might likewise be admitted (Pahl-Smith 1985, p. 257).

It is possible that more recent PMS defences do not appear in the literature because the syndrome is being used in pretrial mitigation as a result of the *Santos* publicity and the plethora of legal journal articles advocating such a course of action. If PMS is indeed a defence bargaining tool in the United States, where a high percentage of cases are finalised at the plea bargaining stage, this informal off-the-record type use would not be noted.

Australia

There are no criminal cases with a defence plea involving PMS reported in the literature. Further, a computer search of law reports and unreported judgments for New South Wales, Victoria, Western Australia, South Australia and Tasmania only revealed

two civil cases where the term premenstrual 'tension' appears and in both instances it is unclear what effect, if any, the PMS had on the final disposition. In *Maxwell v. Mather* (Supreme Court of New South Wales, December 1988) a husband and wife were suing for damages for nervous shock arising from a car accident. One of the repercussions, they claimed, was the negative effect this shock had had on their marriage. The defence argued that the marriage was already disharmonious but Barbara Maxwell told the judge that pre-accident stormy marital scenes were in fact solely related to her PMT.

In *Smith v. Henderson* (1990) heard in the Supreme Court of South Australia, the only mention of 'PMT' by the judge was a reference to medical testimony that alluded to the respondent's continuing headaches as at least in part attributable to the 'PMT', and not solely the result of the automobile accident.

Thus, it would appear that PMS has been ignored by the Australian legal profession as a defence or mitigation. However, the latter, at the least, is not true. Informal interviews conducted with representatives of the Office of the Director of Public Prosecutions in two states, a Public Defender, and several barristers indicate that each has heard 'PMT' used in shoplifting cases as a mitigation factor. Although several recalled instances of postnatal depression being raised as a defence, no-one recollected 'PMT' as a defence in their courtroom experiences.

One female barrister believes that it has not been used in this country because it relates to women and the legal profession has been dominated by men who are unaware of defences such as PMS. Further, press reports such as one appearing recently in the *Sydney Morning Herald* (Harris 1990) certainly would not promote PMS as a defence. In the article on female murderers, the brief paragraph on premenstrual tension cites an Adelaide forensic psychiatrist, 'Research has a long way to go before PMT can be considered as a cause'. Others have attributed the relatively rare use of PMS in Australian courts to the strength of the feminist movement in this country and its stance, as described below, on this issue.

The Feminists' View

Those who are concerned with gender equality are faced with a dilemma. Although they do not want the small number of severe PMS sufferers to be dismissed as neurotic or charlatans, the primary concern is that people might generalise from the few and negatively stereotype all women or all those who experience premenstrual symptoms. Like all medical disorders, a whole class of people with similar maladies can be stigmatised. This has occurred for epileptics when epilepsy has been used for pleading diminished responsibility (Sommer 1984). Scutt (1982) reports that Australian feminists strongly objected to the *English* and *Craddock/Smith* cases fearing that such dispositions would once again reinforce the view of women as slaves to their hormones and thus unable to occupy responsible employment positions. The days of biological deterministic theories of male superiority were recalled with the concern that PMS as a defence would revive this perspective with its obvious implications.

Other arguments point to possible uses of PMS in the courtroom which could work against the sufferer. For example, the syndrome has been employed to deny a mother custody of her child (D'Emilio 1985). However, another custody battle was won by the mother although she had been diagnosed as having premenstrual syndrome. There is also fear that PMS could be used by a male batterer as justification for his behaviour, for example, 'She just got so irritating and obnoxious that I couldn't handle it any more . . .'

The general consensus appears to be that PMS should not be used frivolously but ought to be restricted to cases involving the small minority of women whose premenstrual symptoms are so incapacitating that they lack the necessary criminal intent. When these infrequent circumstances arise, some feel it should be regarded as other illnesses and not as a woman's defence (Chait 1986). Another less threatening way of presenting the defence would be to focus on the **symptoms**, which are not unique to females; instead of on the **syndrome** (McArthur 1989).

The Future

The prevailing view presented in legal journals is that a need exists for a greater knowledge about PMS and a subsequent greater acceptance within the medical community. As this occurs, it is likely to be raised more often in courts around the world. Specifically, we need to know more about specific diagnostic criteria, aetiology and effective treatment. The latter is particularly important in the courtroom context since a judge cannot mitigate a sentence with PMS treatment if no medically effective or accepted course is available. A search of 1989-90 medical journals revealed over 50 articles on PMS; almost one-half of these were descriptions of experimental trial use of different remedies from relaxation to inhibition of ovulation. Many treatments, including progesterone have been found by some to be no more effective than a placebo. Although several look promising, it is too early to say that a particular hormone or chemical will alleviate all symptoms or all sub-types of PMS, if indeed there are different premenstrual symptomatic clusters that are being incorrectly classed as one syndrome.

Pahl-Smith (1985) believes that the medical and legal communities should not be unduly concerned with achieving a consensual view of the cause or treatment but might better serve legitimate victims of PMS by focussing on the syndrome's effects and recognising their relationship with deviant behaviour. Further, concerns about both abuse of the plea and possible sexism can be in some part overcome by requiring a heavy burden

of proof such as endocrinological and psychiatric experts and detailed charting. It must also be clearly indicated both in court and by the media that although a large proportion of women experience some premenstrual symptoms, only a small percentage manifest those that can substantially impact on their actions, and even according to some, produce a psychotic state.

In the 1990 supplement to *Crimes of Violence: Homicide and Assault,* the noted American lawyer, F. Lee Bailey devotes a chapter to PMS, noting that it

> *is a fruitful area for the diligent attorney to pursue . . . Those who suffer symptoms severe enough to impair their emotional or mental functions are a small proportion of the women who suffer from PMS. Do not try to raise the defence unless you can back it up with solid medical evidence' (Bailey & Fishman 1990, p. 728).*

This guide to lawyers in the United States goes on specifically to advise about expert witnesses and their preparation, jury consideration, testimony by the defendant and PMS sentencing. Thus, although it has not been used in the United States to the same extent as in Canada or the United Kingdom, certainly an awareness of the need and potential is growing. The same cannot be said for Australia. It may indeed be time for medical practitioners in this country to change the terminology from 'tension' to 'syndrome' and recognise the seriousness of PMS for some women. Australian solicitors and barristers could then ensure that these women do not fall through the cracks of justice, possibly imprisoned either for acts committed without requisite intent or without the consideration in sentencing given to lack of prior record, emotional trauma or other mitigating factors.

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Note: The terms PMS and PMT (premenstrual tension) are often used interchangeably in the literature. However, PMT is actually a component symptom of PMS.

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