PREMENSTRUAL SYNDROME (PMS) IN THE COURTROOM[1]

Dr Patricia Easteal
Senior Criminologist
Australian Institute of Criminology
Canberra

THERE HAS LONG BEEN AN INTEREST IN FEMALE CRIMINALITY WITH A plethora of theories proposed to explain why some women commit antisocial acts. These biological, sociological and psychological explanations were seen as particularly necessary since a view of women's persona emerged in the 19th century in which females were regarded as innately angelical and by the natural order, incapable of violence. A violent woman was thus unnatural. 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!

Nineteenth-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. Thus, PMS began to be used either as a defence or as a mitigating factor in a number of countries.

In Overseas Courts

Although the major headlines in the United Kingdom about PMS in court occurred in the early 1980s, this defence argument had already resulted in acquittals and/or successful pleading of diminished responsibility prior to the 1980s for offences ranging from shop-lifting to manslaughter. However, none of these cases caused the same media coverage and reverberations as the following murder trials, 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: thirty prior sentences for theft, arson and assault. Charged with murdering a co-worker, years of diaries and institutional records indicated a

1 This paper was abstracted from Easteal 1991.

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 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 Magistrate's 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 and 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 (Johnson 1987, p. 340).

A great deal of controversy ensued during and after these trials; however, PMS has continued to be raised in both United Kingdom civil and criminal courts.

The use of PMS as a defence or in sentencing also 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). 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 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' (1989 p. 860).

The most recent overseas case widely publicised in the press was heard in the United States during 1991. It may be reflective of the perspective contained in the

1990 supplement to *Crimes of Violence: Homicide and Assault,* by the noted American lawyer, F. Lee Bailey. He 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 defense 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 to specifically advise about expert witnesses and their preparation, jury consideration, testimony by the defendant and PMS sentencing.

The Controversy of PMS

In the United States case above, the woman was acquitted of drunk driving charges when her lawyer argued that PMS had exacerbated the effects of the alcohol. This created a furore among many, particularly feminists. Indeed, 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 could be stigmatised. This has occurred for epileptics when epilepsy has been used for pleading diminished responsibility (Sommer 1984). Thus, Scutt (1982) reports that Australian feminists strongly objected to the use of PMS in the British cases of the early 1980s fearing that once again the view of women as slaves to their hormones and therefore unable to occupy responsible employment positions would be reinforced. Biological deterministic theories of male superiority were recalled with the concern that PMS as a defence would revive this perspective with its obvious implications. This may well be part of the answer why the defence has never been raised in this country. 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 shop-lifting 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.

Further, press reports such as one appearing recently in the *Sydney Morning Herald* (Harris 1990) certainly would not promote PMS as a defence. In that 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'. Another contributing factor may be the domination of the legal occupation by males with little knowledge about PMS and its potential use in court.

Are these viewpoints valid? Must the few genuine severe sufferers lose their defence out of fear of the risk to the entire gender? To counteract such a halo effect the bona fide nature of the ailment and the relationship of some of its symptoms to criminal behaviour needs to be established. A strict burden of proof also needs to be implemented and lastly, its use as a criminal defence needs to be seriously weighed, in most instances, the preferred course being not to use it as grounds for insanity or diminished responsibility but as a mitigating factor. Each of these considerations will be briefly examined in the following sections.

Medical Perspective

There is certainly no universally accepted medical consensus about the aetiology, symptomology or treatment of PMS. In fact, particularly in Australia, there seems to be a reluctance by physicians to accept PMS as a legitimate entity to the degree that most refer to it by the anachronistic term, PMT—premenstrual tension or trivialisation. 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 or diabetic hypoglycaemia, they have become better defined and thus more acceptable as components of criminal defences.

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'. It is unfortunate that this acceptance has not been accompanied by a universal consensus or even understanding about aetiology and treatment. Thus the latter remains an area of debate among medical researchers and practitioners. No single therapy has emerged as effective in alleviating all symptoms; this could be the by-product of the varying types of PMS. The 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.

There is agreement in the literature about diagnosing the severe form of PMS. The following criteria must be met:

- recurrent symptoms;
- 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 symptomology following menses are the key denominators cited by all.

Burden of Proof

The burden of proof needs to focus upon the particular symptoms that have been found to contribute to acts of deviance. 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. Only a small percentage of sufferers actually experience some of the more severe symptoms. 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 shop-lifting, 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 (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.

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). **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**.

The burden of proof in the courtroom should involve rigid evidence requirements. The medical evidence must indicate that the woman has a clinically demonstrable physical disorder with the preceding symptoms plus a causal connection must be shown between the premenstrual symptom(s) and the criminal act (Chait 1986). Proof 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 woman 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) states 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' (p. 154).

Types of Use in Court

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 premenstruum 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 looked at the various defences or bargaining uses of PMS: their limitations, strengths if any, and consequences. It should be noted that with insanity, automatism or diminished responsibility 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 which is of course problematic. 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? Further, 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'. Osborne (1989) elaborates, commenting that the only cognitive symptoms of PMS are decreased concentration, indecisiveness, paranoia and others that do not indicate impaired intellect. It is also doubtful that many would choose an insanity defence both 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.

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 and a plea of automatism is appropriate. However, one might respond 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 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, Northern Territory and ACT. However, 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.

Conclusion

To reiterate, 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. Limiting its use to mitigation in pretrial decisions such as bail or in sentencing could be construed as a useful compromise possibly appeasing those who fear either abuse of it as a plea or sexist generalisation to an entire gender. It is also to be hoped that mitigation takes away from the tendency to think deterministically—in other words, cause is no longer an issue; instead the emphasis is upon influencing. Perhaps then the pitfalls, potentially involved in using pleas which imply causation, could be avoided.

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