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Recommended Citation

Lee Solomon, *Premenstrual Syndrome: the Debate Surrounding Criminal Defense*, 54 Md. L. Rev. 571 (1995)

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PREMENSTRUAL SYNDROME: THE DEBATE SURROUNDING CRIMINAL DEFENSE

INTRODUCTION

This past summer the American Psychiatric Association (APA) updated its Diagnostic and Statistical Manual (DSM-IV),¹ and added premenstrual dysphoric disorder (PMDD), a severe form of premenstrual syndrome,² to the list of depressive disorders. This new classification is controversial among feminists and women's health activists due to the implications PMDD may have for the legal field and for society in general.³ The new classification of PMDD will impact aspects of criminal as well as civil law.⁴ For instance, the PMS defense, already used in criminal trials in England⁵ and the United States,⁶ will have a more solid foundation now that the APA classifies PMDD as a psychiatric disorder.⁷ Although some view the PMS defense as a positive development,⁸ it is important to recognize other, broader societal ramifications. Feminists fear that the inclusion of PMDD in the DSM-IV will lead to discrimination in the workplace, the family, and the community.⁹

1. AMERICAN PSYCHOLOGICAL ASSOCIATION, DIAGNOSTIC & STATISTICAL MANUAL IV (1994) [hereinafter DSM-IV MANUAL]. Published by the APA, the manual describes nearly 300 different psychiatric disorders. DSM-IV is the basic diagnostic reference tool for mental health professionals. Constance Holden, *Proposed New Psychiatric Diagnoses Raise Charges of Gender Bias*, 231 SCI. 327, 327 (1986). Insurance companies and lawyers also use the manual. *Id.*

2. DSM-IV MANUAL, *supra* note 1, at 715-18. Premenstrual dysphoric disorder is a severe form of "PMS" characterized by dysfunctional mood and behavior. Holden, *supra* note 1, at 327.

3. Position Paper by Paula Caplan, Psychologist at the University of Toronto, to the Legislative Assembly of the American Psychiatric Association (on file with author). Over six million individuals and many organizations, such as the American Psychological Association, the Women's College Hospital in Toronto, and the National Organization of Women, have voiced opposition to the classification. *Id.*; see also Paula Span, *Vicious Cycle: The Politics of Periods; After Tomorrow, Many Women May Be Told They're Plain Crazy*, WASH. POST, July 8, 1993, at C1.

4. Span, *supra* note 3, at C2.

5. Joseph R. Tybor, *Women on Trial: New Defense*, NAT'L L.J., Feb. 15, 1982, at 1.

6. Lawrence Taylor & Katharina Dalton, *Premenstrual Syndrome: A New Criminal Defense?*, 19 CAL. W. L. REV. 269, 276-77 (1983).

7. Span, *supra* note 3, at C1, C2.

8. Holden, *supra* note 1, at 328.

9. Span, *supra* note 3, at C2. Feminists question whether this disorder will be used against women in their quest to obtain custody of children. *Id.* The National Women's Health Network drafted a sample letter for use by its members to protest the APA's decision to include PMDD in the new diagnostic manual. The letter argued that there was no

This Comment will first explain premenstrual syndrome by examining the myths, history, and medical data surrounding the menstrual cycle. It will then analyze the American Psychiatric Association's classification and the debate surrounding the creation of the PMDD category in the DSM-IV. Finally, this Comment will discuss how the new psychiatric "disorder" supports a criminal defense based on premenstrual symptoms and what broad societal impact may ensue.

Prior to the PMDD classification, it was difficult to mount a successful PMS defense because of divergent definitions within the medical community and because PMS was considered a hormonal, not a mental, illness.¹⁰ The new PMDD classification eliminates many of these difficulties and may lead to the increased use of premenstrual symptoms either as a defense or as a mitigating factor in criminal trials.¹¹ Although the defense will help women who commit crimes while suffering from severe PMS, this benefit must be weighed against the potential damage to women in the workplace, in civil trials, and in society in general.

I. BACKGROUND

Myths surrounding women's menstrual cycle have pervaded all societies, cultures and religions for centuries.¹² Philosophers legitimized these myths by explaining women's physical characteristics in negative terms.¹³ "But it was not until the advent of modern science that the patriarchal view of women as inherently inferior was alleged to be grounded in biological 'fact'."¹⁴ For hundreds of years, medical theories have provided sexist rationalizations for women's inferior social status.¹⁵ Nineteenth century medical theories viewed a woman's natural state as one of illness.¹⁶ Scientists saw menstruation as proof

sound empirical basis for PMDD and the classification would endanger women socially, politically, and economically. *PMS Diagnosis Protested*, NETWORK NEWS (The National Women's Health Network, Wash., D.C.), May/June 1993, at 5.

10. See generally Linda R. Chait, *Premenstrual Syndrome and Our Sisters in Crime: A Feminist Dilemma*, 9 WOMEN'S RTS. L. REP. 267, 271 (1986) (noting that PMS was considered a "defense without merit"); see also PAULA CAPLAN, *THEY SAY YOU'RE CRAZY: HOW THE WORLD'S MOST POWERFUL PSYCHIATRISTS DECIDE WHO'S NORMAL* (forthcoming 1995).

11. Span, *supra* note 3, at C2.

12. Chait; *supra* note 10, at 272. "Menstrual taboos are found universally and are thought to originate in male abhorrence of the menses, which is attributed to a fear of blood." *Id.* at 272 n.63.

13. *Id.* at 271-73.

14. *Id.* at 273.

15. *Id.* at 277.

16. *Id.* at 275. "Abnormalities from irritability to insanity were traced to some ovarian disease." *Id.*

of this theory, lending scientific reality to the myth.¹⁷ Premenstrual syndrome, and more recently premenstrual dysphoric disorder are the latest additions to this mythology.

In 1931, endocrinologist and gynecologist, Robert Frank, first described premenstrual syndrome and attributed the changes in women's personalities to fluctuations in the ovarian hormones.¹⁸ In 1965, Doctors Hamish Sutherland and Iain Stewart defined premenstrual syndrome as "any combination of emotional or physical features which occur[s] cyclically in a female before menstruation, and which regress[es] and disappear[s] during menstruation."¹⁹ Dr. Katharina Dalton,²⁰ an expert in the field of premenstrual syndrome, defines PMS as a hormone deficiency disease that "includes a wide variety of symptoms which regularly recur in the same phase of each menstrual cycle, followed by a symptom-free phase."²¹ The condition is noted to be most acute in the last seventh (premenstruum) and the first seventh (menstruation) of a twenty-eight day cycle which is subdivided into seven four-day intervals.²²

17. *Id.*

18. Robert T. Frank, *The Hormonal Causes of Premenstrual Tension*, 26 ARCHIVES NEUROLOGY & PSYCHIATRY 1053 (1931). Frank's conclusions were later supported by Dr. Joseph Morton's research in 1946 through 1950. See Joseph H. Morton, *Chronic Cystic Mastitis and Sterility*, 6 J. CLINICAL ENDOCRINOLOGY 802 (1946). By the mid-1950s, PMS was recognized as a distinct medical entity which interfered with the health of many women. Chait, *supra* note 10, at 277.

19. Hamish Sutherland & Iain Stewart, *A Critical Analysis of the Premenstrual Syndrome*, 1 LANCET 1180, 1182 (1965); see also Robert M. Carney & Brian D. Williams, *Recent Decisions*, 59 NOTRE DAME L. REV. 253, 255 (1983).

20. Dr. Dalton is the director of the Premenstrual Syndrome Clinic at the University College Hospital in London, England. Over a 30 year period, she has studied approximately 30,000 cases and written many books and articles regarding this disorder. Additionally, Dr. Dalton served as an expert witness in *Regina v. Craddock*, *Regina v. Smith*, and *Regina v. English*, the three leading cases that established PMS as a defense in British criminal trials. Tybor, *supra* note 5, at 12.

21. Taylor & Dalton, *supra* note 6, at 271-72.

22. Aleta Wallach & Larry Rubin, *The Premenstrual Syndrome and Criminal Responsibility*, 19 UCLA L. REV. 210, 219 (1971).

There are many symptoms characteristic of PMS,²³ and doctors cannot agree on the most common ailments.²⁴ Nor do medical experts agree on the cause of premenstrual syndrome.²⁵ For instance, Dr. Dalton believes that an excess of estrogen in relation to progesterone during the premenstrual phase causes PMS.²⁶ Other theories that define the causes of premenstrual tension include:²⁷ the rise and fall of both estrogen and progesterone; the rapid decline in a metabolite of a neurotransmitter; yeast overgrowth in the intestines; allergies; and psychological stress.²⁸

Another source of uncertainty about premenstrual syndrome is the frequency with which it occurs.²⁹

Estimates of the incidence of PMS vary according to the breadth of the definition used. One study suggests that nearly twenty percent of all women requires treatment for the syndrome. Another study suggests that between seventy and ninety percent of the female population experiences PMS symptoms, while twenty to forty percent suffers temporary mental or physical incapacitation due to PMS.³⁰

23. *Pre-Menstrual Syndrome (PMS) or Menopause? It's Hard to Tell!* A FRIEND INDEED FOR WOMEN IN THE PRIME OF LIFE (A Friend Indeed Publications, Inc., Montreal, Québec) Nov. 1987, at 1-3 [hereinafter (*PMS*) or *Menopause? It's Hard to Tell!*]. The following symptoms may occur premenstrually when suffering from "PMS": abdominal bloating, abdominal cramping, absentmindedness, accident-proneness, acne, alcohol intolerance, anger, anxiety, asthma, backpain, breast swelling and pain, cardiac arrhythmias (irregular heartbeats), confusion, crying, depression, dizziness, eating disorders, edema, eye difficulties, fainting, fatigue, food binges, hand tingling and numbness, headaches, hemorrhoids (flairups), herpes (oral, skin, genital), hives, indecisiveness, infections, insomnia, irritability, joint swelling and pain, lack of coordination, lactation difficulties, lethargy, muscle aches, nausea, noise sensitivity, palpitations, panic states, paranoia, pimple eruptions, rashes, salt cravings, seizures, (lack of) self-esteem, sex-drive changes, slurred speech, smell sensitivity, spaciness, stiff neck, sties, suicidal thoughts, sweet cravings, tension, tiredness, touch sensitivity, urinary difficulties, violence, weight gain, and withdrawal. *Id.* at 2-3.

24. Carney & Williams, *supra* note 19, at 255. Dr. Dalton believes that irritability, anger, confusion and other behavioral symptoms are most common. Other doctors identify physical symptoms such as headaches, swelling of the breast. *Id.*

25. *PMS or Menopause? It's Hard to Tell!*, *supra* note 23, at 5-6.

26. *Id.* at 5; see also Wallach & Rubin, *supra* note 22, at 219 (stating theories of hormonal influence predominate among doctors).

27. Some early literature used the diagnosis as "Premenstrual Tension Syndrome" to describe the same symptoms as found in premenstrual syndrome. But, premenstrual tension is actually only one characteristic of PMS. Wallach & Rubin, *supra* note 22, at 212 n.9.

28. *PMS or Menopause? It's Hard to Tell!*, *supra* note 23, at 5-6.

29. Robert L. Reid & S.C. Yen, *Premenstrual Syndrome*, 139 AM. J. OBSTETRICS & GYNECOLOGY 85, 86 (1981). "Efforts to compare epidemiologic data on PMS are likely to be misleading because of variable interpretation of the clinical manifestations and the obvious difficulties encountered in quantitating [sic] the severity of symptoms." *Id.*

30. Carney & Williams, *supra* note 19, at 257. The difficulties in determining the number of women suffering from PMS may be the result of inconsistent definitional re-

Premenstrual syndrome is distinguishable from premenstrual discomfort. The latter is experienced by most menstruating women, while PMS is a more serious exacerbation of the condition that a lesser, yet substantial, number of women experience.³¹ Dr. Dalton provides an example of a woman with PMS, which illustrates the severity of the syndrome:

Janet is a thirty-year-old housewife living in London, England. She is in most respects a "normal" individual, except that seven days before the beginning of her menstrual periods she begins to experience irritability and tension which accelerate into aggressive and violent behavior toward her husband, her children, and even herself. This monthly reaction began when Janet was a teenager: in the intervening years she has attempted suicide by ingesting overdoses of aspirin and of valium, by slashing her wrists, by stabbing herself, and by jumping from a train. Each of these suicide attempts occurred during her premenstrual cycle. On the first day of menstruation, however, all symptoms ease and she becomes calm, friendly, and rational.³²

Despite extensive research and diagnostic progress with PMS, many questions remain concerning the premenstrual condition.³³ PMS often remains undiagnosed and untreated due to its breadth of symptoms and the readiness of persons to categorize sufferers as simply neurotic.³⁴ These factors have created a double-edged sword. If ignored and not recognized as a true medical condition, many women who suffer from the syndrome will continue to lack treatment.³⁵ But, if society recognizes the condition, it could be viewed as evidence of women's biological inferiority.³⁶ Dr. Michelle Harrison explains the dilemma surrounding premenstrual syndrome.

The feminist in me wishes that our biology were irrelevant. The doctor in me sees the need for recognizing and treating premenstrual symptoms. The woman in me recognizes the power of the biological forces within me, and

quirements. For example, if the definition includes commonplace dysmenorrhea, the incidence of the syndrome would increase. Wallach & Rubin, *supra* note 22, at 232 n.95.

31. Wallach & Rubin, *supra* note 22, at 212-13.

32. Taylor & Dalton, *supra* note 6, at 269.

33. Chait, *supra* note 10, at 278.

34. Wallach & Rubin, *supra* note 22, at 214.

35. Betsy A. Lehman, *A Little Revision is Creating a Big Furor*, BOSTON GLOBE, May 10, 1993, at 17.

36. Chait, *supra* note 10, at 271.

wishes I lived in a society in which my menstrual cycle were seen as an asset, not a liability.³⁷

II. APA'S CLASSIFICATION

A. *The Diagnostic and Statistical Manual*

In 1952, the American Psychiatric Association created the Diagnostic and Statistical Manual of Mental Disorders (DSM).³⁸ The original handbook listed several dozen mental illnesses and accompanying definitions.³⁹ In 1968, the book was restructured to coincide more closely with the mental disorders listed in the International Classification of Diseases and the book was retitled DSM-II.⁴⁰ In 1974, the APA once again decided to revise the manual.⁴¹ Toward this end, the APA formed a committee of nineteen mental health professionals to clarify the diagnoses as well as the scientific research associated with each classification.⁴² When the committee finished this task, the revised manual, DSM-III, had quadrupled from its previous size, and the list of disorders grew to over 200 classifications.⁴³ Each disorder listed in DSM-III included a checklist of precise and "fairly objective" attributes of the disorder.⁴⁴ The DSM is considered "the bible of mental illness" and is utilized not only by therapists but also by insurance companies and judges to identify and define the mentally ill.⁴⁵

B. *Late Luteal Dysphoric Disorder and DSM-III-R*

In late 1985, an APA work group convened to create the DSM-III-R.⁴⁶ When the plan for this revision was announced, proponents characterized it as a "technical revision to clear up problems that had been overlooked in the massive reorganization of the manual in 1980

37. *Old Problem, New "Disease": The Controversy Surrounding Premenstrual Syndrome (PMS)*, NETWORK NEWS (The National Women's Health Network, Wash., D.C.), Summer 1984, at 5 [hereinafter *Old Problem, New "Disease"*].

38. Deborah Franklin, *The Politics of Masochism*, PSYCHOL. TODAY, Jan. 1987, at 52.

39. *Id.*

40. *Id.* See also Herb Kutchins & Stuart A. Kirk, *DSM-III-R: The Conflict Over New Psychiatric Diagnoses*, HEALTH & SOC. WORK, May 1989 at 91, 92 (noting developers of the revised manual claimed that it was unbiased and more scientific while many critics of DSM-III claimed that the manual was unfair and prejudiced against women).

41. Franklin, *supra* note 38, at 52.

42. *Id.*

43. *Id.*

44. *Id.* In theory, this attempt at standardization should help health professionals diagnose patients in a consistent manner. *Id.* Problems arise, though, due to the subjective nature of mental health. *Id.*

45. *Id.*; see also *supra* note 1.

46. *Id.*

and to take into account recent research."⁴⁷ Controversy surrounded many of the new diagnostic categories proposed for the revised manual.⁴⁸ One of the proposed diagnostic categories was late luteal phase dysphoric disorder (LLPDD).⁴⁹ The APA Work Group coined the term LLPDD in order to distinguish it from PMS.⁵⁰ The diagnostic criteria for LLPDD included psychological disturbances that seriously interfere with work, ordinary social activities, or relationships.⁵¹ These disturbances occur during the luteal phase, the week before the onset of menses, and end within a few days after the onset of menstruation.⁵² LLPDD differed from PMS by "a clear emphasis on mood and behavioral as opposed to physical symptoms."⁵³ In addition, the LLPDD diagnostic criteria focused on the severity, frequency, and types of the patient's complaints, the interference with normal functioning, and the need for confirmation over two menstrual cycles.⁵⁴

Controversy immediately arose regarding the classification of LLPDD.⁵⁵ Many felt that the disorder would become a catch-all diagnosis used in lieu of more specific, and difficult, determinations.⁵⁶ Other critics thought the diagnosis would be stigmatizing and that the research literature was inadequate.⁵⁷ Due to these concerns, the LLPDD classification was not included in the main text of the DSM-III-R, but inserted into the appendix as a "proposed diagnostic category needing further study."⁵⁸

C. Premenstrual Dysphoric Disorder and DSM-IV

On July 9, 1993, when the American Psychiatric Association reconvened to revise the Diagnostic and Statistical Manual,⁵⁹ Premen-

47. *Id.* at 92.

48. *Id.* at 93. Objections were raised regarding "sexual assault disorder," "masochistic personality disorder," and "PMS." *Id.*

49. American Psychiatric Association Work Group, *DSM-IV Literature Review; Late Luteal Phase Dysphoric Disorder* [hereinafter *DSM-IV Literature Review*] (working paper) (on file with the American Psychiatric Association).

50. *Id.* at 4, 75.

51. *Id.* at 4-5.

52. *Id.*

53. *Id.* at 9.

54. *Id.* This is a questionable distinction because previous definitions of "PMS" appear to be very similar to the new classification. See *supra* notes 21-23 and accompanying text.

55. "A longstanding controversy has existed as to whether PMS is a gynecological or psychological disorder. The *International Classification of Diseases* includes a gynecological diagnosis of premenstrual tension syndrome." Kutchins & Kirk, *supra* note 40, at 94.

56. *DSM-IV Literature Review*, *supra* note 49, at 5.

57. *Id.*

58. *Id.* at 4.

59. Span, *supra* note 3, at C1.

strual dysphoric disorder was among the new disorders to be classified.⁶⁰ This disorder is essentially the same as LLPDD.⁶¹ The APA organized a working group of six members to discuss and research whether to incorporate the new diagnosis into the DSM-IV.⁶² The Work Group studied five proposals.⁶³ Option #1 maintained the status quo, kept the diagnosis in the DSM appendix, and did not include it within the official text.⁶⁴ Option #2 included the classification in the nomenclature.⁶⁵ Option #3 viewed the condition as clinically significant, but rather than label it as a mental disorder, included it in a section for other significant conditions that may be the focus of diagnosis or treatment.⁶⁶ Option #4 omitted the category completely.⁶⁷ And, option #5 listed it as an example of a "Depressive Disorder Not Otherwise Specified and/or Anxiety Disorder Not Otherwise Specified."⁶⁸ The APA ultimately decided to list premenstrual dysphoric disorder in the main text of DSM-IV as a possible form of depression, but placed the definitional symptoms in the appendix.⁶⁹

D. *The Debate Surrounding the Categorization of PMDD*

The current controversy surrounding the classification of PMDD as a mental disorder has many facets. First, many critics say that there is insufficient empirical research to support the classification.⁷⁰ For instance, Sheryle J. Gallant and Jean A. Hamilton conducted a study

60. *Id.*

61. *DSM-IV Literature Review*, *supra* note 49, at 75. The APA decided to change the name from late luteal phase dysphoric disorder to premenstrual dysphoric disorder for two reasons. First, LLPDD is a cumbersome name; and second, it is potentially misleading because the symptoms may not be exclusively related to the endocrine state of the late luteal phase. *Id.*; see Appendix, *infra*.

62. *DSM-IV Literature Review*, *supra* note 49, at 6.

63. *Id.* at 76.

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.* As of the completion of the Working Copy of the Literature Review, the Work Group had not completed reviewing the evidence to determine its recommendation.

69. *A New Psychological Bible Has Been Created* (Nat'l Pub. Radio broadcast, July 11, 1993).

70. *PMS Diagnosis Protested*, *supra* note 9, at 5.

[E]normous numbers of studies have been done, but most are profoundly flawed and certainly do not constitute evidence that there should be such a disorder. Indeed, the DSM subcommittee studying PMS reached an impasse about whether or not it should go into the handbook and took the curious step of asking two other people to review the research and decide what should be done.

Id.

which used daily ratings to confirm PMS.⁷¹ Their study utilized a control group of women without PMS symptoms and a group of women with a provisional diagnosis of LLPDD (which uses the same definitional symptoms as PMDD).⁷² The results of the study indicated that there was no reliable difference between the two groups of women based on their daily symptom ratings regardless of the criteria used.⁷³ The two researchers further stressed that the DSM-IV Work Group's study involved no control groups.⁷⁴ The APA has noted in its own literature that empirical research difficulties exist.⁷⁵ Feminists argue that "there is no proof that any such disorder exists and that without better evidence, no women should be labeled mentally ill."⁷⁶ Critics maintain that classifying some women who have mood swings as mentally ill will harm all women. A more solid empirical basis is needed.⁷⁷

Paula Caplan, a University of Toronto psychologist, explains that both PMS and PMDD may have other societal and interpersonal causes.⁷⁸ For example, upsetting life situations such as abuse in the family, lack of support, and economic woes can lead to depression associated with this disorder.⁷⁹ The depression is aggravated when the physical symptoms of the premenstrual cycle manifest themselves.⁸⁰ Because we live in a sexist society, women and men too easily sub-

71. Sheryle J. Gallant & Jean A. Hamilton, *Letters to the Editor*, 54 *PSYCHOSOMATIC MED.* 723, 725 (1992).

72. *Id.*

73. *Id.*

74. *Id.* Gallant and Hamilton stressed that had the APA Work Group's study included the use of control groups, they would probably have come to the same result: "that the proportion of women with a provisional diagnosis who met prospective symptom criteria was not statistically greater than the proportion of individuals in the various control groups who met these criteria." *Id.*

75. *DSM-IV Literature Review*, *supra* note 49, at 75. The APA Work Group stated "[T]here is accumulating, but preliminary, evidence that a disorder meeting the criteria for LLPDD [the group had not yet decided to change the name to PMDD] as proposed in the DSM-III-R Appendix does exist However, there are many methodological problems in the research to date." *Id.*

76. Lehman, *supra* note 35, at 17.

77. *Id.* Other adverse consequences that have been advanced in opposition to the classification include: (1) A fear that "[a]rbitrary features of the proposed diagnosis will prematurely foreclose and bias research in the field" for lack of attention to the issues of reliability and validity and for the exclusion of physical symptoms; (2) Concern that the diagnosis only appears to help women clinically because "[t]here is no one proven treatment for the proposed disorder"; (3) The label could be used to discriminate against women in the workplace. Jean A. Hamilton, *Action Alert on Sexism in Psychiatric Diagnoses* (Institute for Research on Women's Health) (on file with the American Psychological Association).

78. Telephone Interview with Paula Caplan (Oct. 24, 1993).

79. *Id.*

80. *Id.*

scribe to the idea that PMS is the reason for their frustration and depression.⁸¹ These latter problems can be helped by a change of diet and in self-help groups.⁸² Mental illness, however, is not normally cured in this manner, a discrepancy which underscores the argument that PMDD differs from other mental illnesses.⁸³

A related quandary is the premise that PMS and PMDD are "constructs" which can lead to possible misuse.⁸⁴ The phrases premenstrual syndrome and premenstrual dysphoric disorder can have different meanings depending on the person defining the condition.⁸⁵ The subjective meanings often lead to divergent interpretations with the result that some women are classified as having a mental illness while others are not.⁸⁶ For some, the term PMS may mean a debilitating condition, but for others it may mean some physical and mental discomfort prior to the onset of menstruation.⁸⁷ This discrepancy can lead to disastrous results when applied in a scientific arena and explains why critics believe a more solid foundation of research should be established prior to formal classification.⁸⁸

Protests surrounding PMDD also focus on the classification's social and political dangers to women.⁸⁹ The APA recognized this risk when it admitted that classification "might confirm the cultural belief that menstruation causes disability and makes women less fit for positions of responsibility."⁹⁰ Kim Gandy, executive vice president of the National Organization for Women, stated that this classification "'gives credibility to an old myth, to an old stereotype"; she feared "that women will be called mentally unstable once a month and that the listing will be used against women who are vying for jobs or child custody in divorce hearings."⁹¹ Moreover, the "diagnosis reifies itself and becomes a self-fulfilling prophecy, partly because of women's internalized beliefs about menstruation and because the most stigma-

81. *Id.*

82. *Old Problem, New "Disease," supra* note 37, at 6.

83. *See Span, supra* note 3, at C2.

84. Interview with Paula Caplan, *supra* note 78.

85. *Id.*

86. *Id.*

87. *Id.*

88. *See supra* notes 70-77 and accompanying text.

89. *PMS Diagnosis Protested, supra* note 9, at 5.

90. *DSM-IV Literature Review, supra* note 49, at 70.

91. Laura Beil, *PMS: Still a Mystery to Doctors, Sufferers; For All Its Infamy, Premenstrual Syndrome Remains Entangled In Misconceptions*, ORLANDO SENTINEL, Aug. 20, 1993, at E1.

tizing aspect—reports of impairment in *occupational functioning*—are never subject to external validation.”⁹²

Further, “[w]hile it is true . . . that some medical and psychiatric conditions are confined by their very nature to one gender or the other, identifying a menstrually-related psychiatric disorder as a free standing entity or a special kind of affective disorder raises conceptual as well as related social problems.”⁹³ There is skepticism regarding the rationale for establishing a psychiatric illness related exclusively to hormonally linked symptoms found only in women.⁹⁴ This skepticism is heightened by the fact that there are no parallel categories for men.⁹⁵

III. THE IMPLICATIONS

A. *The Classification Will Lay a More Solid Foundation For PMS as a Defense*

Premenstrual syndrome has already appeared in the legal context as a defense to criminal liability.⁹⁶ In France, juries have recognized PMS as a form of legal insanity⁹⁷ and in England courts have accepted PMS as a mitigating factor.⁹⁸ Although no appellate court in the United States has ruled on the validity of the premenstrual syndrome defense, it has appeared in trial courts with varying degrees of success.⁹⁹ The APA’s classification of premenstrual dysphoric disorder as a “mental disorder” will further substantiate the PMS defense and lead to the increased use of the syndrome in criminal cases in the United States.

92. Hamilton, *supra* note 77 (internal citations omitted). Hamilton explains that labeling menstruation a mental disorder reinforces the belief that women are defective because of their innate physiology. Such a negative stereotype will be internalized by women and adversely affect their self-esteem, attitudes, menstruation, and their bodies. *Id.*

93. *DSM-IV Literature Review*, *supra* note 49, at 68.

94. *Id.* at 68.

95. *PMS Diagnosis Protested*, *supra* note 9, at 5. “There is no parallel category for men, no suggestion that the well-documented mood and behavior changes that result from variations in ‘male hormone’ changes should be given the label of a mental illness (no ‘testosterone-based’ aggressive disorder).” *Id.*

96. See *supra* notes 5-6 and accompanying text.

97. Howard L. Oleck, *Legal Aspects of Premenstrual Tension*, 166 INT’L REC. OF MED. & GEN. PRAC. CLINICS 492, 496 (1953).

98. See *infra* notes 107, 111 and accompanying text.

99. See *infra* notes 126, 141, 145.

1. *Current State of the Law.*—Defendants have introduced PMS as a defense in Europe, Canada,¹⁰⁰ and the United States. In England, PMS is accepted as a mitigating factor in criminal cases. In the 1980 case of *Regina v. Craddock*,¹⁰¹ Sandie Craddock was arrested for stabbing a fellow barmaid to death.¹⁰² At trial, her murder charge was reduced to manslaughter and Craddock was released on probation after her attorney pleaded that she suffered from premenstrual syndrome.¹⁰³ Craddock had more than thirty prior convictions, mainly for criminal damage and assault, and had attempted suicide on multiple occasions.¹⁰⁴ Upon reviewing diaries that Craddock had maintained over the years, her attorney discovered that each criminal offense or suicide attempt occurred at approximately the same time in her menstrual cycle.¹⁰⁵ Dr. Katharina Dalton, the defense's expert witness, diagnosed Craddock as suffering from premenstrual syndrome, and prescribed progesterone treatment.¹⁰⁶ The medication stabilized Craddock's personality and she received probation contingent on continuance of her treatment.¹⁰⁷

Craddock reappeared in court in 1982, under the name of Sandie Smith.¹⁰⁸ Smith was charged with two counts of threatening to kill a police officer, and one count of carrying a weapon.¹⁰⁹ Dr. Dalton testified that she had been progressively reducing Smith's medication when the offense occurred.¹¹⁰ Smith was found guilty on all counts, but the trial court again recognized PMS as a mitigating factor and sentenced her to probation.¹¹¹

100. James W. Lewis, *Premenstrual Syndrome as a Criminal Defense*, 19 ARCHIVES SEXUAL BEHAV. 425, 426 (1990). In Alberta, Canada, a woman accused of shoplifting asserted a premenstrual syndrome defense and was acquitted. The judge opined that at the time of the criminal offense, the defendant was irrational and not capable of forming the requisite intent to steal. *Id.*

101. 1 C.L. 49 (1980).

102. *Id.*

103. *Id.*; see also Tybor, *supra* note 5, at 1.

104. *Craddock*, 1 C.L. at 49.

105. Carney & Williams, *supra* note 19, at 258-59.

106. *Id.* at 259; see *supra* note 27.

107. *Id.* at 259.

108. *Regina v. Smith*, No. 1/A/82 (C.A. Crim. Div. Apr. 27, 1982) (LEXIS, Enggen library case file) at *14. By the time of this trial, Craddock/Smith had already accumulated 45 convictions for which she had appeared in court on 28 different occasions. Many of the charges against her had involved inexplicable violent behavior. *Id.* at *15.

109. *Id.* at *14.

110. *Id.* at *15. Dr. Dalton had reduced Smith's dosage in order to see whether Smith could carry on a normal life without the massive progesterone treatment. *Id.*

111. *Id.* at *15-16. During her testimony, Dr. Dalton was asked whether Smith "would have done what she did, knowing what she was doing?" *Id.* at *15. Dr. Dalton answered that, "She knew what she was doing, but she could not control herself. She lost her moral

The British Court of Appeals for the Criminal Division held that the appropriate application of a PMS defense was as a mitigating factor rather than a substantive defense.¹¹² The appellate court reasoned that

[p]rimarily, the function of the criminal law is to protect society and if one asks oneself what would the consequences [be] if we acceded to [the defense attorney's] submission [to acquit], one would find this picture. After she had stabbed the barmaid to death, the Appellant would be entitled to come before the court and seek an acquittal because she would properly be able to say that as a result of the lack of the necessary hormone, she lost control of herself and that she is not morally guilty. As a result of that, she would be acquitted and discharged with all the consequent risks to society. *There would be no control over her by society through the courts and she would continue to be a danger to all around her. That would be a totally unacceptable state of affairs.*¹¹³

Admitting the serious nature of the offense, the court of criminal appeals nonetheless concluded that the lower court had wide discretion with respect to sentencing and could impose probation.¹¹⁴

In another British case, *Regina v. English*,¹¹⁵ a trial court accepted PMS as a mitigating factor. Christine English had deliberately pinned her boyfriend to a pole with her car and killed him.¹¹⁶ Dr. Dalton testified at this trial and diagnosed English as suffering from "an extremely aggravated form of premenstrual physical condition."¹¹⁷ The court reduced the murder charge to "manslaughter due to dimin-

safeguards." *Id.* The trial court did not allow the jury to consider the defense of automatism and therefore the jury returned a verdict of guilty. *Id.* at *16. The court defined automatism "as connoting the state of a person who, though capable of action, is not conscious of what he is doing It means unconscious involuntary action and it is a defence because the mind does not go with what is being done." *Id.* (quoting *Bratty v. Attorney Gen. N. Ir.*, 46 Crim. App. 1, 28 (1962)).

The *Smith* court believed, "It is quite clear from the doctor's evidence that this woman knew exactly what she was doing, intended to do it, but was led into doing it because the dark side of her nature appeared" *Id.* at *16. The type of conduct that the court described more closely mimics actions consistent with the defense of "irresistible impulse." *Id.* at *17. But this defense is not available in England, and the court was not willing to examine this area of law. *Id.* at *17-18.

112. *Id.* at *18.

113. *Id.* at *17 (emphasis added).

114. *Id.* at *17-18.

115. Tybor, *supra* note 5, at 1, 12 (citing *Regina v. English* (Norwich Crown Ct. Nov. 10, 1981) (unreported)).

116. Carney & Williams, *supra* note 19, at 261.

117. *Id.*

ished responsibility" and stated that English acted under exceptional circumstances.¹¹⁸

Finally, in *Regina v. Reynolds*,¹¹⁹ the Court of Appeals for the Criminal Division reduced a conviction and life sentence for murder to manslaughter and supervised probation.¹²⁰ Reynolds had killed her mother by hitting her on the head with a hammer.¹²¹ On appeal, Dr. Katharina Dalton testified that "this was a case of diminished responsibility, the cause of that being a conjunction of premenstrual syndrome and postnatal depression."¹²² After hearing Dr. Dalton's testimony, the prosecuting attorney stated that if there were a retrial he would accept a plea of guilty to manslaughter based on diminished capacity.¹²³ With the prosecutor's concession and on medical evidence that the appellant suffered from diminished responsibility, the court substituted a verdict of manslaughter.¹²⁴ The court then stepped beyond British precedent and explicitly accepted premenstrual syndrome as fitting within the defense of diminished capacity.¹²⁵

The first American case to offer premenstrual syndrome as a defense occurred in April 1982 in *People v. Santos*.¹²⁶ Charged with assault of her child, Shirley Santos argued that she suffered from premenstrual syndrome at the time of the offense.¹²⁷ Santos' attorney entered a plea of not guilty on the grounds that Santos had PMS.¹²⁸ The attorney described PMS as "a 'distinctive' and 'separate' entity belonging to . . . the specific category of genitourinary and/or endocrine reactions."¹²⁹ This defense was never tested in the court, how-

118. *Id.*

119. Crim. L.R. 679 (C.A.) (1988) (LEXIS, Enggen library, cases file).

120. *Id.* at *14-15.

121. *Id.* at *2.

122. *Id.* at *10.

123. *Id.* at *11.

124. *Id.* at *12, *15. In terms of sentencing, the court stated,

[T]here clearly was a degree of responsibility which still remained and which calls for the imposition of the appropriate sentence. However, as we have said she has already served a substantial period in custody. We feel that the interests of justice, as well as the interests of the appellant herself, who is not yet 20 and therefore very young, would be served by placing her on probation with a condition of psychiatric supervision

Id. at *15.

125. Lewis, *supra* note 100, at 431-32. A plea of diminished capacity is not a complete excuse to criminal behavior but operates to reduce the severity of a charge to a lesser offense. See *infra* note 172.

126. No. 1KO46229 (Crim. Ct. Kings County Nov. 3, 1982) (unpublished opinion).

127. Chait, *supra* note 10, at 269 (citing Santos, No. 1KO46229).

128. *Id.*

129. *Id.* (quoting Santos, No. 1KO46229).

ever, because the parties subsequently negotiated a plea bargain.¹³⁰ Brooklyn's District Attorney, Elizabeth Holtzman, agreed to drop all felony charges against Santos in return for a guilty plea to a charge of harassment.¹³¹ Holtzman claimed this negotiation was not based on the merit of a PMS defense.¹³² The defense attorney, Stephanie Benson, strongly disagreed, stating: "I never expressed any doubt as to the viability of PMS as a defense. I advised my client to do the most sensible possible thing. . . . Precedents may be important, but my client's best interest remains paramount."¹³³ Although *Santos* ended in a plea bargain, commentators take note of it because the judge agreed to hear PMS testimony to support a defense, even if only in the pre-trial stage of the litigation.¹³⁴

In 1983, the courts faced the validity of a PMS defense in a bankruptcy proceeding. In *Lovato v. Irvin*,¹³⁵ Jamie Lynn Irvin stabbed her lover, Betty Ann Lovato, in the back and across the chest with a steak knife.¹³⁶ In addition to the criminal charges, Lovato filed a civil suit seeking compensation for her injuries.¹³⁷ The parties settled in the amount of \$5,200.00.¹³⁸ Shortly thereafter, Irvin filed a petition in bankruptcy, seeking discharge of all debts including the money owed to Lovato.¹³⁹ Lovato sought to have her judgment excepted from the discharge under Title 11, section 523 of the United States Code, because Irvin's conduct was a "willful and malicious injury by the debtor to another" ¹⁴⁰ Irvin contended that her conduct was not willful but the result of uncontrollable conduct due to premenstrual syndrome.¹⁴¹

130. *Id.* at 271.

131. *Id.*

132. Elizabeth Holtzman, Letter to the Editor, *Premenstrual Symptoms: No Legal Defense*, 60 ST. JOHN'S L. REV. 712, 713-14 (1986). Holtzman stated that her office did extensive research on PMS in their preparation of the *Santos* case. They reviewed 3000 medical publications, interviewed gynecologists, psychiatrists, and endocrinologists. *Id.* at 712. Holtzman stated that this research showed there is no "single well-defined medical condition which can be called 'premenstrual syndrome.'" *Id.* at 712-13. She further noted that there was no scientific evidence that supported the determination that the onset of the menstrual cycle prompts aggressive or violent behavior. *Id.* at 713.

133. Stephanie Benson, *Letter to the Editor*, NAT'L L.J., Nov. 29, 1982, at 14.

134. Richard T. Oakes, *PMS: A Plea Bargain In Brooklyn Does Not a Rule of Law Make*, 9 HAMLIN L. REV. 203, 205 (1986).

135. 31 B.R. 251 (Bankr. D. Colo. 1983).

136. *Id.* at 253.

137. *Id.*

138. *Id.* at 254.

139. *Id.*

140. *Id.* 11 U.S.C. § 523(a)(6).

141. *Irvin*, 31 B.R. at 254. "Irvin testified that she had begun menstruating on April 27, 1979 [the date of the attack], that she was suffering from cramps and pain, was confused

The *Irvin* court found the scientific evidence relating to PMS inconclusive and ruled that it could not be accepted as an explanation for otherwise willful and malicious conduct.¹⁴² In order for premenstrual syndrome to be accepted as a defense, the *Irvin* court required that two conditions be met. "First, the premise upon which any such scientific theory is based must have achieved general acceptance in the medical community; and secondly, there must be evidence that, to a reasonable degree of medical certainty, the conduct was proximately caused by the medical disorder."¹⁴³ While rejecting the PMS defense in this case, the court recognized that "[t]here may well be a circumstance in the future where sufficient [scientific evidence] establishes premenstrual syndrome as a legitimate defense to criminal or tortious conduct committed by an unfortunate sufferer from this medical difficulty."¹⁴⁴

In June 1991, a Virginia court accepted America's first successful criminal defense based on PMS.¹⁴⁵ While driving home from a friend's house, Geraldine Richter was stopped by police officers for straddling the white broken line.¹⁴⁶ The results of a breathalyzer test suggested that she was legally intoxicated.¹⁴⁷ Richter's attorney successfully used a two-pronged defense, bringing in experts to testify that PMS adversely affected Richter's conduct and, alternatively, that the breathalyzer test was inaccurate.¹⁴⁸ Using PMS as a mitigating fac-

and frightened, that she couldn't think, and that as the events unfolded it was as if 'someone else took over' her body She attributes all of her bizarre conduct during the period surrounding April 27, 1979, to suffering from premenstrual syndrome." *Id.*

142. *Id.* at 259. The court relied on testimony by clinical psychologist Dr. LaFleur who stated that "the theory of PMS is very new in the medical profession, it is highly controversial and there is little literature on the subject." *Id.* The court also noted Dr. David Muller's statement that "the DSM-III, relied upon by psychiatrists in the diagnosis of psychiatric disorders, doesn't even recognize PMS as a mental problem." *Id.*

143. *Id.*

144. *Id.* at 261-62.

145. Martin Kasindorf, *Allowing Hormones to Take the Rap; Does the PMS Defense Help or Hinder Women?*, *NEWSDAY*, June 16, 1991, at 17. Several courts, nevertheless, have rejected the PMS defense. *See, e.g.*, *Commonwealth v. Grass*, 595 A.2d 789, 792 (1991) (holding defendant failed to show that PMS rendered her incapable of making a knowing and conscious refusal to take a breathalyzer test).

146. DeNeen L. Brown, *PMS Defense Successful in Va. Drunken Driving Case*, *WASH. POST*, June 7, 1991, at A1. After stopping Richter, the police officer noticed a strong odor of alcohol. *Id.* Richter refused to take field sobriety tests, tried to kick the officer in the groin, used offensive language, and threatened the officer by saying, "You son of a [expletive]; you [expletive] can't do this to me; I'm a doctor. I hope you [expletive] get shot and come to my hospital so I can refuse to treat you . . ." *Id.*

147. *Id.* Geraldine Richter's breath test registered at a 0.13. The legal limit in Virginia is 0.10. *Id.*

148. *Id.* One witness testified that PMS affects some women's behavior, another testified that the breathalyzer reading was skewed. *Id.*

tor, the defense posited that, because PMS causes some to become irritable and hostile, it was a reasonable explanation for Richter's behavior.¹⁴⁹

The *Richter* case was controversial. Proponents of the PMS defense argue "[i]t's fair that PMS should be admissible in a court of law, because . . . for many women there's nothing they can do to control it."¹⁵⁰ Opponents believe "the case sounds like what I'm scared of—the use of a psychiatric diagnosis to excuse inexcusable behavior."¹⁵¹ This controversy parallels the opposing sides taken in the premenstrual dysphoric disorder battle. The debate centers on the need to diagnose and treat the severe premenstrual symptoms that affect some women, but also to recognize the risk that a PMS defense will inevitably produce negative stereotypes, myths, and repercussions affecting all women.

2. *Problems with the PMS Defense.*—Critics cite many legal obstacles that effectively invalidate a PMS defense. Some note it would be difficult to obtain the required proof due to the subjective nature of the syndrome.¹⁵² Others cite evidentiary and definitional problems with respect to an insanity plea.¹⁵³ These concerns were valid prior to adoption of the PMDD diagnosis in the Diagnostic and Statistical Manual IV but have since lost some of their authority.

a. *Insanity Defense.*—Common to all recognized versions of the insanity defense¹⁵⁴ are two basic requirements. The defendant must prove (1) that she suffers from a mental disease or defect, and (2) that there is a causal nexus between the disease and the criminal action.¹⁵⁵ Before adopting the PMDD classification, these elements were difficult to achieve in a PMS defense because many researchers thought PMS was a physiological problem, not a disease of the mind.¹⁵⁶

149. *Id.*

150. Kasindorf, *supra* note 145, at 17 (quoting Gloria Allred, a California attorney active in women's legal issues).

151. *Id.* (quoting Dr. Nada Stotland, a University of Chicago psychiatrist and chairperson for an American Psychiatric Association study that considered whether severe PMS should be listed as a mental illness).

152. *See infra* note 158.

153. *See infra* notes 156, 160.

154. Versions of the insanity defense include the *M'Naghten* test, the irresistible impulse test, the product test, and the substantial capacity test. 1 WAYNE R. LAFAYE & AUSTIN W. SCOTT, *SUBSTANTIVE CRIMINAL LAW* § 4.2 (1986).

155. *Id.*

156. Lewis, *supra* note 100, at 430; *see also* Carney & Williams, *supra* note 19, at 264 ("PMS is not a disease or defect of the mind, . . ."); Lillian Apodaca & Lori Fink, Note,

The *M'Naghten* rule is the prevailing standard for insanity defenses in the criminal context.¹⁵⁷ Under the *M'Naghten* test a defendant cannot be convicted of a crime if,

at the time [she] committed the act, [she] was laboring under such a defect of reason, from a disease of the mind, as not to know the nature and quality of the act [she] was doing; or, if [she] did know it, as not to know [she] was doing what was wrong.¹⁵⁸

It is not clear what type of mental disease or defect is required to be a "disease of the mind" under the *M'Naghten* test, but "it would seem that any mental abnormality, be it psychosis, neurosis, organic brain disorder, or cognitive intellectual deficiency will suffice *if* it has caused the consequences described in the second part of the test."¹⁵⁹

Prior to adoption of the PMDD classification there were two reasons why a person suffering from premenstrual syndrome would not qualify as "insane" under the *M'Naghten* test. First, PMS was not considered a disease of the mind, but rather, it was believed to be a problem associated with a hormonal disorder.¹⁶⁰ Second, even if it were considered a mental disease, research established that cognitive abilities were not impaired by the menstrual cycle.¹⁶¹ Katharina Dalton and Lawrence Taylor stated that "a hormonal aberration such as PMS does not seem to affect individual's ability to appreciate the 'nature

Criminal Law: Premenstrual Syndrome and the Courts, 24 WASHBURN L.J. 54 (1984) (stating a hormonal disorder cannot be a mental disease or defect).

157. 1 LAFAVE & SCOTT, *supra* note 154, § 4.2. Sometimes called the right-wrong test, the *M'Naghten* rule prevails in a majority of jurisdictions, but a substantial minority reject *M'Naghten*, usually in favor of the *Model Penal Code's* substantial capacity test. *Id.*; see also *infra* note 176.

158. *Id.* at 304.

159. *Id.* at 312 (emphasis in original). In order to satisfy the second part of the test, the defect must affect the defendant's ability to understand the nature and quality of the act or that the act was wrong. *Id.*

160. See Taylor & Dalton, *supra* note 6, at 271 ("The premenstrual syndrome is a hormone deficiency disease."); see also Reid & Yen, *supra* note 29, at 86. "Although to date the pathogenesis of this disorder remains speculative, the weight of evidence supports the premise that PMS is related to an aberration in the cyclic function of the hypothalamic-pituitary-ovarian axis." *Id.*

161. Sharon Golub, *The Effect of Premenstrual Anxiety and Depression on Cognitive Function*, 34 J. PERSONALITY & SOC. PSYCHOL. 99, 103 (1976). To analyze the cognitive function of women during their menstrual cycle, fifty women between the ages of thirty and forty-five were placed in groups matched by similar age and life situations. *Id.* at 100. The two groups were tested for anxiety, depression and cognition—one group was tested premenstrually, and the other intermenstrually. *Id.* at 100-01. The tests measured sensory-perceptive factors, memory, problem solving, induction, concept formation and creativity. *Id.* at 101. The study found there were changes with respect to depression and anxiety, but mood changes had no effect on the cognitive test performance. *Id.* at 101-03.

and quality' of criminal conduct, or to understand whether it is right or wrong. Rather, the ability to control one's behavior is affected."¹⁶² In jurisdictions that follow the *M'Naghten* rule, PMS sufferers would consequently lack an effective defense based on their symptoms.

On the other hand, jurisdictions that use the "substantial capacity test" of the American Law Institute's *Model Penal Code*¹⁶³ will more likely accept a PMS defense because a total impairment of capacity is not necessary.¹⁶⁴ Under the *Model Penal Code*, "[a] person is not responsible for criminal conduct if at the time of such conduct as a result of the mental disease or defect [she] lacks substantial capacity to appreciate the criminality [wrongfulness] of [her] conduct or to conform [her] conduct to the requirements of law."¹⁶⁵ Under this test, the proximate causation obstacle is less problematic, but the idea that premenstrual syndrome is not a mental disease or defect still persists as an impediment.¹⁶⁶

Regardless of the test used, public policy and legislative history create a presumption that all women are sane and discourage the insanity defense. For example, the United States Department of Justice takes the position that "Congress intended to exclude mental or emotional processes which impair behavioral controls. Indeed, it appears that all disorders, short of psychotic behavior¹⁶⁷ are excluded from the insanity defense in federal court."¹⁶⁸ Additionally, both Congress and state legislatures have enacted provisions which create stringent evidentiary standards that must be overcome in order to establish the insanity defense.¹⁶⁹ These changes narrow the scope of the insanity

162. Taylor & Dalton, *supra* note 6, at 279.

163. MODEL PENAL CODE § 4.01 (1985).

164. Taylor & Dalton, *supra* note 6, at 280. "[T]he woman suffering from a premenstrual condition which can be shown to strongly inhibit her capacity to control anti-social acts would arguably have a complete defense." *Id.*

165. MODEL PENAL CODE § 4.01 (1985).

166. Taylor & Dalton, *supra* note 6, at 280.

167. See Marc P. Press, *Premenstrual Stress Syndrome as a Defense in Criminal Cases*, 1983 DUKE L. REV. 176, 177 n.14. Psychosis is typically defined as

profound, sweeping mental disorders characterized by partial or total loss of contact with or distortion of reality. Also characteristic are severe disturbances of perception, thought processes, feelings and behavior, retreat from or perversion of social relationships, and often a disintegration of the personality structure, leading to the release of processes which ordinarily operate only unconsciously.

Id.; see generally M. BLINDER, PSYCHIATRY IN THE EVERYDAY PRACTICE OF LAW § 2.1, at 23 (2d ed. 1982).

168. Oakes, *supra* note 134, at 211 (citations omitted).

169. *Id.* In federal court, a defendant must prove an insanity defense by clear and convincing evidence. See also Chait, *supra* note 10, at 287 (noting state legislatures have enacted standards which require defendants to rebut by a preponderance of the evidence the presumption that every person is sane).

plea and make it difficult, if not impossible to assert PMS as a defense.¹⁷⁰

The "diminished capacity defense"¹⁷¹ is a more realistic use of premenstrual syndrome in criminal trials than an insanity defense.¹⁷² Persons use diminished capacity defenses when they are ineligible for a finding of not guilty by reason of insanity, but where their mental abnormality may be a relevant and important consideration in the determination of whether they are guilty of the alleged crime.¹⁷³ This defense is not a complete excuse but serves to obtain a reduction in the severity of the crime charged.¹⁷⁴ In order to prove diminished capacity, the defendant must produce expert testimony and evidence on her mental condition in order to determine whether she had the requisite mens rea for the crime charged.¹⁷⁵ The use of this defense is also limited to the minority of jurisdictions which have approved the doctrine.¹⁷⁶

b. Factual and Evidentiary Problems.—Before a defendant can prove that she suffered from premenstrual syndrome, a common definition for the disorder is needed. Prior to the adoption of the PMDD classification, and arguably continuing after, PMS was an ill-defined phenomenon with many divergent opinions regarding its causes, symptomology, cures,¹⁷⁷ and prevalence within various segments of

170. Oakes, *supra* note 134, at 211.

171. 1 LAFAYE & SCOTT, *supra* note 154, § 4.7. This doctrine is also referred to as "partial responsibility" and "partial insanity." *Id.*

172. Lewis, *supra* note 100, at 432. Some PMS symptoms, such as hypoglycemia, are comparable to ailments that are successfully used under a partial responsibility defense. See Chait, *supra* note 10, at 270 n.41. In *People v. White*, No. 98663 (Cal. Super. Ct. S.F. Cty. 1979) (unreported), the defendant was allowed to plead diminished capacity due to hypoglycemia—the "twinkie defense." See also Ruth Macklin, *The Premenstrual Syndrome (PMS) Label: Benefit or Burden*, in *PREMENSTRUAL SYNDROME* 17, 23 (Benson E. Ginsberg & Bonnie Frank Carter eds., 1987). Macklin believes that PMS and XYY chromosomal abnormalities are similar because "[i]n both instances, it is suggested that finding a biological cause to antisocial or aggressive behavior can mitigate the individual's moral responsibility for that behavior." *Id.*

173. 1 LAFAYE & SCOTT, *supra* note 154, § 4.7.

174. Lewis, *supra* note 100, at 431-32.

175. 1 LAFAYE & SCOTT, *supra* note 154, at § 4.7; see also Apodaca & Fink, *supra* note 156, at 73.

176. LAFAYE & SCOTT, *supra* note 154, § 4.7, at 522 n.2. As of 1986, fewer than 25 states had approved the diminished capacity doctrine, and subsequent case law suggests that its acceptance is on the wane. *Id.*

177. Carney & Williams, *supra* note 19, at 256-57.

Because the etiology of PMS is unclear, the efficacy of any treatment is neither fully understood nor universally accepted. Researchers have conducted several studies to find the ideal treatment, but these studies are inconclusive, due partly to difficulties in evaluating the wide range of PMS symptoms. Moreover, most

the population.¹⁷⁸ It is, therefore, difficult for a defendant to provide the necessary factual basis for a PMS defense.¹⁷⁹

The lack of an agreed working definition of PMS also creates substantial evidentiary obstacles that must be overcome in order to successfully plead a scientific defense.¹⁸⁰ When a jury evaluates issues beyond the knowledge of the average layperson, the use of expert testimony is both proper and helpful for the deliberation.¹⁸¹ In a criminal trial, expert medical testimony on premenstrual syndrome will generally be required because the average layperson will probably not understand the defendant's testimony nor attach proper weight to it.¹⁸² Therefore, the court's decision regarding the admissibility of expert testimony will essentially determine whether the defendant will be able to establish a cogent defense.¹⁸³

The admissibility of scientific expert testimony depends on whether the trial is conducted in federal or state court. The two standards that are most often applied in state courts are the "relevance test" and the "Frye test."¹⁸⁴ In federal courts, the universal standard followed is codified in the *Federal Rules of Evidence*.¹⁸⁵

studies have lacked sufficient control and rigor to allow for meaningful interpretation of the results.

Id.

178. Kay A. Heggestad, *The Devil Made Me Do It: The Case Against Using Premenstrual Syndrome as a Defense in a Court of Law*, 9 *HAMLIN L. REV.* 155, 156 (1986). There is wide variation in the estimates of the prevalence of PMS among the population. Some studies state that at least 95% of menstruating women suffer from some symptoms, with 20 to 40% of these women suffering from severe PMS that negatively affects their lives. *Id.* Other studies state that only 10, 5, or 2% suffer from extreme symptoms. *Id.* These estimates vary according to how the researcher defines the syndrome. *Id.*

179. Lewis, *supra* note 100, at 429.

180. *Id.*

181. See JOHN W. STRONG ET AL., *MCCORMICK ON EVIDENCE* § 13 (1992) [hereinafter *MCCORMICK ON EVIDENCE*].

To warrant the use of expert testimony two general elements are required. First, some courts state that the subject of inference must be so distinctively related to some science [or] profession . . . as to be beyond the ken of laymen Other cases will admit expert opinion concerning matters about which the jurors may have general knowledge if the expert opinion would still aid their understanding of the fact issue.

Id.

182. Press, *supra* note 167, at 178. A layperson's definition of PMS is probably very different from the symptoms related to severe premenstrual syndrome, suffered by a minority of women. *Id.*

183. *Id.*

184. See *infra* notes 186-196 and accompanying text.

185. *FED. R. EVID.* 702. In *Daubert v. Merrell Dow Pharmaceuticals*, 113 S. Ct. 2786 (1993), the Supreme Court held that the *Federal Rules of Evidence*, not *Frye*, provide the standard for the admission of expert scientific testimony in a federal proceeding. *Id.* at 2793.

3. *State Courts.*—"In the jurisdictions that follow *Frye*, the proponent of the evidence must prove general acceptance, by surveying scientific publications, judicial decisions, or practical applications, or by presenting testimony from scientists as to the attitudes of their fellow scientists."¹⁸⁶ Scientific evidence relating to premenstrual syndrome will come within the ambit of the "general acceptance" standard if the court can first define the relevant scientific community, then define the scientific concept that the community should embrace, and finally determine whether the community accepts or rejects the concept.¹⁸⁷

Prior to DSM-IV, it was unlikely that these three criteria could be met because medical literature suggested the recognition and diagnosis of PMS had not gained general acceptance within the medical community.¹⁸⁸ Further, there was uncertainty as to which scientific community was the appropriate forum because the syndrome could fall into more than one medical field.¹⁸⁹ Psychiatry, gynecology, endocrinology and neurology were all possibilities because PMS relates to both psychological and physiological aspects of the body.¹⁹⁰

Admission of expert testimony relating to PMS would be easier to admit in jurisdictions that do not follow *Frye*.¹⁹¹ In these jurisdictions, the applicable test is relevancy.¹⁹² Expert testimony is considered admissible when it is proven relevant, absent compelling reasons for its exclusion.¹⁹³ The evidence is considered relevant if it tends to make the existence of any determinable fact more or less probable.¹⁹⁴ This approach requires a balancing test in which the court must weigh the relevance of the evidence against its unfair prejudicial effect.¹⁹⁵

186. MCCORMICK ON EVIDENCE, *supra* note 181, § 203 at 363.

187. Press, *supra* note 167, at 185-86.

188. See *supra* notes 24-27 and accompanying text.

Many legal commentators have stated that PMS cannot be asserted as a defense because the scientific community does not generally agree on its existence, its cause, or its treatment: it is too vague, too general, all women suffer from it, and if allowed it will be asserted as a blanket defense to all criminal behavior by women.

Lewis, *supra* note 100, at 428.

189. Press, *supra* note 167, at 186.

190. *Id.*

191. Lewis, *supra* note 100, at 429-30. Although in the last 20 years the *Frye* standard has been severely criticized, limited, modified, rejected, or ignored, it remains the majority approach. *Id.*

192. *Id.* at 430. The relevancy test is considered the minority approach and was developed by Professor McCormick. Press, *supra* note 167, at 180.

193. See FED. R. EVID. 403. Compelling reasons for exclusion of testimony include danger of unfair prejudice, confusion of the issues, potential to mislead the jury, considerations of undue delay, waste of time, or needless presentation of cumulative evidence. *Id.*

194. Press, *supra* note 167, at 193; compare FED. R. EVID. 401.

195. Press, *supra* note 167, at 193.

Under this test, the evidentiary complications associated with a PMS defense would decrease.¹⁹⁶

4. *Federal Courts.*—The Supreme Court recently resolved the evidentiary standard for federal courts in *Daubert v. Merrell Dow Pharmaceuticals*.¹⁹⁷ The Court held that the *Federal Rules of Evidence* determine the proper standard for admitting expert testimony.¹⁹⁸ Specifically, Federal Rule of Evidence 702 provides: “[i]f scientific . . . knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert . . . may testify.”¹⁹⁹ The Court further explained that nothing in the rule or its history established “general acceptance” as a prerequisite to admissibility.²⁰⁰

Although the Court endorsed a more liberal rule, limitations remain in place to ensure that the testimony is reliable and relevant.²⁰¹ The trial judge must preliminarily assess “whether the reasoning or methodology underlying the testimony is scientifically valid and . . . whether the reasoning or methodology properly can be applied to the facts in issue.”²⁰² This requirement is more flexible than the *Frye* test and is intended to create a more permissive standard. The *Daubert* decision, along with the new PMDD classification, will create a more favorable evidentiary environment for defenses based on premenstrual symptoms, which will inevitably lead to an increased use of the PMS defense in federal trials.

5. *DSM-IV Classification of PMDD's Effect with Respect to the Use of a PMS Defense.*—Prior to the PMDD classification in the DSM-IV, there was much skepticism toward the PMS defense. The biggest obstacle was that PMS was not a “generally accepted” mental defect or dis-

196. *Id.* A relevancy standard for admission of expert testimony would permit medical evidence regarding PMS because it would be relevant to prove that a defendant was suffering from a mental condition and, therefore, the defendant could not form the requisite mens rea to commit a crime. *Id.* In this instance, the court could only exclude evidence if its relevancy was outweighed by the potential for unfair prejudice, etc. *Id.*; see *supra* note 193 and accompanying text.

197. *Daubert v. Merrell Dow Pharmaceuticals*, 113 S. Ct. 2786 (1993).

198. *Id.* at 2793. Prior to *Daubert*, the circuits were sharply divided as to whether the *Federal Rules* or *Frye* applied.

199. FED. R. EVID. 702.

200. *Daubert*, 113 S. Ct. at 2794.

201. *Id.* at 2786. The Court stated that “[t]he subject of an expert’s testimony must be ‘scientific . . . knowledge.’ The adjective ‘scientific’ implies a grounding in the methods and procedures of science.” *Id.*

202. *Id.* at 2796.

ease.²⁰³ The fact that it was not so defined led directly to evidentiary and substantive difficulties.²⁰⁴ Additionally, courts were apprehensive about using this syndrome as a defense due to the potentially large number of women who could use PMS as an excuse for irrational and inexcusable behavior.²⁰⁵

Current research surrounding the classification, however, suggests that only an insignificant proportion of women suffer from PMDD (approximately two to five percent), substantially less than that reported in prior PMS research.²⁰⁶ Because insanity defenses are intended for exceptional cases, this narrowing of the percentage of women who suffer from PMDD places the PMS defense in a position comparable to other illnesses which fall within the insanity classification.²⁰⁷ This circumstance may reverse the negative view of courts and critics toward the use of a PMS defense.

Another impediment to the PMS defense was the belief in many courts that a "mental disease" must be a chronic, permanent disease and not temporary.²⁰⁸ A defendant who suffers from premenstrual syndrome experiences episodes only prior to menstruation.²⁰⁹ Because PMS is episodic, however, does not mean that it is temporary.²¹⁰ The PMDD classification supports the theory that it is a regularly occurring episodic mental impairment.²¹¹

The classification eliminates a major obstacle that once impeded the use of PMS as a defense in relation to any insanity defense because all insanity defenses require a mental defect or disease.²¹² Prior to the DSM classification, a prosecutor could easily establish that PMS was a physiological ailment, not a mental defect, and questions of the degree of mental impairment would never arise. With the PMDD classification, the defendants need not argue that PMDD is a disease, but

203. Carney & Williams, *supra* note 19, at 264. Prior to this classification, "the medical profession's inability to arrive at universally accepted theories on the definition, cause, and treatment of the premenstrual syndrome . . . impeded unanimous recognition of PMS by the legal profession." *Id.* at 267.

204. *Id.*

205. *Id.* See *supra* note 30 and accompanying text; see also Heggstad, *supra* note 178, at 160.

206. See *DSM-IV Literature Review*, *supra* note 49.

207. See Christopher Boorse, *Premenstrual Syndrome and Criminal Responsibility*, in *PREMENSTRUAL SYNDROME* 81, 88 (Benson E. Ginsberg & Bonnie Frank Carter eds., 1984).

208. ABRAHAM S. GOLDSTEIN, *THE INSANITY DEFENSE* 3 (1967).

209. Apodaca & Fink, *supra* note 156, at 68-69.

210. *Id.*

211. *Id.* at 68.

212. See *supra* notes 157-159 and accompanying text.

only that the disease affected the individual to a substantial degree and inhibited certain functions.²¹³

The difficulty of the defendant's task depends on the test applied in the jurisdiction. In jurisdictions that use the *M'Naghten* test, the PMS defense faces a difficult time.²¹⁴ For the substantial capacity test, however, "a [defendant] is not responsible for criminal conduct if, as a result of [her] mental disease or defect . . . [she] lacks substantial capacity . . . to conform [her] conduct to the requirements of law."²¹⁵ Arguably, the symptoms related to PMDD fit well within the structure of this test. Some of the PMDD symptoms include markedly depressed mood, marked anxiety, persistent or marked anger, and a subjective sense of being out of control.²¹⁶ These symptoms show a reduction of the premenstrual woman's self control, which can lead to behavior incompatible with the law.²¹⁷

The substantial capacity test is a vague standard²¹⁸ and reflects a departure from the belief that a complete impairment of cognitive capacity and self control is necessary for an insanity defense.²¹⁹ For these reasons, a PMS sufferer can successfully utilize an insanity defense in the aftermath of the DSM-IV classification in those jurisdictions that recognize the substantial capacity test. Likewise, under the *Durham* "product" test, the accused is not criminally responsible if the unlawful act was the product of the mental disease or mental defect.²²⁰ The term "product" in this rule is a "but-for" test for causation.²²¹ Once PMDD is classified as a mental disorder, the attorney's burden is reduced substantially. Furthermore, if sufficient evidence is not available to prove a complete insanity defense, the PMDD classification creates strong support for a diminished capacity defense.²²² Because a diminished capacity defense requires expert testimony for its proof, the PMDD classification is important.

Other evidentiary difficulties surrounding the admissibility of expert testimony regarding PMS are similarly relaxed. For example,

213. Taylor & Dalton, *supra* note 6, at 279.

214. See *supra* note 158 and accompanying text for a recitation of the *M'Naghten* test.

215. 1 LAFAVE & SCOTT, *supra* note 154, § 4.3, at 454-55.

216. Katharina Dalton, *Premenstrual Syndrome*, 9 *HAMLIN L. REV.* 143, 152 (1986).

217. *Id.*

218. "The [*Model Penal Code*] draftsmen acknowledged that the word 'substantial' imputes no specific measure of degree, but concluded that identifying the degree of impairment with precision was 'impossible both verbally and logically.'" LAFAVE & SCOTT, *supra* note 154, § 4.3, at 464.

219. *Id.*

220. *Id.* § 4.3.

221. *Id.*

222. See *supra* notes 171-176 and accompanying text.

under the *Frye* doctrine, an admissible scientific concept must be generally accepted by the medical community. But, it remains necessary to define both the terms "general acceptance" and "scientific community." The proportion of experts on PMDD who must accept the technique has never been clearly identified.²²³ Most courts do not require unanimity, but seem to require a substantial majority.²²⁴ For PMS, the scope of the community can be argued to encompass specialists in mental disorders, as well as the biomedical fields of endocrinology and gynecology. For an insanity defense, though, only the mental, or emotional symptoms of premenstrual syndrome are significant. The new PMDD classification, which stresses behavioral, not somatic effects, necessarily narrows the field of practitioners who must accept the syndrome and increases the possibility of general acceptance under the *Frye* standard.

Critics previously argued that acceptance could not be achieved.²²⁵ Many cited the fact that premenstrual syndrome was not contained in the DSM as support for their disapproving conclusion.²²⁶ But the inclusion of PMDD in the recent publication of DSM-IV automatically creates a strong argument in favor of general acceptance and will lead to greater recognition in the future due to the Manual's reputation within the mental health profession.

In jurisdictions that utilize Federal Rule of Evidence 702 or the relevancy standard for the admissibility of evidence, the PMDD classification will lend substantial weight to an expert's testimony that such a syndrome exists. This will strengthen attorneys' arguments that there is a causal link between a particular crime and a premenstrual "attack," leading to a greater use of the PMS defense.

B. Broader Societal Effects

Although a strengthened PMS defense may be a positive development for the few women who suffer from the syndrome, the broader societal implications may be devastating.²²⁷ In essence, the PMDD classification and the use of a PMS defense could lead to erosion of gender equality by reinforcing the myths that women are violent, irra-

223. Boorse, *supra* note 207, at 114.

224. *Id.* at 114-15; *see, e.g.,* United States v. Addison, 498 F.2d 741, 745 (D.C. Cir. 1974); Reed v. State, 283 Md. 374, 396, 391 A.2d 364, 376 (1978).

225. *See* Lovato v. Irvin, 31 B.R., 251, 256 (Bankr. D. Colo. 1983); Oakes, *supra* note 134, at 216-17.

226. *See* Lovato, 31 B.R. at 256.

227. While the societal effects of the PMDD classification should be noted, a detailed discussion of the discriminatory impact is beyond the scope of this Comment.

tional and not responsible for approximately one week out of every month. "For millennia, women have been treated as lesser beings, partly because of their menstrual cycles. Women must be wary of any theory which fuels the public perception that women go crazy every month."²²⁸ Further, the PMS defense could increase the stereotypical view that all women are inferior and not responsible for their actions.

The idea that women may act "less responsibly" during premenstruation can be used to discredit women in the workplace. For many years women have suffered discrimination due to beliefs that women were either unable to make decisions or act responsibly.²²⁹ The PMDD classification and the PMS defense will inevitably lead to increased discrimination.²³⁰

228. Nora Mulligan, Recent Developments, *Premenstrual Syndrome*, 6 HARV. WOMEN'S L.J. 219, 226 (1983).

229. See Scott Bronstein, *Lawmakers Hear Horror Stories on Workers' Comp*, ATLANTA J. & CONST., Nov. 2, 1991, at B3.

230. Although there will undoubtedly be discrimination in the workplace due to the classification, it is questionable whether these women will have a cause of action under the Americans With Disabilities Act (ADA) or Title VII of the Civil Rights Act of 1964.

Under the ADA, an employer can not discriminate against a qualified individual with a disability because of the disability. HENRY H. PERRITT JR., AMERICANS WITH DISABILITIES ACT HANDBOOK 3 (1990). A disability is defined as: (1) a physical or mental impairment that substantially limits a major life activity; (2) a record of such impairment; or (3) being regarded as having that impairment. 42 U.S.C. §§ 12101 to 12213 (Supp. V 1993). The Senate and House Committees report that mental impairment includes emotional or mental illness. PERRITT, *supra*, at 25. It would appear that premenstrual dysphoric disorder fits within the ADA definition. It is important to note, though, that the determination regarding who is disabled under the ADA is handled on a case by case analysis, and therefore, broad based conclusions regarding the cause of action are virtually impossible. *Id.* at 28.

Under Title VII of the Civil Rights Act, it is unlawful for an employer "to discriminate against any individual with respect to compensation . . . because of race, color, religion, sex, or national origin." 42 U.S.C. § 2000e(2) (1964). The term "because of . . . sex" has been clarified by the Pregnancy Discrimination Act to include (but not limited to) "because of or on the basis of pregnancy, childbirth, or related medical conditions." 42 U.S.C. § 2000e(k) (1978). In *International Union v. Johnson Controls*, 499 U.S. 187 (1991), the Supreme Court stated that a policy that explicitly classifies on the basis of potential for pregnancy must be regarded in the same light as explicit sex discrimination. *Id.* at 199. Premenstrual dysphoric disorder, like pregnancy, only implicates one sex and women have historically faced discrimination under both premises. Therefore, a Title VII cause of action may exist for a woman who suffers discrimination on the basis of PMS.

Such a cause of action was successful in *Corn Products Co. v. Erickson*, No. A-3071-80-T3 (N.J. Super. Ct. App. Div. Dec. 16, 1982). The Superior Court of New Jersey affirmed a decision by the director of the New Jersey Division on Civil Rights who found employment discrimination when a female worker was discharged for absence from work due to primary dysmenorrhea. *Id.* at 9. Ms. Erickson proved that she was discharged because of absenteeism resulting from a physical condition from which only women suffer, and that workers who missed as much work as she did for non-sexual physical conditions were not terminated. *Id.* at 39. Erickson analogized her premenstrual dysmenorrhea to pregnancy

Women also risk discrimination with respect to family law issues. In order to receive custody of a child, courts generally examine what is in the best interest of the child. In hostile custody battles, it would not be unreasonable for an opponent to classify the mother as suffering from premenstrual dysphoric disorder.²³¹ Because a PMDD diagnosis often relies solely on information given by the premenstrual sufferer or one who has observed her on a monthly basis,²³² there are no means to prove or disprove scientifically whether the woman actually suffers from PMDD. The accusation could pose a real threat in custody proceedings.²³³

CONCLUSION

The American Psychiatric Association's decision to categorize premenstrual dysphoric disorder as a mood disorder in their "bible of mental illness" has led to much contention over its potential impact on women, the law, and society. Questions have existed throughout history regarding the effects of the menstrual cycle on women with the answers usually leading to social and economic inequality. Although this Article has described what may be considered a positive result of the most recent categorization, the theory may inevitably be used to justify an "inferior status" for women in society.

Prior to the APA's diagnosis of PMS as a mental disease, a defense based on its symptoms was difficult, if not impossible, to prove. The PMDD classification alleviates many of the substantive and procedural impediments associated with the defense. This alteration will make it possible for women who commit crimes while suffering from PMS to defend their actions. A fear remains, though, that a theory of "diminished responsibility" will act as a double edged sword, leading to prejudicial treatment in other areas of women's lives.

Premenstrual Syndrome is a real and serious problem for a small minority of women, and their plight must be recognized. Dr. Michelle Harrison recognized this necessity when she stated:

discrimination. *Id.* at 41. This argument, in conjunction with a disability argument prevailed.

231. In *Tingen v. Tingen*, 446 P.2d 185 (Or. 1968), the Supreme Court of Oregon allowed evidence of PMS to be considered as one of the factors in determining the best interest of the child. *Id.* at 186. But the court further held that the lower court incorrectly isolated factors relating to the mother's ill health to the exclusion of other relevant factors in determining custody. *Id.* The court concluded that after balancing all of the relevant evidence the best interests of the children would be met by granting custody to the mother. *Id.* at 187.

232. Holtzman, *supra* note 132, at 714-15.

233. *Id.*

I am fearful that in our society anything that comes up will be used against women. But I see women whose lives are wrecked by this, who feel they are crazy and can't talk about it. If we don't accept that, we're denying one reality of women's experience, and at this point, it is more important to do something about it, to deal with reality than be controlled by our fears.²³⁴

Although the DSM-IV classification does recognize the problem, and can arguably be said to increase the likelihood of research regarding the malady, a question remains regarding the correct medical forum to analyze the syndrome. Could the same effect be achieved by classifying PMS as a gynecological, or endocrinological problem? This alternative classification could limit the potential for discrimination, yet increase awareness, and treatment of the syndrome.

The benefits of the PMDD classification must be weighed against the potential abuse. For hundreds of years, myths and misconceptions associated with the menstrual cycle have generated stigmatization, stereotyping, and discrimination. The PMDD classification and the PMS defense will probably contribute to negative attitudes associated with PMS. Due to the potential for grave misuse, the PMS defense and the PMDD classification must be applied with extreme caution and balanced against the many risks associated with such a label.

LEE SOLOMON

234. Nadine Brozan, *Premenstrual Syndrome: A Complex Issue*, N.Y. TIMES, July 12, 1982, at C16.

APPENDIX

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 4TH ED.
(DSM-IV)

Diagnostic Criteria For Premenstrual Dysphoric Disorder

A. In most menstrual cycles during the past year, five (or more) of the following symptoms were present for most of the time during the last week of the luteal phase, began to remit within a few days after the onset of the follicular phase, and were absent in the week postmenses, with at least one of the symptoms being either (1), (2), (3), or (4):

(1) markedly depressed mood, feelings of hopelessness, or self-depreciating thoughts

(2) marked anxiety, tension, feelings of being "keyed up," or "on edge"

(3) marked affective lability (e.g., feeling suddenly sad or tearful or increased sensitivity to rejection)

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

(5) decreased interest in usual activities (e.g., work, school, friends, hobbies)

(6) subjective sense of difficulty in concentrating

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

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

(9) hypersomnia or insomnia

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

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

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