

# The Return of the Raging Hormones Theory:

## Premenstrual Syndrome, Postpartum Disorders and Criminal Responsibility

BERNADETTE McSHERRY\*

---

### 1. Introduction

A fundamental purpose of the criminal law is to determine when an individual may be held responsible for his or her actions. Traditionally, certain individuals have been treated as not responsible for their actions because they lack the intellectual capacity to understand the significance of the criminal act. For example, children under a certain age<sup>1</sup> and insane persons<sup>2</sup> are not considered criminally responsible for their actions.

In the last decade or so, there have been suggestions that certain women should be able to rely on biologically based defences in order to exculpate them from their crimes. In the early 1980s, two English cases set the scene for evidence of premenstrual syndrome to be adduced in raising the partial defence of diminished responsibility<sup>3</sup> and subsequent cases in England and Canada have shown that premenstrual syndrome will be taken into account as a mitigating factor in sentencing.<sup>4</sup>

Infanticide provisions exist in England, Canada, Victoria, New South Wales, Tasmania and New Zealand, which reduce a count of murder to that of manslaughter if it can be shown that the balance of the mother's mind was disturbed by reason of her not having fully recovered from the effects of giving birth or by reason of the effects of lactation.

While public discussion and recognition of women's physiological conditions and disorders should certainly be encouraged, it will be argued in this ar-

---

\* Lecturer, Faculty of Law, Monash University.

1 In Tasmania the age is seven: *Criminal Code Act* 1924 s18(1). In the ACT the age is eight: *Children's Services Act* 1986 s27(1). In the other states and in the Northern Territory, the age is ten: *Children (Criminal Proceedings Act)* 1987 (NSW) s5; *Children's Protection and Young Offenders Act* (SA) 1979 s66; *Criminal Code Act* (QLD) 1899 s29; *Children and Young Persons Act* 1989 (Vic) s127; *Criminal Code Act Compilation Act* (WA) 1913 s29; *Criminal Code Act* (NT) 1983 s38(1).

2 The law of insanity is defined in the Australian Capital Territory, New South Wales, Victoria, South Australia and at the federal level by the common law exemplified in the *M'Naghten Rules* (1843) 10 Cl & F 200; 8 ER 718. In Western Australia, Queensland, Tasmania and the Northern Territory, the law is statutory: *Criminal Code Act* (QLD) 1899 s27; *Criminal Code Act Compilation Act* (WA) 1913 s27; *Criminal Code Act* (TAS) 1924 s16; *Criminal Code Act* (NT) 1983 s35.

3 *R v Craddock* unreported, January 1981, London Central Criminal Court (1981) CLY 476; *R v English* unreported, Norwich Crown Court, 10 November 1981.

4 See below at nn119-23.

ticle that it is misleading if not dangerous to reduce women's criminal behaviour to a biological foundation. Further, it will be contended that there is no place in the criminal law for the formulation of a new defence based on postpartum disorders or premenstrual syndrome.

This article will first examine the existence and aetiology of postpartum disorders and premenstrual syndrome. The practice and crime of infanticide will then be examined in some detail in order to exemplify how the law has reduced the complex causes of child-killing to a medical model. Mental state defences will then be explored in order to identify whether postpartum disorders and premenstrual syndrome can fall within the existing law. Finally, the implications of introducing a special defence based on premenstrual syndrome and postpartum disorders will be examined.

## 2. *The Existence and Aetiology of Postpartum Disorders*

In recent years, there has been a growing awareness of the conditions which may affect women after giving birth. There is now little doubt about the existence of postpartum depression and postpartum psychosis. However, there is considerable debate about the causes of such disorders.

Postpartum disorders have been classified into three categories: the "maternal blues", chronic depressive disorders and postpartum psychosis.<sup>5</sup>

### A. *The Maternal Blues*

The condition known as the "maternal blues" is estimated to affect between 50 and 70 per cent of women.<sup>6</sup> Symptoms such as frequent and prolonged crying episodes generally appear within four days following the birth and last for 24 to 48 hours.

Because of the frequency and timing of such minor affective disturbances, theories of hormonal causes have been prominent. However, such theories remain mere speculation. Hormonal theories take for granted that depression begins after childbirth, but certain studies have found that mothers who rated themselves most depressed in the first few postpartum days were reporting equally high levels of depression in the last weeks of pregnancy.<sup>7</sup>

Rather than viewing this transient phase as a biological reaction, it appears that the symptoms of the maternal blues are associated with lack of sleep and general stress. As Brown writes:

The emergence, expression, and severity of the "postpartum blues" are ... likely to be influenced by, among other things, anticipation of the demands of motherhood, physical status, coping mechanisms, orientation to motherhood, social situation, and fatigue.<sup>8</sup>

---

5 Harding, J J, "Postpartum Psychiatric Disorders: A Review" (1989) 30 *Comprehensive Psychiatry* 109.

6 Yalom, I D, Lunde, D T, Moos, R H and Hamburg, D A, "Postpartum Blues Syndrome" (1968) 18 *Archives of General Psychiatry* 16; Kaplan, H I and Sadock, B J, *Comprehensive Textbook of Psychiatry* (5th edn 1989) at 1219.

7 Sandler, M, *Mental Illness in Pregnancy and the Puerperium* (1978) at 84-85.

8 Brown, W A, *Psychological Care During Pregnancy and the Postpartum Period* (1979) at 119-120.

### B. *Postpartum Depression*

"Postpartum depression" is considered to be a more disabling condition than the transient "maternal blues" and it was first described by Pitt who estimated that 10 to 20 per cent of women may experience certain depressive type symptoms.<sup>9</sup>

Symptoms may resemble those of clinical depression and may include tearfulness, mood swings, fatigue, and feelings of anxiety and inadequacy and have their onset in the early postpartum months. Such symptoms are usually most evident after the woman returns home from the hospital and may persist for more than a year.<sup>10</sup>

Sandler writes that hormonal causes are the least plausible in relation to postpartum depression:

Some cases cannot be separated clearly from an initial intense episode of maternity blues, but may begin later and seem more clearly related to the psychological adjustments of motherhood and the burden of bringing up the new baby ... The balance of evidence points to social and psychological causes for these states.<sup>11</sup>

It is revealing that the DSM-III-R, the leading American guide to mental disorders, does not recognise postpartum depression as a separate disorder, but mentions it briefly under the category of Major Depressive Episode.<sup>12</sup> The Manual states:

Some investigators consider a postpartum depressive episode to have an "organic" etiology. However, because of the difficulty of separating the psychological and physiological stresses associated with pregnancy and delivery, in this classification such episodes are not considered Organic Mood Syndromes, and are diagnosed as Major Depressive Episodes.<sup>13</sup>

Depressive disorders are generally divided into endogenous disorders where symptoms appear independently of environmental causes and reactive disorders where symptoms appear to be a response to external stresses.<sup>14</sup> Because hormonal causes are the least plausible in relation to postpartum depression, it would seem that this condition falls within the category of reactive depression.

### C. *Postpartum Psychoses*

Postpartum psychoses appear only once or twice in every thousand births.<sup>15</sup> About 50 per cent of these psychoses have their onset within the first two postpartum weeks, with most of the remainder having their onset over the ensuing four weeks.<sup>16</sup> Symptoms include visual or auditory hallucinations and

9 Pitt, B, "Atypical Depression Following Childbirth" (1968) 114 *Brit J Psychiatry* 1325. This per centage is in line with more recent studies such as Paykel, E S, Emms, E M, Fletcher, J and Rassaby, E S, "Life Events and Social Support in Puerperal Depression" (1980) 136 *Brit J Psychiatry* 339 and Hopkins, J, Marcus, M and Campbell, S B, "Postpartum Depression: A Critical Review" (1984) 45(3) *Psychological Bulletin* 498.

10 Above n8 at 133.

11 Above n7 at 88.

12 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, Revised 1987) at 221.

13 *Ibid.*

14 Gelder, M, Gath, D, and Mayou, R, *Oxford Textbook of Psychiatry* (1983) at 195.

15 Herbst, K R and Paykel, E S, *Depression: An Integrative Approach* (1989) at 125.

emotional lability including rapid changes in mood, uncertainty, indecision and feelings of hopelessness and shame.<sup>17</sup>

In the nineteenth century, postpartum psychosis was believed to be a specific entity with symptoms and prognosis different from those of other psychoses.<sup>18</sup> However, psychiatrists in the twentieth century have treated the clinical features and the prognosis of postpartum psychosis as being much the same as those of the functional psychoses.<sup>19</sup>

The DSM-111-R does not recognise postpartum psychosis as a separate disorder.<sup>20</sup> Postpartum psychosis is simply listed under the heading "Psychotic Disorder Not Otherwise Specified (Atypical Psychosis)".<sup>21</sup>

From this brief overview of the types of postpartum disorders which may occur, it appears that there is very little evidence to show that such disorders stem primarily from hormonal or chemical imbalances. Most researchers would in fact agree that all three types of postpartum disorders are associated with multiple factors such as psychological variables including low motivation for pregnancy and low level of psychological health, demographic variables such as socioeconomic status, stress and previous psychiatric and genetic predispositions.<sup>22</sup> Raging hormones alone cannot be blamed, but rather, it appears that a combination of external and perhaps internal stresses may give rise to such conditions.

### 3. *The Existence and Aetiology of Premenstrual Syndrome*

As stated previously, the existence of postpartum disorders is generally accepted, although the aetiology of such disorders is still uncertain. The existence of "premenstrual syndrome", however, is not universally accepted. It is one thing to say that women experience cyclical changes centred around menstruation but quite another thing to say that certain changes are symptomatic of a pathological syndrome which can lead women to violence.

Despite the lack of concrete evidence concerning premenstrual syndrome, medical opinion at present appears to view premenstrual syndrome as a biological reality rather than a social construct. There is no doubting that many women experience physical changes in the premenstruum. The problem lies in determining what are "normal" changes and what are pathological changes in

---

16 Herzog, A and Detre, T, "Psychotic Reactions Associated with Childbirth" (1976) *37 Dis Nerv Sys* 229.

17 Brown, W A, above n8 at 121.

18 See, eg, Prichard, J C, *A Treatise on Insanity* (1835).

19 See, eg, Bleuler, M, *The Schizophrenic Disorders* (1972) and references listed in Gelder et al above n14 at 390-391.

20 Above n12.

21 *Ibid.*

22 For an overview of research into such variables see Fedele, N M, Golding, E R, Grossman, F K and Pollack, W S, "Psychological Issues in Adjustment to First Parenthood" in Michaels, G Y and Goldberg, W A (eds), *The Transition to Parenthood* (1988) at 85. See also Brockington, I F, Martin, C, Brown, G W, Goldberg, D and Margison, F, "Stress and Puerperal Psychosis" (1990) *157 Brit J Psychiatry* 331; Dennerstein, L, Lehert, P and Riphagen, "Postpartum Depression — Risk Factors" (1989) *10 J Psychosom Obstet Gynaecol Suppl* 53.

need of treatment. Those who have studied premenstrual syndrome disagree about its definition, aetiology, incidence and treatment.

While premenstrual "tension" was first described by R T Frank in 1931,<sup>23</sup> it has only been in the past few decades that the medical profession has begun to explore the aetiology and treatment of "symptoms" which appear linked to the menstrual cycle. The depiction of premenstrual syndrome as a "disease" or "illness" which could be treated owes much to the extensive work of Dr Katharina Dalton.<sup>24</sup>

In her opinion, any complaint may be considered to be a symptom of the disorder as long as it recurs cyclically in the premenstrual phase and abates at or soon after the onset of menstruation. There are no symptoms unique to this stage of the menstrual cycle, thus a wide range of physical and psychological complaints have been viewed as symptoms of premenstrual syndrome.

The physical symptoms have been said to include "swelling, weight gain, feeling bloated or fat, pain in the breasts, acne, symptoms of an allergic nature, headaches, clumsiness or awkwardness, or difficulties with concentration or memory."<sup>25</sup> Such complaints can be viewed as annoying rather than incapacitating or of severe physiological concern.

The psychological "symptoms" are of more concern in relation to determining criminal responsibility. They are diverse and far-reaching:

Psychological symptoms include feelings of anger, irritability, nervousness, food cravings, decreased (or increased) energy levels and sexual desire, feelings of unreality, or depression, including suicidal feelings.<sup>26</sup>

Over 150 symptoms have been posited as varying with the menstrual cycle.<sup>27</sup> Because of this wide-ranging catalogue of symptoms, calculations as to the incidence of premenstrual syndrome vary dramatically, from less than 10 per cent of women of menstrual age to almost 100 per cent.<sup>28</sup>

As to the aetiology of PMS, the most popular theory promulgated by Katharina Dalton, is that the listed symptoms are caused by an imbalance or deficiency in the hormone progesterone. There is, however, no biochemical test available which can determine such a deficiency or imbalance which Dalton herself admits.<sup>29</sup> Although progesterone treatment has been claimed to be effective in relieving symptoms, it is "misleading to reason from effectiveness of treatment to aetiology: headaches are presumably not "caused" by a biogenic deficiency of paracetamol, although paracetamol may cure them."<sup>30</sup>

---

23 Frank, R T, "Hormonal Causes of Premenstrual Tension" (1931) 26 *Archives of Neurological Psychiatry* 1053.

24 Dalton, K, "Menstruation and Crime" (1961) *British Med J* 1752; *The Premenstrual Syndrome* (1964); *The Menstrual Cycle* (1971); "Cyclical Criminal Acts in the Premenstrual Syndrome" (1980) 2 *The Lancet* 1070; "Legal Implications of PMS" (1982) 17 *April, World Medicine* 93.

25 Osofsky, H J and Blumenthal, S J (eds), *Premenstrual Syndrome: Current Findings and Future Directions* (1985) xiii.

26 Id at xiii-xiv.

27 Frankel, B L and Rubinow, D R, "The Premenstrual Syndromes" in Howells, J G (ed), *Modern Perspectives in Clinical Psychiatry* (1988) at 171.

28 Allen, H, "At the Mercy of Her Hormones" (1984) *M/F* 19, 21.

29 Dalton, K, *The Premenstrual Syndrome and Progesterone Therapy* (1984) at 1.

30 Above n28 at 20.

Similarly, other biological theories which range from vitamin deficiencies, to subclinical hypoglycemia, to excess prolactin secretion have failed to be completely substantiated.<sup>31</sup>

Other writers have examined the aetiology of premenstrual syndrome in terms of psycho-social factors with recent research focusing on the social and cultural influences which shape the negative beliefs about and the experience of the menstrual cycle and in particular the premenstrual and menstrual phases.<sup>32</sup> In an overview of psycho-social theories of premenstrual syndrome, Ussher writes that the influence of life stresses upon increases in menstrual cycle complaints is now "one of the most convincing explanations for the finding of any correlation between menstruation and mood or behavioural disturbance".<sup>33</sup> Theories of treatment obviously also vary according to the particular aetiological model used.

With such conflicting and confusing studies in existence, it is little wonder that some authors have queried the existence of premenstrual syndrome in that there is no agreement on pathophysiology, symptoms or treatment.<sup>34</sup> Rodin argues that the inconclusiveness surrounding the existence of premenstrual syndrome is in itself symptomatic of the persistence of cultural beliefs in the production of medical knowledge:

The findings from correlational data (which show that women can become totally incapacitated because of PMS) and from PMS research in general (where the conclusion that hormonal changes influence behavior is maintained despite methodological inconsistencies) are more indicative of unstated assumptions about women and the menstrual cycle than they are of actual causal relationships or the direct hormonal control of emotions.<sup>35</sup>

It would seem that it is still too early to assess whether premenstrual syndrome is in fact a pathological syndrome. However, since evidence of premenstrual syndrome has already been accepted in English courts, it will be assumed for the purposes of this article that premenstrual syndrome manifests itself in certain severe psychological symptoms which affect a small minority of women of menstrual age.

#### 4. *The "Link" between Biology and Crime*

For centuries, women have been defined in relation to men in terms of their reproductive biology. Women's mood swings and "irrational" or aberrant behaviour have often been blamed on hormonal peculiarities. This "link" between female biology and irrationality has been well documented in recent years by authors such as Ussher.<sup>36</sup>

---

31 For a complete list of biological theories see Speroff, L, "PMS: Historical and Social Perspectives" in Keye, W R (ed), *The Premenstrual Syndrome* (1988) and above n27 at 172; Ussher, J M, "Research and Theory Related to Female Reproduction: Implications for Clinical Psychology" (1992) 31 *Brit J Clinical Psych* 129 at 134-141.

32 For an overview of such theories see Abplanalp, J M, "PMS: Psychosocial Theories" in Keye, W R (ed), above n31 at 94.

33 Ussher, J M, above n31 at 136.

34 Speroff, L, above n31; Ussher, J M, *The Psychology of the Female Body* (1989).

35 Rodin, M, "The Social Construction of Premenstrual Syndrome" (1992) 35(1) *Soc Sci Med* 49 at 52.

36 Ussher, J M, above n34; Ussher, J M and Nicolson, P (eds), *The Psychology of Women's*

Until recently, however, women's crime as a subject has not been focused upon by criminologists and this neglect has generated its own literature.<sup>37</sup> When "classical" criminologists did consider women's crime, they used biological theories to explain the dearth of female criminals, rather than arguing that there was a causal link between biology and women's crime. To do the latter would give rise to the obvious criticism that "if women are so inherently pathological, why is there not more women's crime?"<sup>38</sup>

Lombroso and Ferrero provide the most oft-quoted example of biological determinism in relation to female criminality.<sup>39</sup> Their central premise, which as Brown points out has often been misinterpreted,<sup>40</sup> is that women's biology predisposes them to conformity rather than criminality. They state that "ordinary" women are "revengeful, jealous, inclined to vengeance of a refined cruelty", but that in ordinary circumstances, "these defects are neutralised by piety, maternity, want of passion, sexual coldness, by weakness and an undeveloped intelligence".<sup>41</sup> The "born" female criminal is therefore "a monster" because she is an exception amongst criminals who in turn as a class are an exception amongst "civilised people".

In more recent years, Gove has argued that the continuing difference in rates of men and women's crimes is evidence of biological differences. He states that the rarity of women's crime is due to women's "affiliative nature, their physique and to their lack of assertiveness, all of which have a biological base."<sup>42</sup>

An assessment of such biological theories is beyond the scope of this paper. What is interesting, however, is the way in which the medicalisation of women's reproductive biology has led away from the idea of biology being linked to the absence of women's crime to the proposition that it is biology which in fact causes some women to commit crimes.

Certain authors in their studies of premenstrual syndrome and postpartum disorders suggest that women suffering from these conditions become more violent and more prone to committing crimes. This suggestion, if proven to be true, would certainly have far reaching implications for the study of criminology.

It is impossible to deny physical differences between women and men and it is impossible to dismiss the effects of cyclical and other changes in women's bodies. Some women may suffer from severe depression after childbirth and some women may suffer physical and psychological changes prior to menstruating, but, as has been shown, to reduce these states to the effects of "raging hormones" is to take too simplistic an approach to the matter.

---

Health and Health Care (1992) Ussher, J M, *Women's Madness: Misogyny or Mental Illness* (1992).

37 For example, Smart, C, *Women, Crime and Criminology: A Feminist Critique* (1976); Heidensohn, F, *Women and Crime* (1985); Morris, A, *Women, Crime and Criminal Justice* (1987).

38 Brown, B, "Reassessing the Critique of Biologism" in Gelsthorpe, L and Morris, A (eds), *Feminist Perspectives in Criminology* (1992).

39 Lombroso, C and Ferrero, W, *The Female Offender* (1899).

40 Brown, B, above n38 at 50.

41 Lombroso, C and Ferrero, W, above n39 at 151.

42 Gove, W, "The Effect of Age and Gender on Deviant Behaviour: A Biopsychosocial Approach" in Ross, A, (ed), *Gender and the Life Course* (1985) at 138.

Putting to one side however, the aetiology of postpartum disorders and premenstrual syndrome, the next step is to examine whether there is indeed a link between such disorders and women's crime.

### A. *Premenstrual Syndrome*

Lever writes that "premenstrual bad temper can sometimes go beyond verbal abuse to physical violence: It can make you violent, or it can provoke violence in your husband."<sup>43</sup>

Dalton is also of the opinion that premenstrual syndrome can result in criminal acts. She refers to certain features such as the woman acting alone and in an unpremeditated fashion as characteristic of the offences committed by women suffering premenstrual syndrome. She concludes:

Among the premenstrual symptoms which may result in criminal charges are a sudden and momentary surge of uncontrollable emotions resulting in violence, confusion, amnesia, alcoholism, nymphomania and attention-seeking episodes, which represent cries for help.<sup>44</sup>

Is there any scientific evidence to support these views? Certain studies of female prisoners have shown that almost half the prisoners had committed their crime during the premenstruum and that 62 per cent of crimes of violence by women had been committed in the premenstrual week.<sup>45</sup>

The problem with such studies, however, is that the focus is on showing that *women as a whole* commit crimes during the premenstrual phase and not that a small percentage of women suffering from premenstrual syndrome are more prone to commit crimes than are the majority of women.

There is simply no scientific evidence for the proposition that premenstrual syndrome causes aggressive or violent behaviour in a small minority of women.<sup>46</sup> To concentrate on showing that women as a class have a propensity to commit crimes during the premenstrual phase seems largely irrelevant as Holtzman points out:

If women became violent each month our jails would be filled with women. But, as it is, the overwhelming number of jail inmates are men; no menstrual cycle caused their aggression.<sup>47</sup>

As Ussher points out, the belief that premenstrual syndrome causes aggressive behaviour therefore seems to be based in fantasy, not fact.<sup>48</sup>

### B. *Postpartum Disorders*

In relation to postpartum disorders, certain jurisdictions have enacted infanticide provisions based on the presumption that a woman's ability to reason may be affected by the after effects of childbirth and/or lactation.

---

43 Lever, J, *PMT: The Unrecognised Illness* (1979) at 79.

44 Above n29 at 236.

45 Lever, J, above n43 at 91-92.

46 Parlee, M, "The Premenstrual Syndrome" (1973) 80 *Psych Bull* 454.

47 Holtzmann, E, "Premenstrual Symptoms: No Legal Defense" (1986) 60 *St John's LR* 712 at 713.

48 Ussher, J M, "Reproductive Rhetoric and the Blaming of the Body" in Nicolson, P and Ussher, J (eds), *The Psychology of Women's Health and Health Care* (1992) 44.



It is worthwhile examining the practice of infanticide and the history of the crime of infanticide in some detail in order to show how the "link" between postpartum disorders and child-killing can be viewed as a subcategory of the "link" between female biology and crime. It will become clear that the problems associated with infanticide provisions should serve as a warning for those who contend that premenstrual syndrome should form the basis for a gender specific defence in law.

## 5. *The History of Infanticide*

The practice of infanticide has had a long and pervasive history. In the time of Plato and Aristotle, exposure of weak and deformed infants was generally accepted and occasionally encouraged, and the exposure of healthy infants was not regarded as a serious offence.<sup>49</sup> Williamson writes:

Infanticide has been practised on every continent and by people of every level of cultural complexity, from hunters and gatherers to high civilizations; including our own ancestors. Rather than being an exception, then, it has been the rule.<sup>50</sup>

The general acceptance of infanticide in many different cultures appears to be related to the unavailability or ineffectiveness of contraception. The practice of infanticide has been so common that some anthropologists have viewed it as a widely used method of population control.<sup>51</sup>

The emergence of Christianity as the dominant religion in Europe undoubtedly influenced changing perceptions of infanticide. Gradually, the view that infanticide was a cruel and inhuman custom and should be treated as on a par with the murder of an adult became the norm.<sup>52</sup> This change in attitude, however, did not seem to coincide with any discontinuance in the practice.

Accordingly, in England in the seventeenth century, a statute entitled "An Act to Prevent the Destroying and Murthering of Bastard Children" was passed, making it an offence to conceal the death of an illegitimate child.<sup>53</sup> The concealment operated as a presumption of guilt of the murder of the child which was only rebuttable by proof from another person that the child had been born dead.

While initially the indictment rate rose in the wake of the statute, the following century witnessed a decline in the rates of the indictments for infanticide:

Behind the turnabout in numbers in both England and New England lay numerous influences, ranging from the confines of courthouses to the broadest patterns of social life. Magistrates and officials prosecuted fewer women for the crime, and juries grew unwilling to condemn suspects, especially upon mere proof of concealment of birth. Successful defenses against the Jacobean

---

49 Tooley, M, *Abortion and Infanticide* (1983) at 316.

50 Williamson, L, "Infanticide: An Anthropological Analysis" in Kohl, M (ed), *Infanticide and the Value of Life* (1978) at 61.

51 Scrimshaw, S, "Infanticide in Human Populations: Societal and Individual Concerns" in Hausfater, G and Hardy, (eds), *Infanticide: Comparative and Evolutionary Perspectives* (1984) at 440.

52 Tooley, M, above n49 at 318.

53 21 James 1 c27 (1624).

infanticide statute emerged, and judges gave merciful rulings on evidence of stillbirth.<sup>54</sup>

The concealment statute was eventually repealed by *Lord Ellenborough's Act* in 1803.<sup>55</sup> Infanticide trials were therefore placed on the same footing as homicide trials. The burden of proof was shifted back onto the prosecution to prove both that the child had been born alive and the mother had killed it. In recognition of the difficulty in furnishing evidence to support a murder conviction, Lord Ellenborough's Act contained a proviso whereby the jury could make an alternative finding of concealment of birth which had a maximum two year sentence.

Concealment of birth was subsequently made a separate offence by the *Offences Against the Person Act 1828* (Eng).<sup>56</sup> This alternative verdict and separate offence paved the way for a compassionate approach to women accused of killing their infants. Lansdowne writes:

Conviction for murder was difficult to achieve in these cases because juries anxious to avoid the death penalty were very ready to accept the slightest suggestion that the prosecution had failed to prove that the baby was completely born when it died. Evidence was routinely given by doctors that the child may have still been in the birth canal when it was strangled, or even, in some cases, while its throat was cut. Clearly this evidence was generated more by sympathy for the woman's desperate plight than by what was likely or even feasible.<sup>57</sup>

Concealment became the crime of choice. Between the 1830s and the 1860s, trials for concealment increased three fold. In the mid-nineteenth century, there were 5,000 coroner's inquests a year on children under the age of 7, but there were only 39 convictions for child murder between 1849 and 1864. None of these convicted women were executed.<sup>58</sup>

The sympathy directed towards women accused of murdering their infants can be explained by the fact that the vast majority of women who were charged were unmarried and the killing could be seen as a desperate act to avoid the censure of being branded a fallen woman. It has been estimated that in the eighteenth century, half the unmarried women under the age of 26 were employed as live-in servants, a fact which made them vulnerable to seduction or rape:

Because their good "character" was of economic and social value to them, pregnancy for these women was a catastrophe. Travelling and abandoning the child was not an available option, so concealment and infanticide were likely to follow pregnancy.<sup>59</sup>

This link between child killing and illegitimacy carried through to the nineteenth century where the disgrace attached to unwed pregnancy was such as to lead a woman to be cut off from her family and friends and often to be forced to leave her residence in search of anonymity.<sup>60</sup>

---

54 Hoffer, P C and Hull, N E H, *Murdering Mothers: Infanticide in England and New England 1558-1803* (1981) at 65.

55 43 Geo 3c 58.

56 Section XIV. This was amended by the *Offences Against the Person Act 1861* (Eng) s60.

57 Lansdowne, R, "Infanticide: Psychiatrists in the Plea Bargaining Process" [1990] 16 *Mon LR* 41 at 44.

58 Seaborne Davies, D, "Child Killing in English Law" (1937) 1 *Modern LR* 203 at 218.

59 O'Donovan, K, "The Medicalisation of Infanticide" [1984] *Crim LR* 259 at 260.

Law-makers were in a double bind. Obviously juries shied away from murder convictions in order to avoid the death penalty and where convictions for murder were reached, capital punishment was rarely carried out. Yet, it was feared that over generosity to women would lead to moral laxity and an increase in the illegitimacy rates. The Report of the Commission into Capital Punishment (1864-1866) called for changes in the law in relation to child destruction.<sup>61</sup> However, it was not until 1922 that the *Infanticide Act* was finally passed which reduced the offence from murder to manslaughter. This Act will be examined after considering the patterns of infanticide in the twentieth century.

## 6. *The Practice of Infanticide in the Twentieth Century*

At the turn of the century, changing patterns in infanticide have led to a movement away from seeing it as a relatively understandable response to the conditions of poor unmarried domestic servants.

In her thorough research of crimes involving Australian women since 1880, Allen concludes that the declining rate of infanticide at the turn of the century bore an inverse relationship to the increase in abortion rates, thus reinforcing the anthropological belief that the practice of infanticide is linked to the lack of availability or reliability of birth control.<sup>62</sup>

In the 1920s and 1930s in Australia, some cases still involved unmarried mothers who strangled their new born babies, but married women who killed older babies and children predominated in those cases which went to trial. Allen writes:

Trial evidence in married women's cases showed that infanticide was not being used as a family formation (or fertility control) strategy as in earlier decades. Rather, women killed the children who were dependent on them in the context of marital breakdown (due to causes such as infidelity, violence, sexual estrangement, desertion, unemployment and non-support) usually exacerbated by deep psychological depression. A majority of women who killed older babies and children attempted to commit suicide. Such circumstances led to an understanding of infanticide as an irrational act of demented women in need of psychiatric help.<sup>63</sup>

While the pattern of infanticide may have changed in the twentieth century, it appears that socio-economic considerations are still important in understanding its practice.

In a revealing study published in 1979, d'Orban looked at 104 women charged with the killing or attempted murder of their children.<sup>64</sup> The study distinguishes six different categories of maternal filicide: Battering Mothers; Mentally Ill Mothers; Neonaticides (women who killed or attempted to kill their children within 24 hours of birth); Retaliating Women (in these cases,

---

60 See in general Rose, L, *The Massacre of The Innocents: Infanticide in Britain 1800-1939* (1986) and Allen, J A, *Sex and Secrets: Crimes Involving Australian Women Since 1880* (1990).

61 British Parliamentary Papers 1866, Vol 21.

62 Allen, J A, above n60 at 109-110.

63 Id at 162.

64 d'Orban, P T, "Women Who Kill Their Children" (1979) 134 *Brit J Psych* 560.

aggression directed against the spouse was displaced onto the child); Unwanted Children and Mercy Killing.

Of the women charged with the killing or attempted murder of their children, battering mothers formed the largest group. These mothers tended to kill young children; 89 per cent of their victims were aged under three years. There were no instances of planned deliberate cruelty, but the assaults occurred in a state of exasperation and loss of temper. The commonest source of stress within this group was that of severe marital discord with the husband or cohabitee. Thirty-one per cent of this group had themselves been physically assaulted by their husbands or cohabitees. Housing problems and financial difficulties were also significantly more common in this group. These findings tie in with an earlier study by Kaplun and Reich which concluded that child killing is usually the final chapter in a history of maltreatment which develops against a background of poverty and violence.<sup>65</sup>

The second largest group was that of mentally ill mothers. This group consisted of women suffering from psychotic illness, cases of acute reactive depression and cases of personality disorder associated with a suicidal attempt. Interestingly, two thirds of the victims of mothers in this group were aged over one year and in only half the psychotic women did the illness occur in the puerperium:

Thus, contrary to medico-legal tradition these filicides were not especially associated with the puerperium, when women are thought to be liable to kill their children. West (1965) reached the same conclusion about depressive filicides in his study of murder-suicide. In the present study, of the 36 children aged under 6 months only one quarter were the victims of mentally ill mothers.<sup>66</sup>

Of the neonaticide group which formed the third largest category, all but one of the victims were born illegitimate and the average age of the mother was nineteen. The women were all single or separated from their husbands. A later case study by Green and Manohar confirms the premise that neonaticide is usually committed by "young unmarried women, free of any psychotic mental illness, the motivation being that the child is unwanted".<sup>67</sup> The other three categories of maternal filicide also showed signs of the killings or attempted killings being the result of external stresses.

From this overview of the patterns of infanticide in the twentieth century, it appears that postpartum disorders cannot be considered the sole or even a major cause of the practice of infanticide. It is far too simplistic an approach to reduce the causes of child-killing to a medical cause.

## 7. *The Crime of Infanticide*

The link between young unmarried mothers and infanticide in the nineteenth century clearly indicated that infanticide stemmed largely from a combination of socio-economic factors. In this century, the pattern of infanticide may have

---

65 Kaplun, D and Reich, R, "The Murdered Child and His Killers" (1976) 133 *Amer J Psych* 809 at 812

66 d'Orban, P T, above n64 at 570.

67 Green, C M and Manohar, S V, "Neonaticide and Hysterical Denial of Pregnancy" (1990) 156 *Brit J Psych* 121 at 122.

changed slightly, but it appears that socio-economic factors continue to be important in relation to child-killing.

However, when it came to enacting the *Infanticide Act* of 1922, the legislature relied on the belief that infanticide was the result of postpartum disorders arising out of childbirth or lactation. The 1922 Act reduced the offence from murder to manslaughter where a woman caused the death of her "newly born" child "but at the time of the act or omission she had not fully recovered from the effect of giving birth to such child, but by reason thereof the balance of her mind was then disturbed".<sup>68</sup>

In *O'Donoghue*<sup>69</sup> the accused who had killed her 35 day old child was convicted of murder on the basis that the child was not "newly born". Similarly, the trial judge in *Hale*<sup>70</sup> directed the jury to find a woman accused of killing her three week old child guilty but insane because infanticide was not an option, the baby not being "newly born".

Accordingly, the *Infanticide Act* 1938 reformed the 1922 Act by changing the words "newly born" to "under the age of 12 months" and adding the concept of a woman's balance of mind being disturbed "by reasons of the effect of lactation consequent upon the birth of the child".<sup>71</sup>

There are similar infanticide provisions in Victoria, New South Wales and Tasmania and in Canada and New Zealand.<sup>72</sup> All of these provisions are based on proof that the crime was committed when the mother's mind was in such a state following childbirth and/or lactation, that she should not be considered fully responsible for her actions.

This reduction of infanticide to the result of physiological changes was based on nineteenth century beliefs in the general susceptibility of women to mental illness as the result of their reproductive system:

In the thinking of Victorian specialists in mental diseases, insanity manifested itself in behaviour which broke the rigid rules of acceptable Victorian female and maternal behaviour. Doctors diagnosed rebelliousness, aggressiveness, rowdy behaviour, overt sexuality (and particularly masturbation) as indications of insanity. It was entirely logical in this framework, that behaviour so far beyond the ideal of modest passivity as the violent killing of an infant should be seen as the act of a mind disordered by the recent event of parturition.<sup>73</sup>

68 Section 1(1).

69 (1927) 20 Cr App R 132.

70 *The Times* 22 July 1936 at 13.

71 Section 1(1).

72 Section 6 *Crimes Act* (Vic) 1958 (introduced 1949); *Crimes Act* (NSW) 1900 s22A (introduced 1955) *Criminal Code Act* (Tas) 1924 s165A: The wording originally followed the 1922 Act, but was amended in 1973 after the offence was ruled inapplicable when a child was three months old: *R v Taylor* [1968] Tas SR 1. The provision makes no mention of the effect of lactation upon the balance of the mother's mind. Sections 2, 216 *Criminal Code* (Can): The original provision was introduced in 1948 and was based on the 1922 Act, but was amended to follow the 1938 Act after a trial judge excluded the killing of a four and a half month old baby from its ambit: *Marchello* [1951] 4 DLR 751, (1951) 100 CCC 137 (Ont H. C.); *Crimes Act* (NZ) 1961 s178: This provision follows the medical model of the 1938 Act, but applies to the killing of any of the mother's children under the age of 10.

73 Lansdowne, R, above n57 at 46.

The infanticide provisions have been criticised on a number of grounds.<sup>74</sup> The Report of the Committee on Mentally Abnormal Offenders (the Butler Report, 1975) in England and the Law Reform Commission of Canada concluded that because the respective infanticide provisions were based on antiquated medical opinion, they should be abolished.<sup>75</sup>

This appears to be the correct decision. The problem with depending on a medical model to provide a defence for women who kill their children is that it denies the reality of women's lives. Wilson reviews recent studies of child abuse in general and concludes:

... it is a myth to assume that child abuse is equally distributed in all social classes, and a dangerous myth at that. For if the myth is accepted, child abuse becomes seen as a psychiatric problem in the medical model — that is, a disease to be diagnosed, treated and cured. It is not to be seen as it should be — a phenomenon which has a definite link to poverty and social disadvantage.<sup>76</sup>

If the infanticide provisions are abolished, how then should the law treat cases of maternal filicide?

The Criminal Law Revision Committee (CLRC) in its Fourteenth Report accepted that there is little or no evidence for the link between lactation and mental disorder and recommended this reference be removed from the infanticide provision. However, despite evidence from the Royal College of Psychiatrists that "the medical basis for the present Infanticide Act is not proven",<sup>77</sup> the CLRC recommended the retention of the medical model of infanticide, despite its inadequacies, in order to take into account the socio-economic factors involved in child killing.<sup>78</sup>

This is still problematic because of the false premises of the medical model. If there is going to be an infanticide provision, then it should be based fairly and squarely on the existence of socio-economic factors and not on antiquated beliefs in the link between women's physiology and mental illness.

Should such a defence be available? How should evidence of postpartum disorders and premenstrual syndrome be taken into account by the courts? There are three alternatives:

1. PMS and postpartum disorders may form the basis of existing defences such as insanity, diminished responsibility or automatism.
2. A new substantive defence could be enacted based on these conditions.
3. The existence of PMS and postpartum disorders could be accepted as a mitigating factor in sentencing.

---

74 Such as the fact that most provisions only deal with the killing of a child less than twelve months old which may lead to some anomalous situations: See Bartholomew, A, *Psychiatry, the Criminal Law and Corrections* (1987) at 150-153.

75 Report of the Committee on Mentally Abnormal Offenders, Cmnd 6244, (1975) 245; Law Reform Commission of Canada, Working Paper #33, Homicide (Ottawa: Supply and Services Canada, 1984) at 75-77.

76 Wilson, P, *Murder of The Innocents: Child-Killers and Their Victims* (1985) at 31.

77 Criminal Law Revision Committee, Fourteenth Report, *Offences Against the Person*, Cmnd 7844, (1980) para 103.

78 The retention of the Victorian Infanticide provision has also been recommended by the Law Reform Commission of Victoria, albeit in an amended form: Report No 34 *Mental Malfunction and Criminal Responsibility* (1990) at 54-62.

Each of these options will be explored in turn and it will be suggested that the most appropriate alternative is the third one.

## 8. *Mental State Defences*

### A. *Insanity*

The criminal law is based on the presumption that each individual has the ability to freely choose between obeying the law and committing a crime. Where an accused lacks the ability to choose between right and wrong by reason of insanity then he or she will be excused from criminal liability.

At common law, the law of insanity derives from the rules laid down by the English common law judges in 1843 as a result of *M'Naghten's case*.<sup>79</sup> For the defence to apply it must be proved that, at the time of the committing of the act, the accused was labouring under such defect of reason, owing to a disease of the mind, as not to know the nature and quality of his or her act, or, if the accused did know it, that he or she did not know that what he or she was doing was wrong. The defence of insanity under the Australian Codes is largely based on the common law emphasis on knowledge and understanding of the criminal act, but also allows for the deprivation of the accused's capacity to control his or her actions owing to "mental disease".<sup>80</sup> The first part of this defence which must be satisfied is showing that the accused's power of reasoning was affected by a "disease of the mind".

"Disease of the mind" is a legal rather than a medical term and the courts have shied away from defining it. It seems, however, that the term is concerned with the intellect and not with emotions<sup>81</sup> and whether or not there have been organic changes to the brain is irrelevant.<sup>82</sup> Further, there is no distinction drawn between mental conditions which can be assigned a physical cause and ones which cannot.<sup>83</sup> The main focus in determining whether or not a condition is a disease of the mind, however, seems to lie in identifying the condition as arising from an inherent cause or source of stress inherent to the accused rather than it being simply an emotional reaction to an external environmental circumstance.<sup>84</sup>

Psychosis, schizophrenia and paranoia have been held to fall within the ambit of the term disease of the mind.<sup>85</sup> Thus, postpartum psychosis would be considered to be a disease of the mind. A person suffering from a psychotic disorder is generally taken to have lost contact with reality. A psychotic may withdraw into a fantasy world or respond with exaggerated emotions which are often inappropriate to the situation. Thought processes may be disturbed in

---

79 (1843) 10 Cl & F 200; 8 ER 718.

80 *Criminal Code Act 1983* (NT) s35; *Criminal Code* (QLD) s27; *Criminal Code 1924* (TAS) s16; *Criminal Code 1913* (WA) s27. In the Northern Territory, the term "abnormality of mind" is used instead of "mental disease".

81 *R v Porter* (1936) 55 CLR 182 at 188 per Dixon J.

82 *R v Kemp* [1957] 1 QB 399, 407 per Devlin J.

83 *Id* at 407.

84 This "test" distinguishes insanity from "sane" automatism: *R v Radford* (1985) 20. Crim R 388; *R v Falconer* (1990) 96 ALR 545.

85 Weihofen, H, *Mental Disorder as a Criminal Defense* (1954) at 119.

such a way as to give rise to delusions or hallucinations. Clearly, a person suffering from such symptoms should not be held to be criminally responsible.

An example of how postpartum psychosis can form the basis for the insanity defence occurred in America a few years ago.<sup>86</sup> On 17 March 1987 Sheryl Massip gave birth to a son, Michael. Shortly after the birth, Massip began hearing voices telling her that the baby was in pain. On 25 April she experienced a blackout or seizure. Two days later she went to see her obstetrician who believed she was having a nervous breakdown and prescribed tranquilisers. On 29 April, Massip again heard voices telling her the baby was in pain and to put him out of his misery. She felt as if she was in a tunnel and everything was moving slowly. Massip took her baby for a walk and threw him in the path of an oncoming car. The driver swerved to avoid the child. Massip then hit her baby over the head with a blunt tool, backed over him with her Volvo station wagon and dumped his dead body into a garbage bin. Massip told the police that her baby had been kidnapped, but later confessed to her husband that she had run over her baby.

The jury found her guilty of second degree murder. The trial court, however, reduced this conviction to voluntary manslaughter, set aside the jury's finding of sanity, and entered a verdict of not guilty by reason of insanity. The judgment was affirmed on appeal.<sup>87</sup> A number of expert witnesses testified that Massip was psychotic and operating under hallucinations and delusions resulting from severe mental illness. In such a case, there is little problem with the insanity defence being used.

But what of premenstrual syndrome and postpartum depression in terms of the insanity defence?

In the case of postpartum depression it would appear that the evidence is more strongly weighted in favour of this condition being a category of reactive rather than endogenous depression. Therefore it would appear that the test of it being a condition inherent to the accused would not be satisfied. Similarly, there is not enough evidence at present to show that premenstrual syndrome arises from inherent causes as biological theories remain unproven and in conflict. However, even if an accused can be shown to be suffering from a disease of the mind for the purposes of the *M'Naghten Rules*, it must next be shown that the accused lacked the ability to know the nature and quality of the act or that the act was wrong.

There is no firm evidence that premenstrual syndrome and postpartum disorders (apart from postpartum psychosis) affect cognition. In relation to premenstrual syndrome, there is in fact evidence to the contrary. Gannon and Sommer have concluded that in studies on premenstrual syndrome, which have appropriate controls and statistical treatment, no significant variation has been associated with the menstrual cycle for cognitive or motor behaviour.<sup>88</sup>

---

86 Also see *People v Green* analysed in Reece, L E, "Mothers Who Kill: Postpartum Disorders and Criminal Infanticide" (1991) 38 *UCLA LR* 699 at 670-671.

87 *People v Massip* (1990) 221 Cal App 3d 558; 271 Cal Rptr 868; Review granted (1990) 798 P 2d 1212; 274 Cal Rptr 369.

88 Gannon, F L, "Evidence for a Psychological Etiology of Menstrual Disorders: A Critical Review" (1981) 48 *Psych Reports* 287; Sommer, B, "The Effect of Menstruation on Cognitive and Perceptual Motor Behaviour: A Review" (1973) 35 *Psychosom Med* 515.



It could be argued that women suffering from premenstrual syndrome or postpartum depression are deprived of the capacity to control their actions under the "volitional" prong of the insanity defence under the Australian Codes.

The notion of loss of control, however, still necessitates satisfying the requirement that premenstrual syndrome and postpartum depression be diseases of the mind, and this appears unlikely. Problems with loss of control tests in general will be examined in the next section.

Some authors are also wary about introducing evidence of premenstrual syndrome and postpartum depression as the basis of the insanity defence because of the stigma attached to the label. Carney and Williams, for example, write:

Women suffering from PMS are not "insane". To classify them as such would distort the insanity defense and fail to responsively address the pressing legal and medical issues peculiar to PMS.<sup>89</sup>

It would therefore appear that only postpartum psychosis could form the basis for a successful insanity defence. The next question, then is whether or not evidence of postpartum depression and premenstrual syndrome can be taken into account for the purposes of other existing mental state defences.

### **B. Diminished Responsibility**

In general, the criminal law only differentiates between full criminal responsibility and its complete absence. In England, Queensland, the Northern Territory and New South Wales<sup>90</sup>, however, a major exception to this general rule has been introduced by way of the partial defence of diminished responsibility. The Australian laws predominantly follow the English provision. Section 2(1) of the *Homicide Act* (Eng) 1957 reads as follows:

Where a person kills or is a party to the killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being a party to the killing.

When this defence is successful, there is a conviction for manslaughter. The sentence for manslaughter is entirely at the discretion of the court, from life imprisonment down to absolute discharge.

Premenstrual syndrome has been used as a basis for this defence in two English cases. In 1980, Sandie Craddock was tried for stabbing to death a fellow barmaid.<sup>91</sup> She had been previously convicted of a number of minor criminal offences and had attempted suicide on several occasions between 1970 and 1979.

Doctor Katharina Dalton gave evidence that Craddock suffered from premenstrual syndrome. This diagnosis was based on the cyclical pattern of Craddock's criminal behaviour and suicide attempts as well as a series of tests

---

89 Carney, R M and Williams, B D, "Premenstrual Syndrome: A Criminal Defense" (1983) 59 *Notre Dame LR* 253, 264.

90 *Homicide Act* (Eng) 1957 s2(1); *Criminal Code* (Qld) 1899 s304A; *Crimes Act* (NSW) 1900 s23A; *Criminal Code Act* (NT) 1983 s37.

91 *Craddock* above n3.

which revealed a severe progesterone deficiency. The jury found Craddock guilty of manslaughter, presumably because of the well documented evidence of premenstrual syndrome presented by Dalton. Sentencing was delayed for three months in order to see whether progesterone treatments would affect Craddock's behaviour. At sentencing, Dalton gave evidence that massive doses of progesterone had stabilised Craddock's behaviour and the court released Craddock on probation, provided that she continue to receive progesterone treatment under Dalton's direction.

Premenstrual syndrome was also considered in a contemporaneous proceeding.<sup>92</sup> In December 1980, Christine English deliberately drove her car at her lover, pinning him against a utility pole. He died two weeks later. English had been living with her lover for three years, but a short time before the incident, he had announced his intention of seeing another woman. On the day of the killing, he had quarrelled with English outside a pub and there was some evidence that he had punched and slapped her. English said in a statement to police: "He turned and made a V-sign at me. I just wanted to bump him and hurt him."<sup>93</sup> These events leading up to the incident were treated as purely background material. No provocation defence was raised. Rather, English pleaded guilty to manslaughter on the ground of diminished responsibility.

Doctor Dalton testified that English suffered from premenstrual syndrome which caused her to become aggressive and irritable and to lose self-control. Purchas J accepted premenstrual syndrome as a mitigating factor in sentencing and granted English a twelve-month conditional discharge and banned her from driving for one year.

These two cases demonstrate the willingness of the courts to accept premenstrual syndrome as a basis for a diminished responsibility defence. However, it should be noted that in the case of *English*, the trial was concluded by a plea of guilty to manslaughter on the basis of diminished responsibility being accepted by the Crown. It is interesting to contemplate whether or not the outcome would have differed if the diminished responsibility defence had been contested.

There remain certain problems with premenstrual syndrome satisfying the requirements of the diminished responsibility defence. First, an "abnormality of mind" must arise from the premenstrual syndrome. This term was considered by Lord Parker in *R v Byrne*:<sup>94</sup>

"Abnormality of mind" ... means a state of mind so different from that of ordinary human beings that the reasonable man would term it abnormal. It appears to us to be wide enough to cover the mind's activities in all its aspects, not only the perception of physical acts and matters, and the ability to form a rational judgment as to whether an act is right or wrong, but also the ability to exercise will power to control physical acts in accordance with that rational judgment.

---

92 *R v English* unreported, Norwich Crown Court, 10 November 1981.

93 Information gathered from *The Sun*, *The Daily Mirror* and *The Guardian* 11 November 1981. These Reports of the trial are summarised in Laws, Shey, V and Eagan, A, *Seeing Red* (1985) at 69-79.

94 [1960] 2 QB 396 at 403.

While this quotation shows the close link between "abnormality of mind" and the ability to form a rational judgment, it is clearly broader than the expression "disease of the mind" under the *M'Naghten Rules*. Conditions which do not fall within the ambit of the insanity defence such as personality disorders<sup>95</sup> and severe depression<sup>96</sup> have been accepted as abnormalities of the mind. Postpartum depression, therefore could be considered to be an abnormality of the mind. Because the "symptoms" of premenstrual syndrome are not settled, it seems more difficult to view this condition as giving rise to an abnormality of the mind.

However, a further step must then be satisfied. The abnormality of the mind must be proven, usually on expert evidence, to have arisen from one of the four statutory causes.<sup>97</sup> It would seem that in relation to premenstrual syndrome and postpartum depression, it would have to be shown that the abnormality of mind arose from an "inherent cause".

In the past, where severe depressive episodes have been considered to be abnormalities of the mind it has been in the context of such depression arising from a cause internal to the accused, having its source in the accused's psychological make-up.<sup>98</sup> As previously discussed, this seems a difficult test to satisfy as it is still unclear as to whether or not postpartum depression and premenstrual syndrome arise from a source internal to the accused.

The next step in the context of the diminished responsibility defence is to show that the abnormality of the mind substantially impaired the accused's mental responsibility. In *R v Byrne*, it was stated that substantial impairment was a matter of degree, that it meant more than "some impairment" and that it was a question for the jury.<sup>99</sup>

The term "mental responsibility" has been criticised on the basis that it is conceptually problematic, given that responsibility is a moral, not medical term and its use has been avoided in the Queensland and Northern Territory provisions. In *R v Byrne* Lord Parker, in delivering the judgment of the court, stated:

The expression "mental responsibility" for his acts points to a consideration of the extent to which the accused's mind is answerable for his physical acts which must include a consideration of the extent of his ability to exercise will power to control his physical acts.<sup>100</sup>

It would seem that only the most severe endogenous depressions would be viewed as substantially affecting the ability of an accused to control his or her conduct under this requirement. The "maternal blues" would clearly not be enough and even if postpartum depression and premenstrual syndrome could

---

95 *R v Matheson* [1958] 1 WLR 474; *R v Byrne* [1960] 2 QB 396; *R v Walden* (1986) 23 A Crim R 242; *R v Turnbull* (1977) 65 Crim App R 242.

96 *R v Clarke and King* [1962] Crim LR 836; *R v Harvey and Ryan* [1971] Crim LR 664; *R v Fenton* (1975) 61 Crim App R 261; *R v Seers* (1984) 79 Crim App R 261.

97 This requirement is not set out in the provision in the Northern Territory *Criminal Code* 1983. No causes are specified which appears to open the ambit of the defence.

98 *R v Lloyd* [1967] 1 QB 175; *R v Bathurst* (1968) 52 Crim App R 251; *R v Schafferius* [1977] Qd R 213; *R v Seers* (1984) 79 Crim App R 261; *R v Hicks* (1988) 9 Crim App R 502.

99 [1960] 2 QB 396 at 404 per Lord Parker.

100 [1960] 2 QB 396 at 403.

be shown to arise from inherent causes, it would only be in severe cases that this requirement could be fulfilled.

There is therefore a question mark still hanging over the use of premenstrual syndrome and postpartum depression forming the basis for the diminished responsibility defence.

It is also worthwhile noting that the use of this defence is uncertain.<sup>101</sup> The original rationale for the defence which was to avoid capital punishment is now irrelevant. With the trend towards discretionary punishment for murder, the subsequent aim of the defence which was to reduce the inflexibility of the mandatory life sentence for murder is also irrelevant. In addition, it may be more worthwhile concentrating on reformulating the insanity and provocation defences rather than providing a round about way of excusing those who are less blameworthy than those who intentionally kill, but who do not fall within the ambit of those two defences.

### C. Automatism

In relation to the elements of a crime, the criminal law requires that the prosecution prove a voluntary act or omission. Automatism is the term used to cover conduct which is involuntary for legal purposes and which is not caused by a disease of the mind. A complete acquittal results where automatism is properly raised and cannot be dispelled by the Crown.

The distinction between automatism and insanity is a fine one because of the emphasis placed on determining whether the condition causing the involuntary action was a disease of the mind or not. Conditions which have been held to result in involuntary actions for the purpose of the doctrine of automatism include sleepwalking,<sup>102</sup> hypoglycaemia,<sup>103</sup> concussion from a blow to the head,<sup>104</sup> the consumption of alcohol or drugs,<sup>105</sup> and dissociation resulting from acute stress external to the accused.<sup>106</sup> In all these circumstances, the condition manifests itself in a loss of or clouded consciousness. Technically, however, reflex movements may also constitute an involuntary act.<sup>107</sup>

Some authors have suggested that premenstrual syndrome can be seen as a factor leading to an involuntary action. Apodaca and Fink write, for example:

... the PMS defendant has a diagnosable disease which causes symptoms to resurface on a cyclical basis. There should be no distinction between mental and physical diseases since both may affect a defendant's ability to control her behaviour. Furthermore, the penal system's goals of retribution, deterrence and reformation are not fulfilled by imprisoning the automatistic defendant who is in need of medical attention.<sup>108</sup>

101 See Fisse, B, *Howard's Criminal Law* (5th edn 1990) at 112 and footnotes therein.

102 *R v Cogdon* Unreported, 1950, noted in [1951] *Res Judicatae* 29; *R v Holmes* [1960] WAR 122 at 125; *R v Scarth* [1945] St R Qd 38

103 *R v Quick* [1973] QB 910; *R v Bailey* [1983] 1 WLR 5.

104 *Coates v The Queen* (1957) 96 CLR 353; *R v Wakefield* (1958) 75 WN(NSW) 55; *R v Scott* [1967] VR 276; *R v Stripp* (1978) 69 Crim App R 318; *R v Hall* (1988) 36 A Crim R 368.

105 *R v O'Connor* (1981) 146 CLR 64.

106 *R v Radford* (1985) 42 SASR 266; *R v Falconer* (1990) 96 ALR 545.

107 *Ryan v R* (1967) 121 CLR 205 at 214-215 per Barwick CJ.

108 Apodaca, L and Fink, L, "Criminal Law: Premenstrual Syndrome in the Courts?" (1984) 24 *Washburn LJ* 54, 75. See also Carney, R M and Williams, B D, above n89 at 265.

It is, however, difficult to see how postpartum depression or premenstrual syndrome can result in involuntary conduct. Apodaca and Fink are talking in terms of the "defendant's ability to control her behaviour". This is a separate issue to that of automatism which is based on the premise that individuals have the capacity to choose or act voluntarily when performing a criminal act. If an accused finds difficulty in controlling his or her conduct, or is "weak willed" the act is nonetheless chosen.<sup>109</sup> It is not an involuntary act.

Accordingly, in *R v Smith*<sup>110</sup> which will be considered in more detail in the next section, the Court of Appeal held that automatism was not applicable where evidence of premenstrual syndrome was raised. It therefore appears inappropriate to consider premenstrual syndrome and postpartum depression in terms of involuntary actions.

## 9. A Separate Defence

Given that only postpartum psychosis can clearly fall within the existing insanity defence and that there are still problems with considering evidence of premenstrual syndrome and postpartum depression as forming the basis of the partial defence of diminished responsibility, it is next necessary to consider whether or not a separate defence should be created to excuse women from criminal responsibility on the basis of these conditions.

There have been two attempts to have premenstrual syndrome accepted by the courts as forming the basis for a new defence.

In *People v Santos*<sup>111</sup> a New York woman was initially charged with first degree assault against her infant daughter. At a pre-trial hearing, she raised premenstrual syndrome as a defence but plea bargaining ultimately led to Santos pleading guilty to the misdemeanour of harassment. Thus, the question of whether premenstrual syndrome could be used as a separate defence was not considered by the court.

In *R v Smith*,<sup>112</sup> the Court of Appeal was called upon to consider whether a separate defence based on premenstrual syndrome could be considered at law.

This case again concerned Sandie Craddock who changed her name to Sandie Smith shortly after the trial in 1980. Between October 1980 and May 1981, Dr Dalton began to reduce the dosage and number of Smith's progesterone injections.

In June 1980, Smith twice threatened to kill a police officer and shortly after the second threat, she was arrested outside the officer's station. She was carrying a knife at that time.

Smith was charged with two counts of threatening to kill and one count of carrying an offensive weapon in public without authority or excuse. Counsel for the defence argued that because of the reduced dosage of progesterone,

---

109 *R v Holmes* [1960] WAR 122, 124; *R v Burr* [1969] NZLR 736, 747; *R v Dodd* (1974) 7 SASR 151, 157; *R v Harm* (1975) 13 SASR 84, 90.

110 No 1/A/82, Court of Appeal (Criminal Division) 27 April 1982; [1982] Crim LR 531.

111 Unreported, No. 1KO46229 (Crim Ct NY 3 Nov 1982).

112 No 1/A/82, Court of Appeal (Criminal Division) 27 April 1982; [1982] Crim LR 531.

Smith's premenstrual syndrome had recurred and had either reduced her to an automatic state or had led to an irresistible impulse to kill the police officer.<sup>113</sup>

The trial judge directed the jury not to consider the issue of automatism and that there was no defence in law of irresistible impulse. Accordingly, Smith was convicted on all three counts. The trial judge, however, recognised premenstrual syndrome as a mitigating factor at the sentencing stage. Smith was sentenced to three years probation.

On appeal,<sup>114</sup> *Smith's* counsel urged the Court to recognise a special defence based on premenstrual syndrome. The Court held that automatism was not applicable, nor was there any authority for a defence of irresistible impulse based on a temporary medical condition. However, the Court did consider it appropriate for premenstrual syndrome to be seen as a mitigating factor in sentencing and upheld the trial court's three year probation order.

#### A. *A Defence Based on Loss of Control*

The arguments presented by counsel for the defence in *Smith's* case indicate how a separate defence based on premenstrual syndrome and, presumably, postpartum disorders could operate. Such a defence could be based around notions of loss of control in the absence of having to prove the existence of a disease of the mind. That is, because of premenstrual syndrome or postpartum depression, the accused was unable to control her actions, even though her ability to reason about her actions may not have been affected.

The Court of Appeal rightly pointed out that, at present, there is no defence of irresistible impulse based on temporary mental conditions. There are two reasons why such a defence should not be introduced. First, there are serious problems with loss of control tests in general and secondly, a defence based on loss of control undermines the philosophical underpinnings of the criminal law.

The problem with loss of control tests in general is that it is impossible to devise an objectively verifiable test to determine when an accused could not control herself and when she merely would not. Certainly, it can be argued that the question raised is really not so different from the questions of degree which arise throughout the law. It is impossible to draw absolute lines when considering other issues such as "knowledge" or "intent" or "negligence".

However, there remains a further major problem with loss of control tests and that is that such tests are based on an abandoned system of faculty psychology which divided the mind into separate and unrelated compartments.

According to the Dictionary of Psychology, "faculty psychology" refers to "the discredited doctrine that mind is constituted of a number of powers or agencies, such as intellect, will, judgment and attentiveness, which produce mental activities."<sup>115</sup>

Contemporary psychology, however, is based on an holistic model which views "personality" as an integration of functions and not a mere interrelation

---

113 The defence of diminished responsibility was not available as it only serves to reduce a count of murder to that of manslaughter.

114 *R v Smith* No 1/A/82, Court of Appeal (Criminal Division) 27 April 1982; [1982] Crim LR 531.

115 Chaplin, J P, *Dictionary of Psychology* (1985) at 174.

of separate functions be they termed cognition, will and emotion or ego, superego and id. According to this holistic model, there can be no serious impairment of one of these functions without some form of impairment of the others.

Loss of control tests assume that a person can know what he or she is doing is wrong, yet be unable to control his or her actions. Such tests in reality assume that cognition remains completely unaffected and it therefore contradicts the view that the ability to reason plays an essential part in controlling conduct. Hall writes:

What the proponents of "irresistible impulse" are in effect telling us is that the most distinctive and potent function on earth — human understanding in its full amplitude — can be normal but nonetheless impotent even as regards killing or raping or robbing. That is the thesis they are advancing and do not forget that. It can only mean that intelligence is unrelated to the control of human conduct.<sup>116</sup>

### *B. Wider Implications of a Separate Defence*

Loss of control tests are problematic from the viewpoint of modern psychology. However, there is a more fundamental question that needs to be addressed in relation to a defence based on conditions such as premenstrual syndrome and postpartum depression. That is, can such a defence be in accordance with the underlying tenets of the criminal law? The answer appears to be a clear no.

It has previously been suggested that the concept of free will provides an important foundation for the criminal law. Punishment is viewed as justifiable for those who break the law because they *could* have chosen to obey the law but chose not to. Those who are incapable of choosing to obey the law are seen as not criminally responsible for their conduct.

Traditionally, individuals are seen as incapable of exercising their free will if their actions are involuntary or where they lack the capacity to understand their actions.

The operation of the principle of voluntariness is to be found in the law relating to automatism and, as previously stated, it is difficult to imagine how premenstrual syndrome or postpartum disorders could lead to a loss of or clouded consciousness which would result in an involuntary action.

The principle of understanding can be seen in operation in the defence of insanity. It has already been argued that postpartum psychosis may form the basis for the insanity defence if it can be shown that a woman suffering from this disorder lacked the ability to know that what she was doing was wrong.

However, apart from the situation where insanity can be viewed as resulting from postpartum psychosis, voluntariness and understanding do not appear to be affected by conditions such as premenstrual syndrome and postnatal depression.

There is simply not enough evidence to show that women who experience such conditions are affected in such a way as to make their actions involuntary

---

<sup>116</sup> Hall, J, "Mental Disease and Criminal Responsibility — M'Naghten versus Durham and the American Law Institute" (1958) 33 *Indiana LJ* 212 at 223.

or to cause them to lack the capacity to understand the significance of their actions. Put simply, such women are not incapable of choosing to obey the law.

A defence based on conditions such as premenstrual syndrome and postpartum depression therefore goes beyond the line drawn by the criminal law as to when an accused should be held responsible for his or her actions. To argue that a woman should not be held responsible for a criminal act because premenstrual syndrome or postpartum depression made her unable to control her actions, is to deny the importance of the concept of free will which underpins the criminal law system.

There is a further problem in that the creation of a separate defence for women based around premenstrual syndrome and postpartum depression not only goes against the underlying tenets of the criminal law, it also lends credence to an ideology which views women's reproductive cycle in a negative manner:

The dominant ideology ... views women's "circulating hormones" as a liability; women are ruled by their biological make-up, which is inherently unstable ... The menstruating woman is seen as basically 'mad or bad', liable to commit crimes and prone to acts of 'lunacy'. This implies that women might spend one sixth of their reproductive lives suffering from a disabling illness which makes them unfit for many types of work, as well as for many social and sexual activities.<sup>117</sup>

Hence, there is a danger that excusing certain women from criminal responsibility due to premenstrual syndrome or postpartum depression will reinforce the assumption that all women are ruled by their hormones, an assumption which has often been used in the past to define women as dangerous and deviant.

Since a separate defence for women based on premenstrual syndrome and postpartum depression goes against the basic tenets of the criminal law and may reinforce stereotypical beliefs about women being at the mercy of their hormones, it is far better for the existence of such conditions to be considered during sentencing and it is this part of the criminal process which will next be examined.

## 10. Mitigation of Sentence

It has already been mentioned that in the cases of *R v Craddock*<sup>118</sup> and *R v English*<sup>119</sup> premenstrual syndrome was considered to be a factor to be taken into account in mitigating the sentences of these two women. In addition, it has been stated that in *R v Smith*, the English Court of Appeal considered it more appropriate to consider premenstrual syndrome as a mitigating factor in sentencing than as a substantive defence.<sup>120</sup>

Premenstrual syndrome has been raised in addition to other mitigating factors at the sentencing stage in a number of subsequent English cases.<sup>121</sup> In Canada, premenstrual syndrome has also been taken into account in the sentencing process for women accused of shoplifting and assault with a weapon.<sup>122</sup>

---

117 Ussher, J M, *The Psychology of the Female Body* (1989) at 42.

118 Above n3.

119 Unreported, Norwich Crown Court, 10 November 1981.

120 *R v Smith* No 1/A/82, Court of Appeal (Criminal Division); [1982] Crim LR 531.

121 See cases mentioned in Edwards, S, "Mad, Bad or Pre-Menstrual?" (1988) 138 *New LJ* 456.

122 See cases mentioned in Osborne, J A, "Perspectives on Premenstrual Syndrome: Women,



Because of the philosophical underpinnings of the criminal law outlined above, it is much easier to conceive of evidence of premenstrual system and postpartum depression being raised at the sentencing rather than at the trial stage.

There is a marked difference between the extent to which a court will take into account mitigating factors in relation to criminal responsibility at the trial and the sentencing stages. At the trial stage the court is limited to an exploration of whether the criminal act was involuntary or whether the accused lacked the capacity to understand his or her actions. At the sentencing stage however, a court may have regard to a vast amount of material bearing on the accused's background. It is at this stage that evidence of conditions such as postpartum depression and premenstrual syndrome and the socio-economic factors surrounding the accused's life should be taken into account.

### *11. Conclusion*

It has been argued that to excuse women from criminal responsibility on the basis of outmoded medical models is simplistic and misleading. There is no firm evidence to show that raging hormones cause conditions such as premenstrual syndrome or postpartum disorders, nor is there any evidence to show that such conditions lead to female crime.

The exploration of the practice and subsequent crime of infanticide has shown how the medicalisation of child-killing avoids examining the socio-economic link to the phenomenon. It has also been shown that while postpartum psychosis may form the basis for a successful defence of insanity, conditions such as postpartum depression and premenstrual syndrome do not fall neatly within the existing mental state defences and should not form the basis for a new gender specific defence.

It is ultimately more advantageous for women to be considered responsible for their actions and to take into account conditions such as premenstrual syndrome and postpartum depression at the sentencing stage, given the trend to more flexible sentencing options, than it is to formulate defences based on the misleading notion that women are not responsible for their conduct because of their raging hormones.