Premenstrual Syndrome in the Criminal Law

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I: INTRODUCTION

When used to explain the behaviour of women, premenstrual syndrome ("PMS") has caused a great deal of controversy. To confess to experiencing it is sometimes regarded as a sign of weakness. PMS is regularly dismissed by feminists as a manifestation of patriarchal values that demean and diminish women by reference to their biology. It has been used to argue that women are not capable of competing in the marketplace. PMS, as an explanation or excuse for antisocial or criminal behaviour, is therefore extremely unpopular among feminists.

This article aims to show that PMS can be used to explain, but not necessarily excuse, criminal and antisocial behaviour in some women. As a secondary issue, it will be argued that the feminist response to the idea of PMS, and any subsequent legal effects, is a response to a popular notion of PMS. The popular notion does not correspond to the acute medical phenomenon. This is known to affect very few women in a way so severe that it could feasibly provide the basis for a legal excuse or plea of mitigation.

In order to give a clear picture of PMS and its possible role in law, this article will first discuss various medical issues that relate to PMS. The bulk of the article will then work to link the medical with the legal, to discuss whether PMS has a role

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in modern criminal law. The role that PMS might play for a sufferer who has committed an offence and finds herself in court will be examined. Particular forms that the PMS excuse might take will not be addressed until the final section of the paper. Before this, all possibilities will be covered by the phrase "PMS excuse".

This article does not make direct reference to current mental health legislation, as this law is not specifically designed to deal with such issues as PMS. However, PMS is relevant to the general area of mental health as the symptoms that cause criminal behaviour are those most likely to be seen by a psychiatrist.

II: PMS AND THE MEDICAL WORLD

1. What is PMS?

Katharina Dalton has provided a clear and useful definition of what PMS is: "Premenstrual syndrome is the recurrence of symptoms in the premenstruum with complete absence of symptoms in the postmenstruum".[1] This means that PMS is clearly identifiable with the cyclic appearance of symptoms.[2] So claims of ambiguity because of the large range of possible symptoms should be treated with caution. The diagnostic criteria of PMS are strictly limited by time, rather than by the type of symptom.

PMS will, according to Dalton, only affect a person who has menstrual cycles. This excludes "girls whose menstruation has not yet started, those whose menstruation has stopped, whether due to anorexia or taking hormonal contraception, especially the long acting injections, those who are pregnant, have had a hysterectomy and/or removal of their ovaries, and those past the menopause".[3] Men are, of course, also excluded.[4]

2. Is PMS an Acknowledged Medical Phenomenon?

There is little doubt among medical professionals who work in the field of PMS that it exists. All medical articles examined in the research for this article assumed that PMS was a phenomenon that affected many women's lives, sometimes detrimentally. Most of the articles were concerned with the merits of various PMS treatments, rather than whether there was anything to treat.

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1 Dalton, *Premenstrual Syndrome goes to Court* (1990) 44.

2 Ibid, 74.

3 Ibid, 35.

4 However, see supra at note 1, at 3. Dalton alludes to a case where a man was freed after strangling his fiancee on the grounds that he was "defending himself against the violent effect of her premenstrual syndrome".

However, the American Psychiatry Association's *Diagnostic and Statistical Manual of Mental Disorders*[5] ("DSM") has had difficulties defining PMS as a recognised mental disorder. The Association felt it necessary to differentiate between women whose physical symptoms were more predominant and those women whose mood changes were the more obvious effects of PMS.[6] As a result, in DSM-III-R they recommended that the mood related form of PMS be known as "late luteal phase dysphoric disorder". This was subsequently changed to "Premenstrual Dysphoric Disorder" in DSM-IV.[7] Here it was included as a mental disorder for the purposes of encouraging further research.[8]

It seems unlikely that PMS would gain medical attention if women had not mentioned the uncomfortable and repetitive symptoms they were experiencing to medical professionals. Nonetheless, one critic, Candice Smith, has claimed that PMS was invented to maintain the myth of the passive and non-aggressive female.[9] She argues that this is achieved by using the idea of biological abnormality to explain away the aggressive behaviour that can be a symptom of severe PMS.[10] However, in claiming this Smith has taken the popular model of male behaviour and assumed it to be appropriate for women. Smith appears to believe that it is a sign of weakness to admit that something is frightening and beyond a person's control, such as the experiences of those suffering from severe PMS; it is not the "manly" or "rational" thing to do. To dismiss PMS as a patriarchal plot is overly simplistic in the author's opinion. Smith also claims that acceptance of the existence of PMS would detrimentally affect women in general. She believes this is so because, in her opinion, any view, especially medical, that women are not as "balanced" as men damages the feminist movement and women's liberation generally.[11] The following points show that this is an unhelpful and misguided approach.

First, as previously mentioned, PMS is believed to exist by a large part of the medical profession. Although PMS does appear to be misdiagnosed by many doctors in general practice, the broad variety of symptoms involved makes this unsurprising. The denial that PMS is medically accepted (note that this is not acceptance for *legal* purposes), as is made by Smith, is insupportable. Moreover, Smith asserts that PMS is a "medical and social construct". She believes that because there is no exhaustive definition of PMS, which is itself a debatable claim, PMS therefore does not exist.[12] This is false as the mere fact that something cannot be defined does not mean that it cannot exist.[13]

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5 (1994).

6 Freckelton and Selby (eds), *Expert Evidence* (1993).

7 American Psychiatric Association (1994) 716, as cited in Freckleton and Selby, ibid at 1-3393.

8 Ibid.

9 Smith C, *PMS: A Defence with Merit?* (1993) Honours Dissertation, University of Auckland, 1-8.

10 Ibid, 1-2.

11 Ibid.

12 Ibid, 3-4.

13 "Crime" and "truth" are examples of this, for they cannot be conclusively defined, and yet if they

Interestingly, Smith also tries to discredit PMS by virtue of the difficulties in treating sufferers.[14] This is contradictory as it presupposes the existence of PMS. This claim is not made for the sake of argument, or to further discredit the case of PMS advocates.

Second, it would be of no credit to feminism if the movement were to forsake an individual woman to severe sanctions as a criminal when she was not fully responsible for her actions, on the grounds that a legitimate explanation for her actions would reflect badly on the rest of womankind. As Pat Carlen and Anne Worrall observed: [15]

> The political implications of accepting a theory which maintains that many (most?) women are physiologically, emotionally and behaviourally abnormal for between a quarter and a half of their reproductive lives, have clouded the recognition of what could be seen as an otherwise valuable clinical exploration of a neglected area of medicine ....

While Carlen and Worrall's comments support the author's criticism of Smith, this article will argue that the concerns they express at the beginning of their statement are groundless.

Further comment by Carlen in "Women, Crime, Feminism, and Realism" gives a more general view of the need for feminists to support women, even if they are not ideal representatives or convenient to the feminist cause: [16]

> I do, nonetheless, disagree with feminists who argue for a non-interventionist stance on women's lawbreaking and criminalization. For, as a matter of political calculation (and not as a guaranteed theoretical recipe for a desired outcome), knowledge gained from theoretical work can be used in part to inform policy interventions .... My personal view is that if *no* academics were prepared to compromise their claims to theoretical rectitude (or consistency) by committing themselves *as academics* and *as feminists* to campaigns to redress the specific wrongs suffered by women law breakers in the criminal justice and penal systems, it would be to the further disadvantage of those very women who are already amongst the worst casualties of the gender and poverty traps.

It is therefore important for feminism to acknowledge that PMS can detrimentally affect the quality of *some* women's lives. Moreover, to be neutral on the matter by not acknowledging PMS, is to allow an oppressive aspect of the legal process to detrimentally affect those less able to defend themselves.

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do not exist as a result, the criminal justice system as we know it is morally inappropriate. In any event, this paper will assert that PMS can be clearly defined, and consequently, be conclusively diagnosed.

14 Supra at note 9, at 7.

15 Carlen and Worrall, *Gender, Crime and Justice* (1987) 6-7.

16 Carlen, "Women, Crime, Feminism, and Realism" in Naffine (ed), *Gender, Crime and Feminism: The International Library of Criminology, Criminal Justice and Penology* (1995) 435.

3. Diagnostic Criteria

The following statement describes the diverse nature of PMS symptoms, and the difficulty of diagnosis in the absence of case histories:[17]

> Over one hundred and fifty different symptoms have been described which may occur in premenstrual syndrome. The symptoms cover almost every medical speciality and the premenstrual syndrome appears to be amongst the commonest presentations with which each speciality is called upon to deal. Thus, the common symptoms taking women to psychiatrists are depression, irritability, tiredness and tension; the neurologists see most patients complaining of epilepsy, migraine, vertigo and blackouts; the rheumatologists and orthopaedic surgeons see those with backache and vague joint pains; the dermatologists have their appointments filled with women complaining of acne and boils; the chest physicians with those suffering from asthma; the urologists are concerned with recurrent cystitis and urethritis, and the allergists see those complaining of urticaria, rhinitis, asthma and migraine. Nor must one forget those trying to treat the recurrent sore throats, upper respiratory infections and sinusitis. Furthermore, the women with premenstrual syndrome tend to be polysymptomatic, their symptoms often span more than one speciality.

Given the diversity of symptoms it is therefore understandable that there is difficulty in both diagnosis and scepticism about the existence of PMS. This is particularly so when some fortunate women feel fabulous during the days before they menstruate.[18]

It has been argued that symptoms must have recurred over at least three months to be indicative of PMS.[19] These symptoms must occur only in the premenstruum, which is never more than fourteen days before menstruation, even if a woman's cycle is shorter or longer than the twenty-eight days conventionally cited.[20]

Dalton has emphasised the necessity of keeping meticulous records of the symptoms suffered by women suspected of having PMS.[21] This works by charting the problems in the following way:[22]

> The patient fills in the chart by marking the symptom in the appropriate space for that month on the day that it occurs, using agreed symbols identifying the premenstrual symptoms and likewise the days of menstruation. This will show clearly the timing of symptoms in relation to menstruation, so confirming or renouncing the diagnosis of premenstrual syndrome.

Dalton claims that retrospective questionnaires are of little use as people tend not to remain objective, particularly if they are accused of a crime.[23]

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17 Supra at note 1, at 74.
18 Duckworth, *Premenstrual Syndrome: Your Options* (1989) 12-13.
19 Supra at note 1, at 35.
20 Ibid, 36-37.
21 Ibid, 45-46.
22 Ibid, 46.
23 Ibid, 47.

Dalton cites a number of factors that can be used as diagnostic pointers:

(i) Time of onset of PMS and increased severity in PMS:[24] PMS tends to begin or increase in severity at times of great hormonal change. Examples of this are at puberty, after pregnancy, and following sterilisation.

(ii) Painless menstruation:[25] This is often a feature of severe PMS which is why there is sometimes a failure to connect the symptoms with the menstrual cycle.

(iii) Increase in libido in the premenstruum.[26]

(iv) Inability to tolerate the oral contraceptive.[27]

(v) Weight fluctuations:[28] While women tend to have weight fluctuations twice monthly, in PMS sufferers this exceeds the normal change quite dramatically.

(vi) Altered hunger tolerance:[29] Acute symptoms of violence, irritability, panic attacks and fainting often occur after being without food and when suffering from PMS.

(vii) The effects of pregnancy:[30] As progesterone levels are extremely high during pregnancy hormone levels drop after the baby is born. These women tend to suffer post-natal depression, and will often develop PMS subsequently.

The American Psychiatric Association has also set out diagnostic criteria for the psychiatric form of PMS, late luteal phase dysphoric disorder, as it was then known:[31]

> A. In most menstrual cycles during the past year, five (or more) of the following symptoms were present for most of the time during the last week of the luteal phase, begin to remit within a few days after the onset of the follicular phase, and were absent in the week postmenses, with at least one of the symptoms being either (1), (2), (3) or (4):
>
> (1) markedly depressed mood, feelings of hopelessness, or self-depreciating thoughts
>
> (2) marked anxiety, tension, feelings of being 'keyed up', or 'on edge'
>
> (3) marked affective lability (eg, feeling suddenly sad or tearful or increased sensitivity to rejection)

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24 Ibid, 48-50.
25 Ibid, 49-50.
26 Ibid, 50.
27 Ibid, 50-51.
28 Ibid, 51-52.
29 Ibid, 52-53.
30 Ibid, 53.
31 Supra at note 6, at 1-3393.

(4) persistent and marked anger or irritability or increased interpersonal conflicts

(5) decreased interest in usual activities (eg work, school, friends, hobbies)

(6) subjective sense of difficulty in concentrating

(7) lethargy, easy fatigability, or marked lack of energy

(8) marked change in appetite, overeating, or specific food cravings

(9) hypersomnia or insomnia

(10) a subjective sense of being overwhelmed or out of control

(11) other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of 'bloating', weight gain.

Note: In menstruating females, the luteal phase corresponds to the period between ovulation and the onset of menses, and the follicular phase begins with menses. In nonmenstruating females (eg those who have had a hysterectomy), the timing of luteal and follicular phases may require measurement of circulating reproductive hormones.

B. The disturbance markedly interferes with work or school or with usual social activities and relationships with others (eg avoidance of social activities, decreased productivity and efficiency at work or school).

C. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as Major Depressive Disorder, Panic Disorder, Dysthmic Disorder, or a Personality Disorder (although it may be superimposed on any of these disorders).

D. Criteria A, B, and C must be confirmed by prospective daily ratings during at least two consecutive symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation).

The American Psychiatric Association's diagnostic criteria are useful in terms of general legal issues and for this article in particular, for it is in the *psychiatric* area that women who have committed criminal offences may have some recourse under the law. It is psychiatrists who commonly see women with the kind of problems that will cause them to come into contact with the criminal justice system. This will be discussed later in this article.

Although there are some differences between the opinions of Dalton and the American Psychiatric Association as to who is potentially a PMS sufferer (with the latter surprisingly proving more generous in terms of women who do not menstruate), there is still a striking amount of concurrence of opinion. This is particularly satisfying when PMS is considered by some to be such a difficult notion to define. Furthermore, it is important to note that an incomplete homogeneity of opinions in the field is not a sign of discredit. It shows that the field is not completely understood, as could perhaps be said of any medical field and certainly about psychiatry. There is, therefore, no reason to exclude medical evidence with regard to PMS from court, especially that of psychiatrists.

III: CONNECTING THE MEDICAL WITH THE LEGAL

Leaving the medical perspective aside, to assist a PMS sufferer who has been apprehended on criminal charges it must be shown that PMS actually causes women who suffer from it to commit crime, or that PMS uncontrollably influences women to commit crime. Before pure legal issues are discussed the areas in which medical and legal issues overlap must be addressed.

1. Criticisms of PMS as a Legal Excuse

In her article "Premenstrual Syndrome as a Legal Defence" Elizabeth Holtzman made the following comment: [32]

> The need for further research, however, is not to be confused with the issue of premenstrual syndrome (PMS) as a legal defence, which should not be taken seriously. This so-called defence rests on the absurd and baseless claim that some women become criminally insane and are driven to violent criminal behaviour in connection with their menstrual cycle. For obvious reasons the PMS defence has no legal credibility and furthermore has ominous implications for the advancement of the status of women.

Holtzman gave the following reasons for her argument. First, she claims that PMS is not characterised by any one symptom. As some of its manifestations can be bipolar, for example feeling depressed or extremely buoyant depending on the individual, it cannot be labelled a syndrome.[33] Holtzman believes that the cyclic nature of the problem merely indicates that existing problems are being exacerbated. While PMS may exacerbate existing conditions, the symptoms must be absent and not merely minimised in the post-menstrual phase for legal purposes. Thus not all symptoms of PMS can be explained away so easily: PMS has a variable nature. Furthermore, in terms of legal excuse only a few symptoms will be consistently found acceptable to remove or diminish a person's responsibility for their actions. This will be discussed further below.

Second, Holtzman argues that if women menstruate monthly, and if PMS causes them to commit crime, then the prisons should be full of women. She further asks, what excuse could men use, given that they commit ninety percent of crime.[34] The first part of this criticism will be addressed in the following section

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32 Holtzman, Premenstrual Syndrome as a Legal Defence" in Hartley Gise (guest ed), Kase and Berkowitz (series eds), *Contemporary Issues in Obstetrics and Gynaecology: The Premenstrual Syndromes* (1988) 137.

33 Ibid, 138.

34 Ibid, 139.

where the minute numbers of women committing crime as a result of PMS will be discussed. The second statement misses the point entirely. While it is possible that some men will experience hormonal imbalance, they will not have PMS. If they do, then they are in the wrong prison. Nor would every female offender be given a defence to her crime if certain specified women were allowed some form of an excuse based on PMS. There is no good reason to compare the rates of male and female offending if the true nature of PMS is understood. To draw a parallel between the female and male rates of offending as an illustration that PMS cannot be causing crime is illogical.

Holtzman further asserts that women's cognitive abilities are not affected by PMS.[35] However, from Dalton's list of PMS symptoms for use in court we can see that this matter is at least arguable. This may be an issue that a jury can be asked to decide upon when faced with the conflicting evidence of two expert witnesses, although the forty-nine years that Dalton has had working in the field must enhance the credibility of her claims, and thus that of the expert who presents a similar perspective on the matter.

Holtzman also claims that women experiencing PMS merely lose control when they commit a crime. This loss of control may be completely by virtue of the PMS, but she asserts it remains merely a loss of control. The point of her argument is that it is wrong to excuse the results of a loss of control, except in the case of reducing murder to manslaughter.[36] Thus, a woman should still be at least minimally culpable for her actions. This may be acceptable to a certain extent. PMS may not be appropriate as a complete defence. This problem will be addressed below. However, if a woman can be shown to be quite demented when she committed an offence there seems to be little sound purpose in stigmatising her with a criminal conviction when she is clearly not responsible.

Finally, Holtzman asserts that PMS as a legal excuse is "the old hocus-pocus about women in a new guise" and "another way to reduce the humanity of women".[37] Here she mirrors Smith's arguments as addressed previously.[38] Holtzman claims that if a judge stated that he was taking PMS into account when sentencing, then she would refuse to believe him.

A more balanced response to this problem may be to argue that while it is important to ensure that the privilege of a PMS excuse is not abused, PMS must be acknowledged as a real problem for those who suffer from its more severe form. If those women are sufficiently mentally disturbed to commit crime in the absence of real responsibility for their actions, then they should not be stigmatised, whether it damages the interests of the feminist movement or not. The following comments from Nada Stotland and Bryna Harwood in their article "Social, Political, and

35 Ibid, 140.
36 Ibid, 140.
37 Ibid, 142.
38 Supra at note 9.

Legal Considerations" summarise the problem: [39]

> The possible use of a menstrually related diagnosis as a legal defence embodies the double bind described earlier in this chapter. If some small number of women should be so incapacitated by premenstrual symptoms as to lose control of their behaviour, such a plight should be admissible as evidence and should have an impact on the adjudication of their culpability. The implications of headlines linking the menstrual cycle to "raging animals", however, are dire. They reinforce the cultural stereotypes and stigmatization of all women. This real danger necessitates particularly meticulous study and rigorous application of diagnostic criteria. The former is in progress; it is dubious whether the latter can be attained, particularly in courts of law. One lawyer in writing on the subject recommends that, in cases where premenstrual changes may have played a role in a defendant's behaviour, her lawyer cite them as organic disease and not as a form of insanity.

Stotland and Harwood's assertion that there should be careful study coupled with appropriate application of diagnostic criteria is important. While it appears that diagnostic criteria can be applied to a necessary standard, according to Dalton at least, the matter remains arguable. Whether or not the diagnostic criteria have been adequately fulfilled may therefore be a matter for a judge or jury to decide in individual cases. Similarly, if PMS is to be categorised an organic disease, then this should be shown to be as legally useful to PMS sufferers as any other definition. Otherwise women affected will be marginalised in favour of a "better" representation of women from a feminist perspective.

2. The Range of Women Affected

As previously noted, one of the first concerns expressed by people, particularly feminists, when it is suggested that PMS may be used to assist women who are facing criminal charges, is that this will demean the image of women generally by allowing some women to use PMS as an excuse. This concern arguably stems from the idea that PMS is something that all women suffer, and that it is no excuse for bad behaviour. However, medical studies have noted that only ten percent of all women in the reproductive phase of their lives will suffer from severe PMS and only one percent of those severe sufferers will engage in criminal behaviour.[40] This means that PMS could only excuse a very limited number of women; most of the female population would be unable to rely on it to excuse criminal behaviour.

As such, PMS is not an easy option to pursue in court, and there is no good reason that it should diminish the credibility of all women. Nor should PMS be used by men as a discriminatory tool to deny women the right to pursue their preferred employment and vocational options. It has even been suggested that

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39 Stotland and Harwood, "Social, Political, and Legal Considerations" in Gold and Severino (eds), *Premenstrual Dysphorias: Myths and Realities* (1994) 192-193. In this quote they refer to the work of Chait, Premenstrual Syndrome and our sisters in crime: a feminist dilemma" (1986) 9 Women's Rights Law Reporter 267.

40 Supra at note 1, at 129.

employers should assist women employees suffering from PMS with their treatment.[41]

3. Symptoms Likely to be Linked to Offences

Dalton has discussed six symptoms of PMS that are likely to be linked with criminal behaviour. These are:

(a) Depression[42]

Dalton describes depression as a "disease of loss". The sufferer experiences "loss of happiness, pleasure, interests and enthusiasm, as well as the loss of ability to concentrate, to remember, to think clearly, along with the loss of bodily functions like sleep, appetite, weight control and bowel movement".[43] Although anyone can suffer from it, depression in PMS sufferers is predictable in timing and duration, lasting only a few days. It is generally accompanied by weight gain, cravings and increase in appetite. This is unlike typical depression. Moreover, there is a desire to sleep, which is unusual in depression sufferers. Marked irritability and sudden mood changes found in the PMS sufferer are also not typical of depression. The experiences of those with PMS are often associated with feelings of self-loathing and ugliness, worthlessness, and guilt. As Dalton notes, "[d]uring the days of depression all insight is lost, there is no hope or prospect of improvement, and with this feeling that there is no tomorrow and no one cares, the scope for wrongdoing is wide open".[44] Interestingly, theft is crime often committed during premenstrual depression. Dalton speculates that goods act as a comfort to the women at the time, but claims that it is impossible to know this for certain, as sufferers are irrational at the time of the offence.[45] Often women (or occasionally their spouses) will try to return the goods after the premenstrual phase as they neither want nor like the goods they now possess.[46]

(b) Suicide[47]

Attempts to take one's life are not uncommon in the throes of severe PMS. Surveys have shown that half of all female suicides occur in the premenstrual period.[48] While it would be rash to take this as conclusive evidence that women

41 Interview of Dr Niall MacKenzie by Kim Hill, National Radio, 20 October 1995.
42 Supra at note 1, at 75-79.
43 Ibid, 75.
44 Ibid, 78.
45 Ibid, 79.
46 Ibid.
47 Ibid, 79-80.
48 Ibid, 79.

are trying to kill themselves because of PMS, such evidence should not be discounted as an indicator of some disturbance of mind. Females tend to be less successful in suicide attempts than men. It has been suggested that at least one possible explanation of this is that women affected by PMS may not have the necessary clarity of thought to successfully commit suicide because of their PMS symptoms.[49] Moreover, if a person feels sufficiently depressed to attempt suicide they may be more tempted to commit crimes, as a result of caring so little about what happens to them in the future.

(c) Irritability[50]

Sudden changes in temper with outbursts of anger, often violent ones, are not unusual in severe PMS cases. Such violence is often committed against a spouse or child and, as a result, might be less frequently reported than more public attacks. However, should this kind of behaviour be directed at members of the general public it understandably attracts the attention of the criminal justice system.

(d) Psychosis[51]

Although unusual and controversial, Dalton claims that women suffering from severe PMS can experience psychosis in the form of "confusion, delusions, hallucinations or paranoia".[52] As this is temporary, it is a matter of chance whether the woman is placed in a mental institution or arrested if she has committed a crime. If she is delusional, it is not uncommon for property crimes or violent crimes to have occurred. Dalton supports these claims with reference to the work of Endo,[53] who studied menstrually-related psychosis in seven young women aged between thirteen and twenty-five years. He found "manic-confusion, retardation, auditory and visual hallucinations, delusions and paranoia".[54]

(e) Nymphomania[55]

It can cause women with PMS, particularly young women, to harass males. Nymphomania, coupled with delusions and depression could cause real problems; problems that might result in women facing criminal charges.

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49 Ibid, 80.
50 Ibid, 80-81.
51 Ibid, 81-84.
52 Ibid, 81.
53 Endo, Daiguji, Asana, Yamashita, and Takahashi, (1978) J Clin Psychiat, 456 as cited in ibid, 84.
54 Ibid.
55 Ibid, 85.

(f) Alcohol and Drug Abuse[56]

There is a tendency for women with severe PMS to crave alcohol only in the premenstrual period.[57] Often the alcohol has a more substantial effect than it does during the rest of the menstrual cycle.[58] Likewise, there is often a link between use of alcohol and depression.[59] Drug abuse is also common among PMS sufferers, especially excessive use of tranquillisers prescribed to relieve the irritability symptoms.[60] Drug overdose is also the most common form of attempted suicide.[61] With a cocktail of drugs or alcohol and psychosis or depression, it is easy to understand how crimes could be committed without the person committing those crimes being fully responsible.

It is therefore possible to understand that a woman suffering severe PMS, to the point that it interferes with the workings of her mind, may not always be responsible for her actions. Accordingly, there is a good case for encouraging provision for such people in the law. This will be discussed in the purely legal section of this paper.

4. Diagnostic Pointers and their Legal Application

Using the diagnostic criteria described earlier, Dalton claims to provide a formula that can determine a "percentage" based risk of PMS.[62] This could be useful to a lawyer in a case where a woman has offended but she has no medical history of PMS. The formula must be coupled with a menstrual chart at a later point to be appropriate evidence for a court, but the formula alone might provide the beginning of a case for a defence lawyer.

IV: LEGAL MATTERS RELATING TO THE "PMS EXCUSE"

There have been no cases in New Zealand where PMS has been used as an excuse for illegal behaviour. However, there has been enough recognition of the phenomenon overseas to warrant consideration of the matter here. The following section aims to show that PMS should be recognised in New Zealand law. It will also reflect on the forms that such recognition could take. It will be argued that under New Zealand law there is a sufficient structure to enable the courts to approach the matter with fairness and the appropriate skills, and to discern true instances of PMS.

56 Ibid, 85-87.
57 Ibid, 85.
58 Ibid.
59 Ibid, 86.
60 Ibid.
61 Ibid.
62 Ibid, 48-55.

For a PMS excuse to be successful it must fulfil a number of legal criteria. These will vary depending on the extent and implications of the excuse used. This section will discuss each type of excuse in turn. Prior to this, the two basic requirements for criminal responsibility: *actus reus* and *mens rea*, will be examined. The need for expert testimony will be discussed, as will evidential matters and the problem of preventing people from "jumping on the bandwagon".

1. Actus Reus

Actus reus means the guilty act. There is often little difficulty in showing that a woman suffering from severe PMS is the person who performed the act, as she is unlikely to deny the fact, or try to hide her actions.[63] Sometimes these women will even go so far as to ring the police and report themselves.[64] Prosecution lawyers will have little trouble establishing actus reus.

2. Mens Rea

Mens rea means guilty intent. To disprove the presence of mens rea is not merely to show that a person did not mean to commit the crime, but rather that the person concerned did not *know* that they were committing a wrongful act.

As has been discussed, Smith argues that "[t]o contend that a woman does not intend to do what she does because she is about to menstruate simply perpetuates the idea that women are not in control of themselves and should not be held responsible for their actions".[65] However, Smith never discusses the arguments forwarded by people such as Dalton. Dalton claims that a small number of women with severe PMS will be sufficiently disturbed to lose control of their actions, or to be incapable of understanding the implications of those actions. Smith's argument shows unwillingness to accept the reality of PMS for many women. In court, expert witnesses should be allowed to demonstrate that an individual woman did lack mens rea. If this can be done there will be no further case to answer.

Karen McArthur has argued for the establishment of a PMS defence based on the lack of mens rea[66] in her article: "Through her looking glass: PMS on trial".[67] For McArthur, this would mean focusing on the symptoms of PMS[68] rather than the presence of PMS, perhaps as a way of emphasising that to menstruate does not mean that one by definition suffers from PMS.[69] This should work either by showing that the mind of a woman was so severely affected by PMS symptoms

63 Ibid, 9 and 12-13.
64 Ibid, 12.
65 Supra at note 9, at 49.
66 As it is a fundamental element, absence of mens rea will be a complete defence.
67 (1989) 47 University of Toronto Faculty of Law Review (Supplement), 826.
68 Ibid, 825.
69 Ibid, 855.

that it was impossible for her to control her actions, or that she did not have the full mens rea necessary and thereby should have her charge reduced through diminished responsibility.[70] A plea of diminished responsibility is not however, available in New Zealand.

While it is important to focus on the symptoms of PMS that cause a woman to commit a crime, it would be risky not to require defence counsel to show that PMS was in existence through such methods as suggested by Dalton. If there were no requirement to demonstrate the presence of PMS, a person would be able to plead that they were experiencing PMS symptoms without sufficient evidence to show that the symptoms were in fact caused by PMS. Defence counsel could therefore falsely plead PMS on behalf of their clients. This problem aside, consideration of mens rea leads to the ways in which PMS might be used in court, that is, as a defence, a basis for diminished responsibility, or as a mitigating factor. These possibilities will now be discussed.

3. PMS as a Complete Defence

The justification for having a complete defence for those suffering psychological and psychiatric symptoms is that it is unreasonable to punish people for committing an act over which they had no control. If it can be shown that a woman was not in control of her actions as a result of physiological effects, there can be no justice in punishing her for that act. However, to enable a New Zealand court to use such a defence, that is, a defence solely arising from the experience of PMS, some changes to the usual practice of law would be required as there is no precedent for such a move.[71] The idea of a defence based on PMS was rejected in the Court of Appeal in England[72] and it is probable that New Zealand would look to England for guidance. Therefore, if it is to be a defence in New Zealand, legislation may be needed.

Some standard defences will now be examined to see if the symptoms of PMS can be used to fulfil their criteria.

(a) Automatism[73]

To act as an automaton one must act without awareness of what one is doing - sleepwalking for example. Automatism falls between the category of the criminally insane and the criminally liable. There are two types of automatism: non-insane, and insane automatism.

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70 Ibid, 849.

71 *R v Smith* [1982] Crim LR 531 (Eng CA).

72 Ibid.

73 *Adams on Criminal Law*, Vol 1 (1992).

Insane automatism is the obvious categorisation for PMS, because the cause is internal.[74] The unfortunate aspect of this as a defence is that New Zealand law requires the same result as a finding of insanity - institutionalisation.[75] While this seems an inappropriate way to deal with a woman suffering from PMS, despite the fact that her severe PMS makes her behaviour incontrollable, institutionalisation might result in beneficial treatment. There is, however, no real need for a woman to be treated as an inpatient, which would be the result of a court's finding of insane automatism. Any effort to build a plea around insane automatism should be treated with caution.

Non-insane automatism requires some external factor to cause the person to act in an uncharacteristic, automaton way.[76] PMS is not an external factor. However, McArthur has argued that PMS should be put into this category as a matter of social policy.[77] The basis for this could be that it would protect women who are genuinely suffering severe PMS. Such a move would not categorise these women, or other women by proxy, as demented and incapable lunatics.

(b) Insanity[78]

The defence of insanity constitutes an acknowledgment that the legally insane lack a crucial element of criminal responsibility, that is, moral culpability.[79] The burden of proof lies on the person raising it, typically the defendant, and it is decided on the balance of probabilities. The court must hear evidence of incomprehension of the consequences of the act. In the case of a sufferer of PMS such evidence may be debatable, but it could be argued in some instances if Dalton's perspective is accepted. However, it is probable that insanity is not the most helpful form of defence for the reasons already given, since if proven, the person in question will be institutionalised.

The key problem with a complete defence for PMS sufferers is that it would seem strange for someone to be acquitted for any reason except insanity and then be compelled to undertake a course of treatment. In other words, it is peculiar to be found not guilty and then be compelled to follow a direction of the court. Compulsory treatment is, civil liberties aside, essential, particularly if people such as the spouse and children of the defendant are exposed to violence. Given the cyclic nature of PMS, problems will almost certainly recur. Nonetheless, it seems harsh to give someone a criminal record in order to enforce conditions upon them, such as having compulsory treatment for the problem. If a complete defence is to be available there must be some way to ensure that the defendant receives the necessary treatment to maintain a healthy equilibrium.

74 Supra at note 67, at 854.
75 Supra at note 73, at para CA23.41.
76 Supra at note 67, at 855.
77 Ibid.
78 See s 23 of the Crimes Act 1961.
79 Supra at note 67, at 851.

4. Diminished Responsibility

The desire for a fairer criminal justice system may eventually lead NZ to allow the plea of diminished responsibility. However, as it is not currently available, the matter will be discussed only briefly. In contrast, diminished responsibility is available in Britain and diminished responsibility has been successfully used in a PMS case.[80]

The purpose of the diminished responsibility plea is to claim that the defendant did not have full mens rea. As McArthur notes, "it recognises that if one is not fully possessed of accountability as a result of a mental abnormality, then one is not as morally blameworthy".[81] In England, the defendant is required to show that the defendant was "bordering on insanity, although not reaching it; a mind so affected that the responsibility is diminished from full responsibility to partial responsibility".[82] If it is difficult to persuade the court to accept that a person suffering from severe PMS was psychotic at the time of the act (and thus eligible for a full defence) diminished responsibility would be a useful plea.

5. Mitigation

Mitigation is used both to reduce a charge, for example from murder to manslaughter, or to reduce a sentence. PMS has been successfully cited in England on a number of occasions to do these two things. The result has often been a reduction of a murder charge to manslaughter, albeit with a probationary sentence.[83] If the woman concerned has genuinely suffered from PMS symptoms that have unbalanced her mind, a successful mitigation plea will not prevent the stigma of conviction. It may, however, lead to a lesser charge or sentence.

Although never attempted in New Zealand, mitigation has real chance of success purely because it has been used successfully in Britain. There does, however, seem to be a problem with the lack of experts in the field of PMS both in Australia and New Zealand.[84]

6. Evidence

To successfully plead PMS, it would be necessary to provide the appropriate evidence. There would need to be evidence of menstruation occurring soon after the commission of the offence, as it must be shown that the woman was in the premenstrual phase.[85] Sources such as a medical examination on entry to prison or

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80 *R v English,* Crown Court, Norwich, 10 November 1981; *R v Craddock* [1981] 1 CLY 476.

81 Supra at note 67, at 852.

82 *HM Advocate v Savage* [1923] SCJ 49, 51, as cited in McArthur ibid.

83 Supra at note 1, at 4-7.

84 Supra at note 41.

85 Supra at note 1, at 102.

a psychiatric institution would be helpful, or the requests from the woman concerned for sanitary protection, if remembered by a member of the institution staff.

Most importantly, there must be evidence that the problem recurs in the premenstrual phase of the woman's menstrual cycle. While this alone is insufficient to show that PMS was the cause of the problem, it may indicate that further investigation is necessary.[86] Indeed, it may be the case that a person habitually commits crime but tends to get caught in the premenstrual phase by virtue of the lethargy and dullness sometimes experienced in less severe cases of PMS. There is also the possibility that the act was committed in the premenstrual phase by coincidence, and should not be excused.

Dalton suggests that proof of the existence of both the recurrence and the presence of problems in the premenstrual phase would be assisted by the establishment of a menstrual chart.[87] Any evidence of the woman's menstrual cycle occurring would be of use, such as the defendant's own records, or those of her spouse. This could show the recurrence of the same kind of behaviour that led to a criminal offence in the first case, and could demonstrate that the behaviour is occurring in the premenstrual phase, if the woman is actually suffering from PMS. A menstrual chart may also indicate the absence of behaviour problems in the postmenstruum.[88] Indeed, there tends to be a surge of energy and ability at this time, which is often observed by companions of the woman.

Dalton suggests the following sources of evidence: [89]

> Careful inspection of other documentation may be helpful in the precise dating of previous incidents of unusual or antisocial behaviour. Police records may reveal dates when a teenager went missing or made hoax telephone emergency calls; absences from school or work are usually accurately recorded in the attendance books; medical files and hospital notes may record dates of suicide attempts, wrist slashing or self mutilation episodes; and prison files record any disorderly conduct. Poison pen writers can usually be timed exactly from the postmark.

It would be the responsibility of the expert and to a lesser extent the defence lawyer to ensure that as much information as possible is revealed.

7. Expert Evidence in New Zealand

To successfully plead PMS under any of the prior examples it would be necessary to show the court that an expert witness was needed. In New Zealand it is possible for an expert to give their opinion as a "general exception to the opinion

86 Ibid, 103.
87 Ibid, 105.
88 Ibid, 107.
89 Ibid, 108.

rule".[90] The opinion of a witness is only admissible when it is based on what the witness perceives as having happened, and that opinion assists in making clear the evidence of the witness.[91] There are different rules governing the admissibility of expert evidence. These rules will now be examined in relation to the provision of evidence in court by experts in the field of PMS.

One of the most important rules about expert evidence is that the purported expert is actually qualified to comment about the matter in question.[92] This matter is assessed by the court in light of the circumstances of the individual case.[93] Expertise might arise through training or practical experience, but the knowledge or skill should be specialised.[94] A medical practitioner who has dealt with PMS sufferers on a regular basis could arguably be an expert witness in a criminal trial.

The expert witness must abide by the "common knowledge" rule.[95] This rule works to ensure that the expert is not called to give information that is attainable by an ordinary researcher. The ultimate purpose of the rule is to ensure that time is not wasted and that the information provided by the expert does not usurp the role of the finder of fact.[96] The Law Commission has claimed that the common knowledge rule has the same effect as the opinion rule, and that the common knowledge rule is therefore unnecessary. Specialised knowledge held by a medical expert will add to the understanding of the jury in a case where PMS is an issue and will therefore not interfere with the concerns above. As there are many commonly held misconceptions about PMS, an expert in the field would be helpful to allay the fears and suspicions that jurors might have. To successfully alter the outcome of a person's trial with a claim that PMS affected the woman concerned, an expert witness will be needed to enable the jurors to appreciate the disturbances suffered by women with PMS.

The expert witness must abide by the "ultimate issue" rule. This is also a rule that the Law Commission says should be replaced by an alternative testing the "helpfulness and reliability of evidence".[97] The ultimate issue rule attempts to exclude the expert from addressing the "ultimate" issue that the jury has to decide, as this will usurp the role of the finder of fact.[98] But the real problem according to the Law Commission is that a jury would be too easily led by an opinion that may be inaccurate. This means aspects of the evidence that are unsatisfactory will need to be examined more closely, and assessed for helpfulness and reliability, rather than whether they address the ultimate issue. This will depend entirely on the

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90 Law Commission, Preliminary Paper No 18, *Evidence Law: Expert Evidence and Opinion Evidence: A discussion paper* (1991) 13.

91 Ibid, 11.

92 Ibid, 13.

93 Ibid, 14.

94 Ibid.

95 Ibid, 15.

96 Ibid, 15.

97 Ibid, 17.

98 Ibid, 16.

quality of the expert witness, so it cannot be applied definitively to the subject of PMS.

It is possible that expert testimony on PMS would fall into the category of novel scientific evidence. However, PMS has in fact been recognised for the best part of this century, not least by Katharina Dalton who has studied the matter and practiced medicine in the field since 1948. No medical journal examined in researching this paper considered the possibility that PMS did not exist. All were concerned with the appropriate treatment of the symptoms of PMS. So, PMS should not be seen as a novel phenomenon. It is only in the eyes of the general public that the effects of PMS on some women have only come to light recently, and these perceptions are typically inaccurate.

To conclude, as long as expert opinion can be seen to be based on fact, then the expert has a role to play in the criminal trial of women with PMS. Previous parts of this article address the factual basis on which the expert evidence in the field of PMS is founded.

8. Avoiding the Problem of Those Who Wish to Jump on the Bandwagon

To avoid the situation where any woman is able to claim that she is not responsible for her actions on account of PMS, strict criteria should be set out for the use of a PMS plea in court. Such criteria should prevent lawyers from using the defence in circumstances where it is not appropriate. There is certainly no advantage to the law or to women generally if the plea is abused. Furthermore, if treatment is compulsory those who have a genuine detrimental condition will benefit, along with society in general. A non-sufferer may, however, be put off making a plea if she knows that treatment will result. Moreover, the plea of PMS has not succeeded easily in England, and has never been raised in New Zealand. As a result, it is not an option that should be taken lightly by lawyers and their clients.

9. The Necessity of Recognising PMS

Aside from the confusion and fear of women who suffer PMS, which is an unpleasant enough experience itself, it can be very embittering for a woman to find out what has caused her problems, only to be dismissed by the courts and other institutions when she tries to explain her behaviour. This has an alienating effect on women, which is not a productive way of facilitating the changes which are necessary to ease the symptoms of PMS. If a woman, particularly a young one, is to be institutionalised when she is effectively innocent, institutionalisation may well be the end of that innocence. It is therefore necessary for the courts and the general public to both recognise and take seriously the effects of severe PMS on women and their families.

V: CONCLUSION

PMS is an ascertainable and definable syndrome that affects a small number of women in a way that is beyond their control. It is unreasonable to deny these women justice by excluding the option of using PMS as a way of explaining their (criminal) behaviour. The claim that such an excuse will diminish the intrinsic worth of all women, while relevant, is not as important as the pursuit of sustainable justice for those with a genuine problem.

Admittedly, there will be people, who will persist in holding erroneous views of the effects and prevalence of PMS. However, it seems foolish to take heed of these opinions and attempt to appease the people who hold them when such opinions are patently false and when PMS can be shown to severely affect a few. To do so would be to punish the victim again.

It is therefore important that the courts of New Zealand remain open to the possibility of allowing the PMS excuse to be available to women in one of the forms previously suggested. With appropriately rigorous diagnostic criteria it will be a difficult course of action to take, and should thus only excuse the behaviour of women severely affected by PMS.