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Grose: Premenstrual Dysphoric Disorder as a Mitigating Factor in Sentenc

# PREMENSTRUAL DYSPHORIC DISORDER AS A MITIGATING FACTOR IN SENTENCING: FOLLOWING THE LEAD OF ENGLISH CRIMINAL COURTS

## I. INTRODUCTION

During the first two weeks of each month, friends and family describe twenty-four year old Karen as cheerful, realistic, rational, and able to socialize with others. During the last two weeks of each month, she is radically different. She is angry, manipulative, testy, unstable, depressed, paranoid, even belligerent and assaultive. Karen underwent psychological tests which showed that she experiences schizophrenic symptoms such as delusions, anxiety, and hallucinations. Karen was also arrested for attacking one of her doctors. Since she began menstruating, Karen had premenstrual suicidal tendencies. She has attempted suicide many times during her premenstrual phase, but at no other time during her cycle.<sup>1</sup> Karen is not crazy. She suffers from a severe form of premenstrual syndrome (PMS), premenstrual dysphoric disorder (PMDD).

In the past, society considered menstruation a disability that impaired a woman's daily activities.<sup>2</sup> For example, when a New Guinea tribesman found his wife lying on his blanket while she was menstruating, he divorced her.<sup>3</sup> When he continued to feel her evil presence, he killed her with an ax.<sup>4</sup> Recently, the women's movement sought to dispel the myth that menstruating women have evil powers by proving that women were capable of handling themselves in the marketplace during all phases of their menstrual cycle.<sup>5</sup>

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<sup>1</sup> This story is derived from the case study described in greater detail in Aleta Wallach & Larry Rubin, *The Premenstrual Syndrome and Criminal Responsibility*, 19 UCLA L. REV. 210, 227 (1971).

<sup>2</sup> Robin Marantz Henig, *Dispelling Menstrual Myths*, N.Y. TIMES, Mar. 7, 1982, § 6, at 64 (discussing in detail the biological processes of menstruation, as well as the debate surrounding PMS as a criminal defense).

<sup>3</sup> *Id.*

<sup>4</sup> *Id.* This behavior resulted from the central belief in his culture that any contact a man had with menstrual blood or with a menstruating woman would corrupt his vital juices, permanently dull his mind, and lead him to a slow death. *Id.*

<sup>5</sup> *Id.* The women's movement sought to dispel the views of the early seventies that menstruation was a disability that hampered a woman's job and bedroom performance. Henig, *supra* note 2, at 64.

Today, most women adequately function in the marketplace despite suffering from PMS. However, a small percentage of women become severely incapacitated each month.<sup>6</sup> These women, much like Karen, suffer from a severe form of PMS. While the medical community has recognized PMS, and the more severe form of PMDD, as a disorder, the American legal community does not accept this disorder as a mitigating factor in sentencing or as a legitimate defense to criminal acts.<sup>7</sup> Conversely, the American legal community has allowed other disorders, such as post traumatic stress disorder, to be considered as mitigating factors in sentencing.<sup>8</sup>

When the judge considered all of the possible mitigating factors permitted under state law, none were applicable in Karen's case. If the state allowed PMDD as a mitigating factor in sentencing, Karen's sentence would likely have been less than one year in prison or possibly probation. Such a sentence would more appropriately reflect Karen's lessened culpability caused by her struggle with PMDD. This example illustrates the need for American criminal courts to recognize PMDD as a mitigating factor in sentencing.

This Note proposes that the legal community should recognize PMDD, the most severe form of PMS, as a mitigating factor in sentencing. This Note, however, does not advocate using PMDD as an affirmative defense, like self-defense. Furthermore, this Note does not advocate the use of PMDD as a mitigating factor in cases where the woman committed a crime that involved premeditation.

In order to fully develop the theme of this Note, Section II begins with a basic medical discussion of PMS and its more severe form, PMDD.<sup>9</sup> Section III provides further background with its discussion of cases decided in English and American criminal courts that raised PMS

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<sup>6</sup> See *infra* note 54 and accompanying text.

<sup>7</sup> Katharina Dalton, *Premenstrual Syndrome*, 9 HAMLIN L. REV. 143 (1986). A study conducted by Dr. Katharina Dalton shows a correlation between premenstrual women and criminal acts. Lawrence Taylor & Katherina Dalton, *Premenstrual Syndrome: A New Criminal Defense?*, 19 CAL. W. L. REV. 269, 274 (1983). In an English women's prison 49% of 156 new inmates who had committed offenses during the previous twenty-eight days had been sentenced for crimes committed during the four days before their period and four days after their period. *Id.* Women who are in this eight day period are overrepresented among women involved in car accidents (48%), newly admitted women prisoners (49%), emergency hospital admissions (53%), and attempted suicides (more than 50%). Henig, *supra* note 2, at 65.

<sup>8</sup> See *infra* Section IV.

<sup>9</sup> See *infra* Section II.

as a defense or a mitigating factor.<sup>10</sup> Section IV then analogizes PMDD to post traumatic stress disorder, a disorder that American courts have recognized as a mitigating factor.<sup>11</sup> Next, Section V discusses the impediments to recognizing PMDD as a mitigating factor, as well as critiques of these arguments.<sup>12</sup> Finally, Section VI proposes a model sentencing guideline that American criminal courts may use to ensure the proper use of PMDD as a mitigating factor in sentencing for crimes that do not involve premeditation.<sup>13</sup>

## II. MEDICAL ASPECTS OF PREMENSTRUAL SYNDROME AND PREMENSTRUAL DYSPHORIC DISORDER

In order to fully analyze whether courts may consider PMDD as a mitigating factor, a discussion of the basic medical facts surrounding PMS and PMDD is necessary. First, this Section illustrates the frequency of PMS in the population of menstruating women, with an emphasis on the multitude of symptoms associated with PMS and their effects on women.<sup>14</sup> Next, this Section discusses the different theories concerning the causes of PMS and the varying treatment options that are available for women who suffer from PMS.<sup>15</sup> In addition, this Section describes PMDD, by explaining the diagnostic criteria for this disorder and its possible causes.<sup>16</sup> This Section will also explain the various treatment options for women who suffer from this disorder.<sup>17</sup>

### A. *Medical Aspects of PMS*

Although Karen's angry outburst toward her doctor may seem unusual or extraordinary, in reality, women who suffer from PMS symptoms similar to those experienced by the fictitious character Karen, act in the same manner. At one time, the medical community would have dismissed these women as "crazy" or would have claimed that these symptoms were all in their heads.<sup>18</sup> However, the medical

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<sup>10</sup> See *infra* Section III.

<sup>11</sup> See *infra* Section IV.

<sup>12</sup> See *infra* Section V.

<sup>13</sup> See *infra* Section VI.

<sup>14</sup> See *infra* notes 20-27 and accompanying text.

<sup>15</sup> See *infra* notes 28-50 and accompanying text.

<sup>16</sup> See *infra* notes 53-66 and accompanying text.

<sup>17</sup> See *infra* notes 67-70 and accompanying text.

<sup>18</sup> Henig, *supra* note 2, at 68 (pointing out that the old recognition that menstrual distress originated in the psyche has been replaced by the new recognition that menstrual distress correlates to hormonal fluctuation).

community today recognizes that PMS has a basis in biological fact and that women who suffer from this condition need treatment.<sup>19</sup>

Some researchers estimate that as many as ninety-five percent of women who menstruate suffer from PMS.<sup>20</sup> A leading researcher in the field of women's health defined PMS as the recurrence of symptoms before menstruation and the complete absence of symptoms after menstruation.<sup>21</sup> Researchers have identified over 150 PMS symptoms that are specific to or diagnostic of PMS.<sup>22</sup> However, some PMS symptoms are not like those from which other non-menstruating women, men, and children suffer. For example, menstruating women suffer from a different form of depression than men, children, and non-menstruating women.<sup>23</sup>

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<sup>19</sup> Dalton, *supra* note 7, at 154. Dr. Dalton argues that in severe cases of PMS which may or have resulted in criminal behavior, medical treatment is required because self-help, relaxation, hypnotists, and nutritionists cannot relieve the symptoms. *Id.* at 151.

<sup>20</sup> Scholars have varying estimates concerning the prevalence of PMS in the United States. See Dalton, *supra* note 7, at 145 (proposing that 40% of women of menstruating age suffer from PMS); William R. Keye, Jr. & Eric Trunnell, *Premenstrual Syndrome: A Medical Perspective*, 9 *HAMLIN L. REV.* 165, 167 (1986) (stating that the prevalence of PMS has been reported to range from 5-95%); Ellen W. Freeman, *Can Antidepressants Be Used to Tame Psychological Symptoms of PMS?*, at 2 (visited Oct. 10, 1997) <<http://www.medscape.com>> (maintaining that up to 80% of women of reproductive age experience physical and behavioral changes premenstrually); Barbara L. Parry, *Psychobiology of Premenstrual Dysphoric Disorder*, 15 *SEMINARS IN REPRODUCTIVE ENDOCRINOLOGY* 55 (1997) (stating that 20-80% of women of menstruating age suffer from PMS); Meir Steiner, *Premenstrual Syndromes*, 48 *ANNOT. REV. MED.* 447, 448 (1997) (proposing that as many as 75% of women with regular menstrual cycles suffer from some of the symptoms of PMS).

<sup>21</sup> Dr. Dalton emphasizes that this definition must include three conditions: (1) recurrence of symptoms in a minimum of three menstrual cycles, (2) presence of symptoms in premenstrual phase, and (3) complete absence of symptoms after menstruation. See Dalton, *supra* note 7, at 145.

<sup>22</sup> See Keye & Trunnell, *supra* note 20, at 167. These symptoms may be divided into three categories: (1) physical symptoms including abdominal bloating, headaches, breast tenderness, fatigue, acne, pelvic cramps, lack of coordination, leg cramps, constipation, dizziness, nasal congestion, joint pain, itching, and heart palpitations; (2) emotional symptoms including depression, anger, hostility, tension, anxiety, guilt, rapid mood changes, panic, feeling overwhelmed, paranoia, and suicidal thoughts; (3) behavioral symptoms including intolerance, restlessness, overly critical, cravings for sweets, social isolation, hysteria, increased use of alcohol, confusion, forgetfulness, physical violence, insomnia, accident proneness, and decreased sex drive. *Id.* at 167, n.6. See also Dalton, *supra* note 7, at 146. Dr. Dalton also includes a short-lived psychosis in her list of PMS symptoms. *Id.* This psychosis may produce visual or aural hallucinations, confused ideas, feelings of persecution, and interminable reiterating thoughts, and amnesia. *Id.* at 148. The psychosis may be harmless, causing the woman to take bizarre actions, or it may be compulsive. *Id.* See also Freeman, *supra* note 20, at 8-9.

<sup>23</sup> Premenstrual depression is distinguishable from typical endogenous depression in that the former has a shorter duration counted in days rather than months or years, predictable

This wide variety of symptoms greatly affects the lives of PMS sufferers. As a result of these symptoms, some women may be less efficient in their daily tasks, pay less attention to their own appearance, miss work, or perform at sub-standard levels.<sup>24</sup> After many months, many women report decreased assertiveness, self-esteem, and self-confidence and an otherwise negatively altered self-image.<sup>25</sup> This in turn may lead to the avoidance of social activities, social isolation, decreased goal setting, loss of friendships, and loss of employment or educational opportunities.<sup>26</sup> In addition, severe PMS may affect relationships with family and friends.<sup>27</sup>

While researchers have articulated a list of symptoms indicative of PMS and the impact of PMS on its victims, the researchers know less about the causes of PMS.<sup>28</sup> Currently, researchers do not even agree on a specific cause of PMS.<sup>29</sup> Some researchers recognize four categories of causes: sociobiological,<sup>30</sup> social,<sup>31</sup> psychological,<sup>32</sup> and biological.<sup>33</sup> Other

timing before menstruation, and the presence of irritability and excessive sleep. Dalton, *supra* note 7, at 146-47.

<sup>24</sup> These results stem from PMS symptoms such as extreme fatigue, headache, inability to concentrate, confusion, and poor memory. Keye & Trunnell, *supra* note 20, at 170.

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> *Id.* at 170-71. Because of unpredictable mood swings and a tendency of PMS sufferers to become extremely irritable, overcritical, and hostile, many women may isolate themselves, and friendships may dissolve. *Id.* at 170. Also the PMS sufferer, aware of the pain she inflicts upon others, may be hesitant to make new friends. Keye & Trunnell, *supra* note 20, at 170.

<sup>28</sup> See *infra* notes 29-34 and accompanying text.

<sup>29</sup> See *infra* notes 30-34 and accompanying text. Some psychological concepts that have been offered to explain violent mood swings associated with PMS are an expression of a woman's unconscious denial of her desire for a child, unresolved oedipal conflicts, marital discord, dissatisfaction with the female role, and repressed sexuality. See also Henig, *supra* note 2, at 64.

<sup>30</sup> Keye & Trunnell, *supra* note 20, at 171-72. According to the sociobiological theory, PMS may be an example of evolution. *Id.* at 172. Women with PMS historically had an evolutionary advantage because the hostility of the premenstrual phase discouraged attempts by the male to mate. *Id.* As a result, males had an increase in the desire for copulation during the postmenstrual and fertile phase of the woman's cycle, thus enhancing the likelihood of conception. *Id.* The authors note that this explanation fails to account for the cause of premenstrual symptoms. *Id.*

<sup>31</sup> *Id.* The social theory states that PMS is the result of negative social and cultural attitudes toward menstruation. *Id.* These attitudes may encourage women to view the premenstruum as a time of ill-health and suffering, leading to the conversion of these negative attitudes into an altered physical or emotional state. *Id.* The authors note that this model fails to explain the disappearance of premenstrual symptoms in some women who are taking hormones to stop ovulation, but not menstruation. *Id.*

<sup>32</sup> *Id.* Proponents of the psychological model believe that PMS is merely an atypical manifestation of one or more well-established psychiatric diseases. *Id.* This hypothesis

researchers have developed different classification systems for the causes of PMS.<sup>34</sup> Despite this lack of consensus concerning the causes of PMS, the medical profession has established several methods to aid in the diagnosis of PMS.<sup>35</sup>

Practitioners do not diagnose PMS by the type, severity, or multiplicity of symptoms, but instead diagnose it according to the timing of the symptoms in the menstrual cycle.<sup>36</sup> Medical personnel use several methods to quantitatively diagnose PMS.<sup>37</sup> Among these methods are the sex hormone binding globulin capacity (SHBG) test,<sup>38</sup> a daily symptom rating chart,<sup>39</sup> the diagnostic checklist score,<sup>40</sup> the *International*

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originated from a study of women. Those who were told that they were premenstrual reported more PMS symptoms than women who were told that they were not premenstrual. *Id.*

<sup>33</sup> *Id.* at 173. Theories of this type are the most numerous and popular. These hypotheses suggest the involvement of several symptoms such as the endocrine, neurological, and immune systems. *Id.* Biological theories of PMS include the following: estrogen excess, altered ratios of estrogen, progesterone, or both, progesterone deficiency, altered sex steroid metabolism, prolactin excess, fluid retention, aldosterone excess, vitamin deficiencies of vitamins A and B6, hypoglycemia, nutritional deficiencies, progesterone allergy, endometrial toxins, altered neurotransmitter metabolism, yeast overgrowth syndrome, and endogenous opiate excess or withdrawal. *Id.* at 173, n. 23. This model illustrates that PMS is caused by a single abnormality in the body's physiological function. The authors suggest that another model, the biopsychosocial model, is needed to account for the experience, beliefs, attitudes, and personality of the patient, as well as the social context in which the patient lives. *Id.* at 173.

<sup>34</sup> Helen Smith & Sandra P. Thomas, *Anger and Locus of Control in Young Women with and Without Premenstrual Syndrome*, 17 *ISSUES IN MENTAL HEALTH NURSING* 289, 290 (1996). Researchers tend to classify the cause of PMS as a physical condition that produces psychological symptoms, a result of social conditioning, or as a result of psychological traits. *Id.* One research team has hypothesized that PMS is the result of an abnormal response to normal hormonal changes. See Peter J. Schmidt et al., *Differential Behavioral Effects of Gonadal Steroids in Women with and in Those Without Premenstrual Syndrome*, 338 *NEW ENG. J. MED.* 209 (1998).

<sup>35</sup> See *infra* notes 36-43 and accompanying text.

<sup>36</sup> The precise days of menstruation and the dates of the symptoms, together with the days of complete absence of symptoms after menstruation, determine whether the woman suffers from PMS. Dalton, *supra* note 7, at 148.

<sup>37</sup> See *infra* notes 38-43 and accompanying text.

<sup>38</sup> The sex hormone binding globulin capacity (SHBG) test is a biochemical test that differentiates normal menstruating women from those suffering from PMS. See Dalton, *supra* note 7, at 149. Researchers have found that women with severe PMS had a SHBG level that was below normal. *Id.*

<sup>39</sup> See Freeman, *supra* note 20, at 4-5. The University of Pennsylvania Medical Center has developed the daily symptom ratings chart as a diagnostic tool. *Id.* The chart contains spaces for the date, whether the patient is menstruating, whether the patient is taking any medication, as well as a space for each premenstrual symptom that the patient rates from zero (not present at all) to four (very severe: symptom is overwhelming or patient is unable to perform daily activity or both). *Id.* This chart must be used over two successive

*Statistical Classification of Diseases and Related Health Problems*,<sup>41</sup> as well as other methods of symptom quantification.<sup>42</sup> Other diagnosticians have developed specific methodologies to aid in the diagnosis of PMS.<sup>43</sup> Once physicians diagnose PMS, they must formulate treatment options.<sup>44</sup>

Physicians rely on several different types of theories to treat women who suffer from PMS.<sup>45</sup> Some researchers divide the treatment options into the following categories: symptomatic therapy,<sup>46</sup> therapy based on

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menstrual cycles, and for a diagnosis of PMS, there must be a cyclic pattern with peak severity in the premenstrual week and remission following menstruation. *Id.*

<sup>40</sup> See Dalton, *supra* note 7, at 149-50. Diagnosticians use several known risk factors to show the likelihood that a particular individual suffers from PMS. *Id.* These factors include the time of onset, the time of increased severity, painless menstruation, inability to tolerate birth control pills, increased libido in the premenstruum, inability to tolerate long intervals without food, adult weight swings exceeding twenty-eight pounds, effect of pregnancy, and varying tolerance of alcohol. *Id.* The patient answers whether these factors are positive, negative, or not relevant. *Id.* at 150, n. 48. The diagnostic checklist score is determined by the number of positives multiplied by 100, divided by the number of positives plus the number of negatives. *Id.* A score of 70% or higher suggests the possibility of PMS, but a score of 100% is not by itself diagnostic. *Id.*

<sup>41</sup> Steiner, *supra* note 20, at 450. Only one symptom, such as breast tenderness, change in appetite, or poor concentration is sufficient for a diagnosis; the symptom must both occur in premenstrual phase and must cease with menstrual flow, or soon after. *Id.* at 451.

<sup>42</sup> See Meir Steiner, *Premenstrual Dysphoric Disorder: An Update*, 18 *GENERAL HOSPITAL PSYCHIATRY* 244, 246 (1996). These methods include the Prospective Record of the Impact and Severity of Menstruation (PRISM), the Calendar of Premenstrual Experiences (COPE), and the Visual Analogue Scales (VAS). *Id.* COPE is a one-page calendar that tracks menstrual bleeding and cycle length and allows respondents to rate symptoms, indicate life events, and record current medications. *Id.* VAS are used to determine symptom severity. *Id.*

<sup>43</sup> See Keye & Trunnell, *supra* note 20, at 175. One strategy is to conduct an initial interview during the premenstrual phase of the woman's cycle which assesses the premenstrual symptoms, psychiatric history, and a medical history in order to eliminate the possibility of any underlying disorders. *Id.* The next phase consists of an interval where the patient records the presence and severity of symptoms each day during the menstrual cycle. *Id.* At a second interview, a physician formulates a diagnosis. *Id.* Another strategy is to conduct an initial interview with the patient and her partner to obtain a medical history and a history of the premenstrual symptoms. *Id.* For two months the patient then records her symptoms daily. *Id.* Next, the patient undergoes a series of psychological evaluations during different phases in her cycle, followed by a physical examination during the luteal phase of her cycle to document any changes. *Id.* Then lab and radiologic studies are conducted to rule out any underlying physical disease. *Id.* There is another interview to establish a tentative diagnosis. *Id.* at 175-76.

<sup>44</sup> See *infra* notes 45-50 and accompanying text.

<sup>45</sup> See *infra* notes 46-50 and accompanying text.

<sup>46</sup> Keye & Trunnell, *supra* note 20, at 177. Symptomatic therapy includes psychoactive drugs, over-the-counter drugs, belladonna alkaloids, and diet. *Id.* Psychoactive drugs are used to treat anxiety, depression, irritability, and hostility. *Id.* Over-the-counter drugs, such as acetaminophen, aspirin, caffeine, and antihistamines are used to treat such physical symptoms as headache, joint pain, and bloating. *Id.* However, women with severe



presumed etiology,<sup>47</sup> and anovulation therapy.<sup>48</sup> Other types of therapy include psychotherapy and exercise.<sup>49</sup> Unfortunately, no single medical treatment relieves premenstrual symptoms in all women.<sup>50</sup>

This discussion illustrates that PMS is common among menstruating women, although the symptoms and effects vary greatly.<sup>51</sup> In addition, neither the causes of PMS nor the methods of diagnosis and treatment options are agreed upon by all practitioners.<sup>52</sup> The next Section will focus on the severe symptoms of PMDD.

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symptoms do not report dramatic relief from these drugs. *Id.* Belladonna alkaloids may be used to combat fatigue, breast tenderness, irritability, and lethargy. *Id.* Diet therapy includes small and frequent meals, salt restriction, and elimination of caffeine, sugar, alcohol, food additives, and preservatives. *Id.* See also Freeman, *supra* note 20, at 7; Parry, *supra* note 20, at 57; Steiner, *supra* note 20, at 451.

<sup>47</sup> Keye & Trunnell, *supra* note 20, at 177-80. This group of therapy consists of diuretics, dopamine agonists, gamma linolenic acid, progesterone, anti-prostaglandins, vitamins, and miscellaneous therapies. *Id.* Diuretics are used to treat edema, bloating, and breast tenderness. *Id.* Dopamine agonists may reduce the breast swelling and tenderness. *Id.* Gamma linolenic acid may reduce tissue sensitivity to prolactin, which some researchers believe plays a role in breast swelling and tenderness, irritability, and depression. *Id.* Researchers also associate progesterone with significant relief of many PMS symptoms. *Id.* Anti-prostaglandins may be effective when pain acts as a cue to the development of premenstrual symptoms. *Id.* Vitamins, such as B6, may also relieve some symptoms of PMS. *Id.* Miscellaneous therapies include pituitary irradiation, thyroxine, immunotherapy, potassium, testosterone, adrenal cortex extract, chorionic gonadotropin, and magnesium sulfate. *Id.* See also Parry, *supra* note 20, at 57; Dalton, *supra* note 19, at 151-52; Steiner, *supra* note 20, at 452.

<sup>48</sup> Keye & Trunnell, *supra* note 20, at 180-81. Anovulation therapy includes birth control pills, depomedroxyprogesterone acetate, danazol, subcutaneous estradiol pellets, gonadotropin-releasing hormone agonists (GnRH-agonists), hysterectomy, and ovariectomy. *Id.* Birth control pills may reduce the severity of symptoms. *Id.* Depomedroxyprogesterone acetate (Depoprovera™) is also a form of birth control that also treats premenstrual symptoms. *Id.* Danazol, used to treat endometriosis, and subcutaneous estradiol pellets also provide relief for PMS symptoms. *Id.* GnRH-agonists abolishes the premenstrual exacerbation of symptoms in some women. *Id.* Hysterectomy and ovariectomy have been performed to eliminate the symptoms of PMS, but a small number of women still report symptoms after these procedures. *Id.* See also Freeman, *supra* note 20, at 7; Steiner, *supra* note 20, at 451.

<sup>49</sup> Parry, *supra* note 20, at 57. Support groups offer women a forum for understanding PMS, for understanding that they are not alone, to enable them to make the necessary lifestyle changes to cope with the symptoms, to learn to assert their needs, reduce guilt, raise self-esteem, improve time management, improve relationships, and avoid unnecessary stress. *Id.* Exercise may reduce some physical symptoms, but may not relieve anxiety or depression. *Id.* See Steiner, *supra* note 20, at 451.

<sup>50</sup> Keye & Trunnell, *supra* note 20, at 181. See Steiner, *supra* note 20, at 451.

<sup>51</sup> See *supra* notes 20-27 and accompanying text.

<sup>52</sup> See *supra* notes 28-50 and accompanying text. As mentioned earlier, this Note does not propose that ordinary PMS, which most women suffer from, should be used as a mitigating

**B. Medical Aspects of PMDD**

Although most menstruating women suffer from some form of PMS, some of these women suffer from a severe form called PMDD. Courts should allow PMDD as a mitigating factor in sentencing. Before the legal community will recognize PMDD as a mitigating factor in sentencing, it must understand the severity of PMDD, including its causes, diagnosis, and treatment.

The American Psychiatric Association (APA) classifies PMDD as a depressive disorder under the category "Depressive Disorder Not Otherwise Specified."<sup>53</sup> Researchers estimate that three to eight percent of women who are of reproductive age have symptoms that fit the definition of PMDD.<sup>54</sup> In the APA's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, it adopted a set of research criteria for diagnosing PMDD.<sup>55</sup> In particular, women suffering from PMDD exhibit

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factor or a defense for women who commit crimes. Instead, this Note advocates that severe PMS (PMDD) be used as a mitigating factor in sentencing.

<sup>53</sup> AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 715, 716 (4th ed. 1994) [hereinafter *DSM-IV*]. Describing nearly 300 different psychiatric disorders, *DSM-IV* is the basic diagnostic reference tool for mental health professionals and is also used by lawyers and insurance companies. See Constance Holden, *Proposed New Psychiatric Diagnoses Raise Charges of Gender Bias*, 231 *SCI.* 327 (1986).

<sup>54</sup> Steiner, *supra* note 20, at 448. See also Parry, *supra* note 20, at 55 (stating that PMDD affects five percent of women at a reproductive age). See also Jamie Talan, *Are Monthly Blues a Mental Disorder?*, *NEWSDAY*, July 10, 1993, at 10 (PMDD affects two to five percent of menstruating women; PMS is likened to a cold, while PMDD is likened to full-blown pneumonia).

<sup>55</sup> *DSM-IV*, *supra* note 53, at 717-18. The diagnostic criteria are:

- A. In most menstrual cycles during the past year, five (or more) of the following symptoms were present for most of the time during the last week of the luteal phase, begin to remit within a few days after the onset of the follicular phase, and were absent in the week postmenses, with at least one of the symptoms being either (1), (2), (3), or (4):
- (1) markedly depressed mood, feelings of hopelessness, or self-depreciating thoughts
  - (2) marked anxiety, tension, feelings of being "keyed up," or "on edge"
  - (3) marked affective lability (e.g., feeling suddenly sad or tearful or increased sensitivity to rejection)
  - (4) persistent and marked anger or irritability or increased
  - (5) interpersonal conflicts
  - (6) decreased interest in usual activities (e.g., work, school, friends, hobbies)
  - (7) subjective sense of difficulty in concentrating
  - (8) lethargy, easy fatigability, or marked lack of energy
  - (9) marked change in appetite, overeating, or specific food cravings
  - (10) hypersomnia or insomnia

signs of severe depression, anxiety, tension, and persistent anger, unlike those women suffering from PMS.<sup>56</sup>

To determine the severity of premenstrual tension that a woman suffers, practitioners use the following diagnostic categories: (1) "pure-pure" PMDD, (2) "pure" PMDD, (3) premenstrual magnification, (4) no PMDD, and (5) PMS.<sup>57</sup> Women who suffer from "pure-pure" PMDD meet the DSM-IV criteria for PMDD and have not suffered from any other past or present psychiatric disorder.<sup>58</sup> Those who suffer from "pure" PMDD meet the DSM-IV criteria for PMDD, but they have no other current psychiatric disorder; they do, however, have a history of a past psychiatric disorder.<sup>59</sup> Individuals with premenstrual magnification may meet the DSM-IV criteria for PMDD, but they also have a current major psychiatric disorder or an unstable medical condition.<sup>60</sup> Females without PMDD do not demonstrate premenstrual symptoms that are severe enough to meet the DSM-IV criteria for PMDD, but may meet the DSM-IV criteria for another psychiatric disorder.<sup>61</sup> Women who are diagnosed with PMS do not meet the DSM-IV criteria for PMDD;

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- (11) a subjective sense of being overwhelmed or out of control
  - (12) other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of "bloating," weight gain
- B. The disturbance markedly interferes with work or school or with usual social activities and relationships with others (e.g., avoidance of social activities, decreased productivity and efficiency at work or school).
  - C. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as Major Depressive Disorder, Panic Disorder, Dysthymic Disorder, or a Personality Disorder (although it may be superimposed on any of these disorders).
  - D. Criteria A, B, and C must be confirmed by prospective daily ratings during at least two consecutive symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation.) *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> Steiner, *supra* note 42, at 246. See also, Steiner, *supra* note 20, at 450-51; Kimberly A. Yonkers, *Anxiety Symptoms and Anxiety Disorders: How Are They Related to Premenstrual Disorders?*, 58 J. CLIN. PSYCHIATRY 62 (1997).

<sup>58</sup> Steiner, *supra* note 42, at 246. In Dr. Steiner's clinic, approximately two-thirds of the women who qualify for a diagnosis of PMDD are in this category. *Id.* at 247.

<sup>59</sup> Most of the women in this category had at least one episode of a mood disorder in the past. *Id.* Of the women in Dr. Steiner's clinic that qualify for the PMDD diagnosis, nearly one-third are in this category. *Id.* at 247.

<sup>60</sup> Up to ten percent of Dr. Steiner's patients suffer from premenstrual magnification. *Id.* at 247.

<sup>61</sup> *Id.*

however, these women do meet the International Classification of Diseases-10-CM criteria for PMS.<sup>62</sup>

Researchers offer several theories as to the cause of PMDD.<sup>63</sup> Some researchers hypothesize that ovarian cyclicity is important in the etiology of PMDD.<sup>64</sup> Another theory is that thyroid dysfunction plays a role.<sup>65</sup> The current consensus is that the normal ovarian function is the cyclical trigger for PMDD-related biochemical events occurring within the central nervous system.<sup>66</sup>

Researchers have thus developed different treatment options that coordinate with these theories of causation.<sup>67</sup> Treatment for women with PMDD usually includes the treatment of symptoms or the manipulation of the menstrual cycle.<sup>68</sup> For women with PMDD who have failed to respond to these treatments, physicians use selective serotonin reuptake inhibitors (SSRI), like Prozac<sup>TM</sup> and Zoloft<sup>TM</sup>, and clomipramine.<sup>69</sup> SSRIs have demonstrated excellent results with minimal side effects, even when taken in low doses.<sup>70</sup>

Similar to PMS, the symptoms of PMDD, along with its methods of diagnosis and treatment, vary among women. As noted previously, far fewer women suffer from PMDD than PMS; however, these women's

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<sup>62</sup> Steiner, *supra* note 42, at 246. See *supra* note 41 and accompanying text.

<sup>63</sup> See *infra* notes 64-66 and accompanying text.

<sup>64</sup> See Steiner, *supra* note 20, at 449. This theory is supported by studies in which suppression of ovulation resulted in the disappearance of premenstrual symptoms. *Id.*

<sup>65</sup> *Id.* Current literature suggests that a small group of women diagnosed with PMDD also have thyroid dysfunction, but PMDD is not a masked form of hypothyroidism. *Id.* See also Parry, *supra* note 20, at 62.

<sup>66</sup> Steiner, *supra* note 20, at 449. A psychoneuroendocrine mechanism triggered by normal endocrine events of the ovarian cycle may be the most plausible explanation for PMDD. *Id.* at 449-50. Increasing evidence suggests that serotonin may play an important role in PMDD. *Id.* at 450. Reduced platelet uptake of serotonin has been shown in women with premenstrual syndrome during the week before menstruation, and women with PMS also have demonstrated a lowered level of platelet serotonin content. *Id.* at 449-50.

<sup>67</sup> See *infra* notes 68-70 and accompanying text.

<sup>68</sup> Steiner, *supra* note 20, at 452. See *supra* notes 46-51 and accompanying text.

<sup>69</sup> Steiner, *supra* note 20, at 452. See Yonkers, *supra* note 57, at 65-66. The SSRIs fluoxetine (Prozac<sup>TM</sup>), sertraline (Zoloft<sup>TM</sup>), nefazodone (Serzone<sup>TM</sup>), and paroxetine (Paxil<sup>TM</sup>) are particularly effective for the treatment of PMDD. *Id.* See also, Steiner, *supra* note 42, at 247. However, the Federal Drug Administration (FDA) has not approved these drugs specifically for treatment of PMS or PMDD. Freeman, *supra* note 20, at 5.

<sup>70</sup> Steiner, *supra* note 20, at 452. If there is no change in symptomatology within two to three menstrual cycles, an alternative therapy should be considered. *Id.* Approximately 60-70% of subjects report a significant reduction of premenstrual symptoms with SSRI treatment. Freeman, *supra* note 20, at 5.

symptoms are significantly more severe.<sup>71</sup> This severity of symptoms becomes important in analyzing PMDD as a mitigating factor, because it illustrates that PMDD may adversely affect women's behavior. An examination of cases where the defendant successfully raised typical PMS as a defense or a mitigating factor will show how this disorder may adversely affect a woman's behavior, thus supporting the argument that PMDD has a more drastic effect on behavior.

### III. THE HISTORY OF PMS IN CRIMINAL COURTS

The use of PMS as a mitigating factor began in the English court system. A mitigating factor does not constitute a justification or an excuse for an offense, but rather under a theory of fairness, it is considered to reduce or extenuate the degree of moral culpability.<sup>72</sup> In the American criminal courts, defendants have introduced PMS as a defense in a small number of cases but not as a mitigating factor.<sup>73</sup> In four major English cases, female defendants successfully raised the argument of PMS as a mitigating factor in sentencing.

#### A. *The English Cases*

The first major case using PMS as a mitigating factor was *Regina v. Craddock*.<sup>74</sup> In *Craddock*, Sandie Craddock was arrested for stabbing a fellow barmaid to death.<sup>75</sup> Craddock's history consisted of more than thirty prior convictions, as well as multiple suicide attempts.<sup>76</sup> Upon reviewing Craddock's diaries, her attorney discovered that each criminal offense or suicide attempt occurred at approximately the same time during her menstrual cycle.<sup>77</sup> The expert witness for the defense, Dr.

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<sup>71</sup> See *supra* notes 54-55 and accompanying text.

<sup>72</sup> BLACK'S LAW DICTIONARY 1002 (6th ed. 1990).

<sup>73</sup> See Joanne D'Emilio, Note, *Battered Women's Syndrome and Premenstrual Syndrome: A Comparison of Their Possible Use as Defenses to Criminal Liability*, 59 ST. JOHN'S L. REV. 558 (1985). PMS was a successful defense in a Canadian court. Prosecutors dropped a shoplifting charge when medical evidence established that the defendant suffered from PMS since her teens. *Id.* at 570.

<sup>74</sup> 1 C.L. 49 (1980). See Joseph R. Tybor, *Women on Trial: New Defense*, NAT'L L. J., Feb. 15, 1982, at 1.

<sup>75</sup> *Id.* See Lee Solomon, *Premenstrual Syndrome: The Debate Surrounding Criminal Defense*, 54 MD. L. REV. 571, 582 (1995).

<sup>76</sup> Tybor, *supra* note 74, at 1. See Nadine Brozan, *Premenstrual Syndrome: A Complex Issue*, N.Y. TIMES, July 12, 1982, at C16. Records described the defendant as pleasant and a law-abiding citizen, but once every 29 days she would attempt arson in her cell, try to drown or strangle herself, or smash windows. *Id.* She had been in prison on and off for about 10 years and, in that time, showed 26 episodes of violence every 29 days. *Id.*

<sup>77</sup> *Id.* Craddock's attorney argued that PMS turned his client into "a raging animal each month" which forced her to act out of character. Tybor, *supra* note 74, at 1.

Katherina Dalton, diagnosed Craddock as suffering from PMS and prescribed progesterone therapy to stabilize this condition.<sup>78</sup> The trial court reduced Craddock's murder charge to manslaughter and released her on probation contingent upon her continuing treatment by a physician.<sup>79</sup> Unfortunately, progesterone therapy did not completely rehabilitate Craddock.<sup>80</sup>

Craddock appeared in court again under the name Sandie Smith for threatening to kill a police officer because he had insulted her three years earlier.<sup>81</sup> Shortly after the threat, Smith was arrested outside the officer's station, carrying a knife while apparently waiting to attack the officer.<sup>82</sup> Smith was charged with two counts of threatening to kill a police officer and one count of carrying a weapon.<sup>83</sup> Dr. Dalton testified that Smith suffered from PMS and that she had progressively reduced Smith's medication during the time the offense occurred.<sup>84</sup> The trial court convicted Smith on all counts, but mitigated her sentence by placing her on probation so that she could continue receiving medical treatment.<sup>85</sup>

In another British case, *Regina v. English*,<sup>86</sup> English deliberately pinned her boyfriend against a pole with her car and killed him.<sup>87</sup> Dr. Dalton also testified at this trial having diagnosed English as suffering from an aggravated form of PMS.<sup>88</sup> The court reduced the murder

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<sup>78</sup> 1 C.L. 49 (1980). Dr. Dalton has studied nearly 30,000 cases for more than thirty years and has been the chief defense witness in this case and other British cases involving PMS. Tybor, *supra* note 74, at 12, 16.

<sup>79</sup> 1 C.L. 49 (1980). See Tybor, *supra* note 74, at 1. See also Solomon, *supra* note 75, at 582.

<sup>80</sup> See *Regina v. Smith*, No. 1/A/82 (C.A. Crim. Div. 1982), LEXIS, Enggen Library, Cases File at \*1.

<sup>81</sup> *Id.* At the time of this trial, Smith had 45 previous convictions and had been before the courts on 28 different occasions, many of them for inexplicably violent behavior. *Id.* at \*2.

<sup>82</sup> *Id.*

<sup>83</sup> *Id.* Smith said that she remembered saying that she intended to kill the officer, but that she did not mean it. *Id.* She also said that she was carrying the knife so that she could slit her own wrists, not to harm the officer. *Id.* at \*4.

<sup>84</sup> *Id.* at \*2.

<sup>85</sup> *Id.* at \*3. The trial judge indicated that the law does not recognize the defense of irresistible impulse, which Smith argued, and that the question of punishment was a matter for the judge and not for the jury. *Id.* Smith appealed this decision on the grounds that the question of her punishment was a question for the jury, and that she should be held criminally responsible only if the jury so concluded. *Id.* The appellate court upheld the trial court's decision because, it reasoned, that Smith's argument was the equivalent to irresistible impulse, which is prohibited under English law. *Id.*

<sup>86</sup> Norwich Crown Ct. 1981 (unreported).

<sup>87</sup> Solomon, *supra* note 75, at 583.

<sup>88</sup> *Id.*

charge to manslaughter, and English pled guilty to the lesser charge.<sup>89</sup> When sentencing English, the judge accepted PMS as a mitigating factor because English had acted under "wholly exceptional circumstances."<sup>90</sup>

Finally, in *Regina v. Reynolds*,<sup>91</sup> the defendant killed her mother by hitting her on the head multiple times with a hammer.<sup>92</sup> She then arranged the scene to make it appear that a burglary had occurred.<sup>93</sup> At trial, Dr. Dalton testified that the defendant suffered from PMS which led to the temporary loss of control and substantial impairment, thus reducing her culpability.<sup>94</sup> However, the jury returned a guilty verdict.<sup>95</sup> Subsequently, the prosecuting attorney expressed a willingness to accept a plea of guilty to manslaughter on the basis of diminished responsibility if a retrial should occur.<sup>96</sup> On appeal, the court overturned the guilty verdict of the trial court and substituted a guilty verdict to manslaughter.<sup>97</sup> The appellate court sentenced her to probation on the condition that she submit to psychiatric supervision.<sup>98</sup> It reasoned that, in light of the new evidence from Dr. Dalton and the government's willingness to accept a plea of manslaughter, it should substitute the guilty verdict of murder for that of manslaughter.<sup>99</sup> The appellate court further noted that allowing a guilty verdict of murder to stand would be wrong and that it was unsafe and unsatisfactory to allow it to remain.<sup>100</sup>

Thus, English courts, relying on expert testimony, are willing to accept PMS as a mitigating factor in sentencing or as the basis for a reduction in a criminal offense. The English courts took into account the defendants' illnesses as proven by expert testimony and decided that the defendant needed treatment. Recognition of PMS as a mitigating factor in England further illustrates the need for the United States to recognize

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<sup>89</sup> See Robert Mark Carney & Brian D. Williams, *Premenstrual Syndrome: A Criminal Defense*, 59 NOTRE DAME L. REV. 253, 261 (1983).

<sup>90</sup> *Id.* English received a sentence of one year probation and lost her driving privileges for one year. Christina L. Hosp, *Has the PMS Defense Gained a Legitimate Toehold in Virginia Criminal Law? Commonwealth v. Richter*, 14 GEO. MASON U. L. REV. 427, 430 (1991).

<sup>91</sup> *Crim. L.R.* 679 (C.A. 1988), (LEXIS, Enggen Library, Cases File, at \*1)

<sup>92</sup> *Id.* at \*3. See Solomon, *supra* note 75, at 584.

<sup>93</sup> *Reynolds*, *Crim. L.R.*, at \*3.

<sup>94</sup> *Id.* at \*11-12. Dr. Dalton testified that this was the case of diminished responsibility with the cause being a conjunction of PMS and postnatal depression. Solomon, *supra* note 75, at 584.

<sup>95</sup> *Reynolds*, *Crim. L.R.* 679, at \*12.

<sup>96</sup> *Id.* See Solomon, *supra* note 75, at 584.

<sup>97</sup> *Reynolds*, *Crim. L.R.* 679, at \*16. See Solomon, *supra* note 75, at 584.

<sup>98</sup> *Reynolds*, *Crim. L.R.* 679, at \*16.

<sup>99</sup> *Id.* at \*13.

<sup>100</sup> *Id.*

PMDD as a mitigating factor in criminal courts. However, United States courts have shown less enthusiasm toward the use of PMS as a mitigating factor.

### B. *The American Cases*

Although defendants have tried to raise PMS as a defense rather than as a mitigating factor, these United States court cases are still important because they represent an increased willingness for women to argue that PMS adversely affects their behavior. The first major case to attempt to use PMS as a criminal defense, *People v. Santos*,<sup>101</sup> occurred in the state of New York.<sup>102</sup> Santos was charged with assaulting her child.<sup>103</sup> In defense of her conduct, Santos argued that she suffered from PMS at the time of the assault.<sup>104</sup> Her attorney entered a plea of not guilty on the grounds that Santos suffered from PMS.<sup>105</sup> Although the court never had an opportunity to hear the merits of this defense after the parties negotiated a plea bargain,<sup>106</sup> one commentator has noted that

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<sup>101</sup> *People v. Santos*, No. 1KO46229 (Crim. Ct. Kings. County, N.Y. 1982) (unpublished opinion). See Solomon, *supra* note 75, at 584.

<sup>102</sup> The PMS defense has also been raised in American civil courts. See *Lovato v. Irvin*, 31 B.R. 251 (Bankr. D. Colo. 1983) (court rejected defendant's PMS claim as a defense that she did not willingly assault the plaintiff, which was material to her filing bankruptcy); *Tingen v. Tingen*, 446 P.2d 185 (Or. 1968) (mother's PMS symptoms introduced regarding her competency in a child custody proceeding); *Reid v. Florida Real Estate Comm'n*, 188 So. 2d 846 (Fla. Dist. Ct. App. 1966) (court reversed Real Estate Commission order which suspended woman's broker license because she was arrested for shoplifting while she was suffering from PMS); *Edwards v. Ford*, 26 S.E.2d 306 (Ga. Ct. App. 1943) (defense attributed driver's unconsciousness to PMS in wrongful death action).

<sup>103</sup> Solomon, *supra* note 75, at 584. Santos was accused of beating her four-year old child with a stick. Elizabeth Holtzman, *Premenstrual Symptoms: No Legal Defense*, 60 ST. JOHN'S L. REV. 712 (1986). See Candy Pahl-Smith, *Premenstrual Syndrome as a Criminal Defense: The Need for a Medico-legal Understanding*, 15 N.C. CENT. L.J. 246, 256 (1984).

<sup>104</sup> Solomon, *supra* note 75, at 584. See Richard T. Oakes, *PMS: A Plea Bargain in Brooklyn Does Not a Rule of Law Make*, 9 HAMLIN L. REV. 203 (1986). Dr. Dalton testified that Santos did not suffer from PMS at the time of the offense. *Id.* at 204-05. See also Marcia Chambers, *Menstrual Stresses as a Legal Defense*, N.Y. TIMES, May 29, 1982, § 2, at 46. During arguments on dismissal, Judge Jerome M. Becker stated that the PMS defense was credible because disruptions of the mind are admissible in evidence; and likewise, physical disruptions of the body should be admitted as well. *Id.*

<sup>105</sup> Solomon, *supra* note 75, at 584. However, her attorney submitted no evidence that Santos suffered from PMS or that she had been treated for recurring PMS. See Pahl-Smith, *supra* note 103, at 256.

<sup>106</sup> Solomon, *supra* note 75, at 584-85. Santos's attorney withdrew the PMS defense in exchange for the prosecutor's promise to drop the felony charges, and Santos pled guilty to a lesser charge of harassment. *Id.* Instead of receiving probation, a fine, or a sentence, Santos received a conditional discharge with the stipulation that she undergo counseling. However, she did lose custody of her child. See Pahl-Smith, *supra* note 103, at 257.



this case is significant because it proves the validity of PMS as a defense in criminal court.<sup>107</sup>

In a South Dakota criminal court in 1986, namely *State v. Lashwood*,<sup>108</sup> another defendant attempted to raise PMS as a criminal defense. Lashwood sought to withdraw her guilty and no contest pleas to forgery on the grounds that she did not make the pleas knowingly.<sup>109</sup> In order to overturn an otherwise effective plea, Lashwood needed to show that her mental condition was so debilitating that she was unable to assist with counsel or understand the proceedings.<sup>110</sup> The court refused to withdraw the pleas, even though a psychiatric examination confirmed that she suffered from PMS. The court reasoned that she still knew right from wrong and had the ability to help in her own defense.<sup>111</sup>

In *Commonwealth v. Richter*,<sup>112</sup> a 1991 case in West Virginia, the defendant again raised PMS as a defense. A state trooper stopped a car driven by Richter, with her three children as passengers, because her car was weaving.<sup>113</sup> The trooper noticed a strong odor of alcohol on her breath and asked her how much alcohol she had consumed.<sup>114</sup> Richter replied that it was none of his business.<sup>115</sup> Then she refused to take sobriety tests, started cursing, and tried to kick the trooper in the groin.<sup>116</sup> When the officer told Richter that he would place her children in protective custody for the night, she replied that her PMS caused her abusiveness toward the trooper.<sup>117</sup> During trial, a gynecologist testified

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<sup>107</sup> Santos' attorney contends that the prosecution dropped the felony charges, because the PMS defense was valid. Pahl-Smith, *supra* note 103, at 257. *But see* David Bird, *Defense Linked to Menstruation Dropped in Case*, N.Y. TIMES, Nov. 4, 1982, at B4. Prosecuting attorney Elizabeth Holtzman disagreed, stating that the injuries to the child were extremely minor, and a harassment charge was the normal penalty for a woman with no previous record. *Id.* 384 N.W.2d 319 (S.D. 1986).

<sup>109</sup> Lashwood argued this on the grounds that she had a prior history of mental problems which precluded her from giving an effective plea. *Id.* at 321.

<sup>110</sup> *Id.*

<sup>111</sup> *Id.* The court noted that since Lashwood's attorney objected to the trial court's line of questioning concerning her mental condition, that she cannot now complain that the court's inquiry was inadequate. *Id.*

<sup>112</sup> No. T90-215256 (Fairfax County Gen. Dist. Ct., Va. 1991) (unreported case). *See* Hosp, *supra* note 90, at 427; DeNeen L. Brown, *PMS Defense Successful in Va. Drunken Driving Case*, WASH. POST, June 7, 1991, A01; Martin Kasindorf, *Allowing Hormones to Take the Rap; Does the PMS Defense Help or Hinder Women?*, NEWSDAY, June 16, 1991, at 17.

<sup>113</sup> Hosp, *supra* note 90, at 432-33. *See* Brown, *supra* note 112, at A1.

<sup>114</sup> Hosp, *supra* note 90, at 433. *See* Brown, *supra* note 112, at A1. Richter consumed four to six glasses of wine in a six-hour period. *Id.*

<sup>115</sup> Hosp, *supra* note 90, at 433. *See* Brown, *supra* note 112, at A1.

<sup>116</sup> Hosp, *supra* note 90, at 433. *See* Brown, *supra* note 112, at A1.

<sup>117</sup> Hosp, *supra* note 90, at 435. *See* Brown, *supra* note 112, at A1.

that Richter suffered from moderate PMS.<sup>118</sup> The trial judge found Richter not guilty of driving while intoxicated because he had a reasonable doubt as to her guilt, but he did not explicitly accept PMS as a defense.<sup>119</sup>

These court decisions demonstrate that the legal community has not explicitly accepted PMS as a defense or as a mitigating factor. However, these cases do show the increased willingness of some women to assert PMS as a defense in criminal cases. In addition, courts have accepted other disorders recognized by the APA as defenses or mitigating factors. One of these defenses, post-traumatic stress disorder, may provide a useful analogy to PMS as a defense.

#### IV. THE HISTORY OF POST TRAUMATIC STRESS DISORDER

Courts have recognized Post Traumatic Stress Disorder (PTSD) as a mitigating factor. First, this Section explores the definition and diagnosis of this disorder, followed by examples of situations where PTSD may arise. Next, this Section explains how courts use PTSD as a mitigating factor to reduce a defendant's sentence. By analyzing the different ways PTSD serves as a criminal defense or a mitigating factor, this Note seeks to show that a strong analogy exists between PTSD and PMDD.

The APA defines PTSD as the development of certain symptoms that follow a psychologically traumatic event involving actual or threatened death or serious injury that is usually outside the range of normal human experience.<sup>120</sup> Like PMDD, PTSD has a certain set of diagnostic criteria defined by the APA.<sup>121</sup> PTSD may include one of

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<sup>118</sup> Hosp, *supra* note 90, at 435. Dr. Cay, a gynecologist, first examined Richter regarding her PMS only one day before trial. *Id.* This period of time is not sufficient to accurately diagnose PMS. See *supra* notes 36-43 and accompanying text.

<sup>119</sup> Hosp, *supra* note 90, at 435. However, the judge failed to consider that Richter's defense of PMS only applied to her behavior after the officer stopped her; it did not explain why she was weaving on the road. *Id.* See Kasindorf, *supra* note 112, at 17. At the time this article was written, Richter faced unrelated charges of fraudulently prescribing tranquilizers for herself in a neighboring county. *Id.*

<sup>120</sup> DSM-IV, *supra* note 53, at § 309.81, 424.

<sup>121</sup> The diagnostic criteria for PTSD is as follows:

- A. The person has been exposed to a traumatic event in which both of the following situations occurred:
  - (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
  - (2) the person's response involved intense fear, helplessness, or horror.

several different traumatic events.<sup>122</sup> One of the more common scenarios concerns armed services veterans and their wartime experiences.<sup>123</sup>

Defendants use the PTSD defense several different ways.<sup>124</sup> Courts have allowed PTSD evidence to support an insanity defense.<sup>125</sup> In

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- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
  - (2) recurrent distressing dreams of the event
  - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
  - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
  - (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
  - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
  - (3) inability to recall an important aspect of the trauma
  - (4) markedly diminished interest or participation in significant activities
  - (5) feeling of detachment or estrangement from others
  - (6) restricted range of affect (e.g., unable to have loving feelings)
  - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- (1) difficulty falling or staying asleep
  - (2) irritability or outbursts of anger
  - (3) difficulty concentrating
  - (4) hypervigilance
  - (5) exaggerated, startled response.
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DSM-IV, § 309.81 at 427-29. Some associated symptoms of PTSD are survival guilt, self-destructive or impulsive behavior, hostility, social withdrawal, and constant feelings of being threatened. *Id.* at 425.

<sup>122</sup> Krista L. Duncan, "Lies, Damned Lies, and Statistics?": Psychological Syndrome Evidence in the Courtroom After *Daubert*, 71 IND. L.J. 753, 758 (1996). Other traumas include rape trauma and battered woman syndrome. *Id.* at 759, 763.

<sup>123</sup> *Id.* Some stressors may include participation in war, being taken as a prisoner of war, witnessing or causing another's death, or viewing dead bodies. *Id.* at 758.

addition, courts allow PTSD to be used as a mitigating factor in some cases,<sup>126</sup> such as *State v. Twelves*,<sup>127</sup> where the defendant's PTSD led to a drastic reduction in sentencing.

In *Twelves*, decided in 1985 by a Florida appellate court, the prosecutor appealed a trial court's decision suspending all but eighteen months of a ten-year sentence.<sup>128</sup> The appellee's military record showed a substantial amount of combat experience and that he received a Purple Heart and a Bronze Star.<sup>129</sup> An expert testified at trial that Twelves suffered from PTSD, and that this disorder may be controlled by drugs and outreach programs.<sup>130</sup> In addition, friends, relatives, and employers testified that they would assist him in his rehabilitation efforts.<sup>131</sup> Based upon these facts, the appellate court held that the trial court acted within the boundaries of the state mitigation statute.<sup>132</sup>

Courts could apply the *Twelves* court's rationale to a case where the defendant suffers from PMDD. The court may consider many factors in its analysis. First, both PMDD and PTSD do not produce ordinary behavior in those that suffer from these disorders. PMDD sufferers, like those who suffer from PTSD, may experience irritability or outbursts of anger, or difficulty falling or staying asleep.<sup>133</sup> Second, expert testimony can prove that a person suffered from one of these disorders at the time the crime occurred. Experts may use the guidelines promulgated by the

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<sup>124</sup> See notes 125-132 and accompanying text.

<sup>125</sup> Michael J. Davidson, *Post-Traumatic Stress Disorder: A Controversial Defense for Veterans of a Controversial War*, 29 WM. & MARY L. REV. 415, 422 (1988).

<sup>126</sup> See *United States v. Burgess*, No. 81-00129 (E.D. Va. 1981); *United States v. Kruttschwski*, Cr. No. 79-376 (D. Mass. 1980); *People v. Saldivar*, 497 N.E. 2d 1138 (Ill. 1986) (PTSD used as a mitigating factor to reduce sentence to statutory minimum); *State v. Spawr*, 653 S.W.2d 404 (Tenn. 1983) (court granted probationary hearing to PTSD sufferer who exhibited signs of rehabilitation); *State v. Twelves*, 463 So. 2d 493 (Fla. Ct. App. 1985) (court reduced sentence of PTSD sufferer by suspending all but 18 months of a ten-year term). See also CAL. PENAL CODE § 1170.9 (West 1997). California enacted a statute which in effect may change a defendant's incarceration for a felony from a state facility to the custody of federal correctional officials if the defendant was a member of the United States military, served in Vietnam, and suffers from substance abuse or psychological problems resulting from that service. *Id.*

<sup>127</sup> 463 So. 2d 493 (Fla. Dist. Ct. App. 1985).

<sup>128</sup> *Id.* at 493. Under Rule 3.701 of the Florida Rules of Criminal Procedure, the trial court has the discretion to mitigate a guideline sentence if clear and convincing exist to warrant a deviation from the guidelines. FLA. R. CRIM. P. 3.701.

<sup>129</sup> *Twelves*, 463 So. 2d at 493.

<sup>130</sup> *Id.*

<sup>131</sup> *Id.* at 493-94.

<sup>132</sup> *Id.* at 494.

<sup>133</sup> See *supra* notes 55, 121 and accompanying text.

APA as an aid in diagnosing both of the disorders.<sup>134</sup> Third, fairness dictates that those who are suffering from these disorders while they commit crimes are less culpable because of their impaired condition. These persons should be rehabilitated rather than punished. Therefore, this analogy may serve to convince American courts that they should use PMDD as a mitigating factor similar to PTSD.

Comparing PMDD to PTSD demonstrates that courts may adopt a similar reasoning which will effectuate the use of PMDD as a mitigating factor. Although the analysis of both case law and analogy reinforce the need for courts to recognize PMDD as a mitigating factor, criticisms exist. The next Section discusses and rejects the criticisms against PMDD as a mitigating factor in the American criminal system.

#### V. THE DEBATE SURROUNDING PMDD AS A MITIGATING FACTOR

This Section examines possible barriers to the acceptance of PMDD as a mitigating factor and offers critiques of each argument.<sup>135</sup> The following criticisms and comments concern the use of PMS as a defense. These criticisms could equally apply to the use of PMDD as a mitigating factor.<sup>136</sup>

##### A. *The Legal Arguments*

While the medical community agrees that PMS causes severe and debilitating symptoms in some women, they disagree on the diagnosis, cause, and treatment of PMS.<sup>137</sup> Critics argue that the lack of consensus in the medical profession concerning the definition, cause, and treatment of PMS hinders a wider recognition of PMS as a defense by the legal profession.<sup>138</sup> However, disagreement within the medical community concerning the symptoms, cause, diagnosis and treatment of PMDD should not be an impediment to its use as a mitigating factor for two reasons.

First, the current rules of evidence do not require universal acceptance within the medical community of the cause, diagnosis, and treatment of PMDD in order for experts to testify concerning the

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<sup>134</sup> See *supra* notes 55, 121.

<sup>135</sup> See *infra* notes 137-80 and accompanying text.

<sup>136</sup> One may reason, however, that because PMDD is more serious than PMS criticisms concerning the use of PMS as a defense should be weaker and the arguments for the use of PMDD as a mitigating factor should be stronger.

<sup>137</sup> See Carney & Williams, *supra* note 89, at 257. See also Solomon, *supra* note 75, at 574.

<sup>138</sup> See Carney & Williams, *supra* note 89, at 267.

defense.<sup>139</sup> In *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,<sup>140</sup> the United States Supreme Court held that the Federal Rules of Evidence displaced the "general acceptance" standard set forth in *Frye v. United States* for the admissibility of expert testimony.<sup>141</sup> The Court held that Rule 702 of the Federal Rules of Evidence is the appropriate standard of admissibility. Under this Rule, expert testimony will be admitted if scientific, technical or other specialized knowledge will assist the trier of fact in determining a fact in issue or in understanding the evidence.<sup>142</sup> Thus, it is not necessary that the medical community reach a consensus concerning PMDD for expert testimony to be admissible. Instead, the evidence must only assist the trier of fact in determining a fact in issue or understanding the evidence.<sup>143</sup> Therefore, the lack of consensus in the medical community concerning PMDD should not serve as an impediment to its use as a mitigating factor.

Second, the argument that the legal community should not recognize PMS as a defense because of its uncertainty in the medical community disregards the best interest of women.<sup>144</sup> Postponing the recognition of the PMS defense until the medical community is more certain is unfair to PMS sufferers who may be unjustly imprisoned and precluded from receiving treatment, because the law has not yet

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<sup>139</sup> See *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579, 588-89 (1993).

<sup>140</sup> *Id.* at 579.

<sup>141</sup> The Frye test required that proffered evidence had gained general acceptance in the field in which it belonged in order to be admissible. See *Frye v. United States*, 293 F. 1013, 1014 (D.C. Cir. 1923). *Daubert* is the current standard for the admissibility of expert testimony in federal court. However, some states still adhere to the Frye standard. See Craig Hunter Wisnom, Note, *Science in Evidence: The Effect of Daubert v. Merrell Dow on Arizona's Frye Rule*, 36 ARIZ. L. REV. 1057, (1994). Arizona, California, Michigan, New York, Utah, and Washington still adhere to the Frye test. *Id.* at 1061. Expert testimony concerning PMDD as a mitigating factor may have a more difficult time being admitted under Frye, but if scientific guidelines exist concerning PMDD, like the diagnostic guidelines set forth by the APA, the expert testimony should not have a problem satisfying the "general acceptance" test of Frye as well.

<sup>142</sup> See *Daubert*, 509 U.S. at 589. The adjective "scientific" implies a grounding in the procedures and methods of science. *Id.* at 590. "Knowledge" implies more than mere speculation. *Id.* In order to determine whether the subject of the testimony is scientific knowledge, courts may look at the following factors: the theory of the subject is capable and has been tested; the theory has been subjected to peer review or publication; the potential rate of error of the theory; and whether the theory has gained widespread acceptance in the medical community. *Id.* at 593-94. See FED. R. EVID. 702.

<sup>143</sup> *Daubert*, 509 U.S. at 589. In *General Electric Co. v. Joiner*, 118 S.Ct. 512, 517 (1997), the Court clarified the *Daubert* test by stressing that the trial judge must act as a "gatekeeper" by screening evidence to ensure that it is not only relevant, but reliable. *Id.*

<sup>144</sup> Carney & Williams, *supra* note 89, at 267.

recognized their disorder.<sup>145</sup> The law cannot wait until the medical profession reaches unanimity on the definition, cause, and treatment of PMS because the process of reaching unanimity may be impossible.<sup>146</sup>

Other critics of the defense argue that proving a woman suffered from PMS at the time the alleged offense occurred is extremely difficult.<sup>147</sup> One critic has argued that a woman may have difficulty proving that she has PMS because the diagnosis of the syndrome results only from information supplied by the alleged sufferer or those that are close to her.<sup>148</sup> Furthermore, the accused woman may know nothing about PMS, and her word may be unreliable.<sup>149</sup> While these may be valid concerns, some factors exist that may overcome patient unreliability.<sup>150</sup> The timing of arrests may overcome an unreliable patient's testimony when she is a repeat offender.<sup>151</sup> If the patient is not a repeat offender, then records kept by those other than family members and friends may negate the possibility of an unreliable patient's testimony.<sup>152</sup>

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<sup>145</sup> *Id.* See Kasindorf, *supra* note 112, at 1-2. Gloria Allred, a California attorney active on women's issues, argues that PMS should be admitted for evidentiary purposes because many women cannot control the symptoms. *Id.*

<sup>146</sup> See Carney & Williams, *supra* note 89, at 267.

<sup>147</sup> See Holtzman, *supra* note 103, at 714-15; Kay A. Heggstad, *The Devil Made Me Do It: The Case Against Using Premenstrual Syndrome as a Defense in a Court of Law*, 9 HAMLINE L. REV. 155, 160-61 (1986). One may argue that women with irregular cycles may have a difficult time proving that they suffered from PMDD at the time the offense was committed. However, women with irregular cycles may still use the same methods that women with regular cycles use to diagnose PMDD, namely charts. The only difference between these two groups of women is that women with irregular cycles will have a different number of days between their last cycle and the onset of PMDD.

<sup>148</sup> Holtzman, *supra* note 103, at 714-15. See Heggstad, *supra* note 147, at 161. One critic fears that medical personnel who are familiar with the workings of PMS may be more convincing in feigning this illness. *Id.* However, if this rationale was controlling, medical personnel could never assert the insanity defense because they have specialized knowledge and could easily feign this illness.

<sup>149</sup> Thomas L. Riley, *Premenstrual Syndrome as a Legal Defense*, 9 HAMLINE L. REV. 193, 197-98 (1986). The woman's word alone may be unreliable because diagnostic charts are easily fabricated, and the family and friends of the accused would be likely to support the accused's testimony. *Id.*

<sup>150</sup> *Id.* at 198.

<sup>151</sup> *Id.* If the arrests occur roughly the same time every month, then it may be true that the offender suffered from PMS at the time she committed the offense. See *Regina v. Smith*, No. 1/A/82 (C.A. Crim. Div. 1982).

<sup>152</sup> Riley, *supra* note 149, at 198. One may look to employment records concerning absences or disagreements with employers or fellow employees, traffic citations, or consultations with marriage counselors. *Id.*

Another impediment to the use of PMDD as a mitigating factor is the possibility for abuse by women who do not really suffer from the disorder.<sup>153</sup> Some fear that all women charged with crimes could escape liability merely by claiming that they suffered from PMS.<sup>154</sup> This fear can be easily calmed. First, PMS is a quantifiable and scientifically proven affliction; if the medical and legal professions properly perform their duties, the possibility of abuse is minimal.<sup>155</sup> Second, although ninety-five percent of women suffer from PMS, only three to eight percent would qualify for the diagnosis necessary in mitigating a woman's sentence.<sup>156</sup> The possibility of indiscriminately using PMS as a mitigating factor is minimal.

In addition, those with ordinary PMS are not likely to commit violent or criminal acts.<sup>157</sup> Furthermore, PMDD should not be an affirmative defense that absolves the accused from all criminal liability; rather, courts should recognize PMDD as a mitigating factor in sentencing only for crimes that have been committed spontaneously or without premeditation. Premeditation is an act of thought, however short, before one commits a crime.<sup>158</sup> For example, a woman who deliberately plans to kill her husband while she is suffering from PMDD should not have her sentence mitigated on the basis of PMDD. This type of crime does not meet the spontaneity requirement.<sup>159</sup>

In addition, the use of PMDD as a mitigating factor in sentencing in limited circumstances still furthers the goals of criminal law.<sup>160</sup> One of

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<sup>153</sup> See *infra* notes 154-59 and accompanying text.

<sup>154</sup> Carney & Williams, *supra* note 89, at 267. These critics fear that this abuse would place the concept of PMS in disrepute, as well as exculpate the blameworthy. *Id.* Women who legitimately suffer from PMS may go untreated. *Id.* Even Dr. Dalton warns that courts must remain suspicious of women who plead the PMS defense. *Id.* at 267-68.

<sup>155</sup> *Id.* at 268. The medical profession may help to minimize this abuse by following the scientifically acceptable guidelines for the diagnosis of PMS, while the legal profession should subject these defense claims to heavy burdens of proof and require adequate expert testimony from such specialists as psychiatrists and endocrinologists. *Id.* See Pahl-Smith, *supra* note 103, at 246. Detailed charting of previous menstrual cycles, testimony from friends and family, personal diaries, and expert testimony from an endocrinologist and psychiatrist may eliminate the problem of potential abuse. Carney & Williams, *supra* note 89, at 268.

<sup>156</sup> See *supra* notes 20, 54 and accompanying text.

<sup>157</sup> Pahl-Smith, *supra* note 103, at 247. See Kasindorf, *supra* note 112, at 3. One attorney calculated that at most, one-tenth of one percent of women with PMS commit violent crimes. *Id.*

<sup>158</sup> BLACK'S LAW DICTIONARY 1180 (6th ed. 1990).

<sup>159</sup> See part VI.

<sup>160</sup> Linda R. Chait, *Premenstrual Syndrome and Our Sisters in Crime: A Feminist Dilemma*, 9 WOMEN'S RTS. L. REP. 267, 291 (1986).



the goals of law is to rehabilitate criminals rather than merely to punish them.<sup>161</sup> Rehabilitation seeks to "punish" the convicted criminal by giving appropriate treatment in order to reform the criminal, eliminating the desire or need to commit future crimes and return him or her to society.<sup>162</sup> This concept rests upon the belief that human behavior is a product of antecedent causes, that these causes are identifiable, and that basic therapeutic measures exist to effect changes in the rehabilitated criminal.<sup>163</sup> The criminal justice system will rehabilitate these women defendants through medical treatment.<sup>164</sup> The state will also retain control over these defendants by placing the women on probation, which further attains the goal of preventing future crimes.<sup>165</sup>

Another possible source of abuse concerns the hormonal nature of the PMDD and men.<sup>166</sup> One critic fears that because men also have hormones and may suffer from hormonal imbalances, men might invent a syndrome of their own to use as a defense or a mitigating factor in order to escape liability.<sup>167</sup> Although men could also suffer from hormonal imbalances, the possibility that men will invent some syndrome that does not exist and provide expert testimony that would meet current evidentiary standards for the admission of expert testimony is highly unlikely.<sup>168</sup>

#### B. *The Feminist Concerns*

Another common fear among critics is that the PMS defense would serve to undermine women's credibility and hinder the advancement of women in society.<sup>169</sup> Lawyers and feminists are concerned that the use of the PMS defense will lead society to label women as deficient and keep them out of high level positions.<sup>170</sup> Similarly, some fear that the

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<sup>161</sup> *Id.*

<sup>162</sup> WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., *CRIMINAL LAW* 24 (2d ed. 1986).

<sup>163</sup> *Id.* at 24.

<sup>164</sup> Chait, *supra* note 160, at 291.

<sup>165</sup> *Id.*

<sup>166</sup> Heggestad, *supra* note 147, at 162.

<sup>167</sup> *Id.*

<sup>168</sup> See *Daubert*, 509 U.S. at 579-80. However, if it is scientifically proven that men suffer from a similar syndrome, this Note does not seek to preclude its use as a mitigating factor.

<sup>169</sup> See Chait, *supra* note 160, at 271; see also Brozan, *supra* note 76, at C16.

<sup>170</sup> See Brozan, *supra* note 76, at 5; see Kasindorf, *supra* note 112, at 17; see Holtzman, *supra* note 103, at 715; Linda L. Castle, *PMS as a Defense in Criminal Cases*, 70 A.B.A. J. 211 (1984); Chait, *supra* note 160, at 271. See also Henig, *supra* note 2, at 68. The new recognition that PMS has its roots in hormones has led many feminists to fear the return of the old stereotype that women are inevitably incapacitated by a curse or taboo, the latter of which is derived from a Polynesian word which means menstruation. *Id.*

recognition of this defense would minimize the advancements that women have made over the years.<sup>171</sup> Furthermore, many critics fear that recognition of the PMS defense will stigmatize women as mentally and physically unstable, a stigma that men may use against women in divorce or custody proceedings.<sup>172</sup> However, the strategy of the defense lawyer may eliminate these concerns.<sup>173</sup>

Dispelling the myths about premenstrual women is necessary for this defense to gain credibility because judges and juries carry these myths with them into the courtroom.<sup>174</sup> To counteract the effects of these myths, defense attorneys may *voir dire* the potential jury members concerning their views on premenstrual women, and may submit pretrial briefs informing judges about this disorder.<sup>175</sup> Defense attorneys may also introduce testimony from sociobiological witnesses in order to separate myth from reality and have the defendants themselves testify that they normally are rational people.<sup>176</sup>

While the recognition of PMDD as a mitigating factor raises legitimate concerns, such recognition could also benefit women.<sup>177</sup> Many women who suffer from PMDD find their lives wrecked by this illness, feel that they are crazy, and feel that they cannot talk about their illness to others.<sup>178</sup> By not recognizing PMDD as a mitigating factor, the legal community denies the reality of the experiences of many women.<sup>179</sup> The legal community must constructively deal with this reality, rather than allowing fear of the problem to control them.<sup>180</sup> In addition, many of the

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<sup>171</sup> See Pahl-Smith, *supra* note 103, at 266. See Carney & Williams, *supra* note 89, at 268. Some feminists reason that throughout history, men have pointed to certain indisposing qualities of pregnancy, childbirth, and the menstrual cycle to support the view that they are superior to women. *Id.* These feminists fear that the recognition of the PMS defense would fuel these prejudices. *Id.*

<sup>172</sup> See Laura Beil, *PMS: Still a Mystery to Doctors, for All Its Infamy, Premenstrual Syndrome Remains Entangled in Misconceptions*, ORLANDO SENTINEL, Aug. 20, 1993, at E1. See Solomon, *supra* note 75, at 596-97. The PMDD classification and the use of the PMS defense could lead to the erosion of gender equality by reinforcing the myths that women are irrational, violent, and not responsible for about one week each month. *Id.*

<sup>173</sup> See Chait, *supra* note 160, at 291-93.

<sup>174</sup> *Id.* at 291.

<sup>175</sup> *Id.* at 292.

<sup>176</sup> *Id.* at 292-93.

<sup>177</sup> See Brozan, *supra* note 76, at 5. In the past, many women who suffered from PMS were misdiagnosed as neurotic. *Id.* If PMS is proven to be the result of hormonal or vitamin deficiencies, that would help women by proving that women who suffer from PMS are not neurotic. *Id.*

<sup>178</sup> *Id.* at 6. See *supra* notes 24-27 and accompanying text.

<sup>179</sup> *Id.*

<sup>180</sup> *Id.*

fears of feminists concerning the effects of the use of PMDD as a mitigating factor will be minimal, because those that qualify for this defense will be few in number.<sup>181</sup>

In light of the controlled circumstances in which this mitigating factor is available, the criticisms of PMDD are not valid. PMDD is a scientifically diagnosable disorder recognized by the APA; women who suffer from these severe symptoms have a legitimate and treatable illness.<sup>182</sup> The validity of the syndrome, in addition to the current standards for the admissibility of expert testimony, will calm many of these fears.<sup>183</sup> The next Section suggests a hypothetical situation where the use of PMDD as a mitigating factor may be useful, and a model sentencing guideline to address real situations.

## VI. PMDD AND A MODEL SENTENCING GUIDELINE

Recall Karen, the twenty-four year old woman who suffers from severe symptoms at the same time each month before the onset of menstruation.<sup>184</sup> A doctor has diagnosed Karen as suffering from PMDD, and plans to treat Karen with an anti-depressant. One day before she began receiving treatment, Karen experienced a marked increase in anger and felt on edge. While waiting at the doctor's office, she became extremely irritable and angry because the doctor was running behind schedule. When the doctor came out of his office, Karen pulled the gun out of her purse that she bought only for protection and shot the doctor, severely injuring him. A nurse called the police, and Karen was arrested.

At trial, Karen is convicted of aggravated assault. She has no criminal record. At the sentencing hearing, the defense attorney introduces expert testimony that his client suffers from PMDD. Similar to the judge in *Twelves*,<sup>185</sup> the judge would have the discretion to deviate from the sentencing guidelines and impose a lesser sentence if clear and convincing circumstances indicate that the guidelines should not apply. The judge could consider expert testimony that Karen suffers from PMDD and that she is willing to receive treatment, like the appellee in *Twelves*. The judge could then reduce the sentence from the guideline

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<sup>181</sup> See *supra* note 54 and accompanying text.

<sup>182</sup> See *supra* note 55 and accompanying text.

<sup>183</sup> See *supra* note 142 and accompanying text.

<sup>184</sup> See section I.

<sup>185</sup> See *supra* notes 128-32 and accompanying text.

minimum of eighteen months to four months. This scenario illustrates the integration of PMDD with sentencing guidelines.

This Section proposes a model sentencing guideline that is derived from the Federal Sentencing Guidelines.<sup>186</sup> After introducing the general principles of these guidelines, this Section proposes a model sentencing guideline for the crime of aggravated assault that states may implement to allow PMDD as a mitigating factor in sentencing.

The Federal Sentencing Guidelines assigns a base offense level to each crime that indicates a range of the minimum and maximum sentences permitted under the guidelines, with no consideration given to any other circumstances.<sup>187</sup> The judge often increases the base offense level because of aggravating factors and may reduce it for mitigating factors.<sup>188</sup> The judge may use the following mathematical formula: Base Offense Level + Aggravating Factors - Mitigating Factors = Offense Level.<sup>189</sup> Next, courts must determine under which category the offender's criminal history falls.<sup>190</sup> In order to determine the guideline range for sentencing, the court must use the sentencing table.<sup>191</sup>

The following is a model sentencing guideline for the offense of aggravated assault:

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<sup>186</sup> UNITED STATES SENTENCING COMMISSION, FEDERAL SENTENCING GUIDELINE MANUAL (1988). Presumably, most crimes where PMDD may be used as a mitigating factor will be used in state court. Because the criminal justice system is an administrative system, and must be administratively workable, state courts may look to the model of the Federal Sentencing Guidelines in order to implement PMDD as a mitigating factor in its own courts. See Stephen Breyer, *The Federal Sentencing Guidelines and the Key Compromises Upon Which They Rest*, 17 HOFSTRA L. REV. 1, 13 (1988).

<sup>187</sup> FEDERAL SENTENCING GUIDELINE MANUAL, *supra* note 186, at 18. The principal purpose of these guidelines is to establish sentencing practices and policies for the federal criminal justice system that will assure the ends of justice by setting forth detailed guidelines prescribing the appropriate sentences for federal criminal offenders. *Id.* at 1.

<sup>188</sup> *Id.* For example, the offense of aggravated assault has a base offense level of 15. *Id.* at 26. If the victim sustained permanent or life threatening bodily injury, then the base offense level is increased by six for an offense level of 21. *Id.* If the offender played a minimal role in the offense, then the base offense level would be reduced by four for an offense level of 11. *Id.* at 178.

<sup>189</sup> *Id.* at 1.

<sup>190</sup> *Id.* at 13. The criminal history category reflects the magnitude of the offender's past criminal conduct, which is a relevant factor in sentencing. *Id.* at 197. For example, a defendant who has no prior convictions would fall into category zero. *Id.* at 197.

<sup>191</sup> *Id.* at 13. The sentencing table consists of one column for criminal history and another column for offense level. *Id.* The sentencing range is the point at which these two numbers intersect. *Id.* For example, a defendant who committed a crime with an offense level of 15 and who has a criminal history category of 13 or more may be imprisoned for 41-51 months. *Id.* at 211.

§ 1A **Aggravated Assault**

(a) Base Offense Level: 15

(b) Specific Offense Characteristics

- (1) *If the defendant who committed the assault suffered from premenstrual dysphoric disorder (PMDD) at the time the offense was committed, decrease by 2 (two) levels.*
- (2) *If the defendant who suffers from PMDD will agree to treatment, decrease by 2 (two) levels.*

**Commentary**

1. *At the sentencing portion of the trial, the court shall permit the defendant to introduce expert testimony that she suffered from PMDD at the time of the offense, and that she will agree to treatment. In states that do not permit new evidence to be introduced at the sentencing phase the defendant must first introduce evidence of PMDD at trial.*

2. *The judge shall determine whether the evidence supports the conclusion that the defendant suffered from PMDD at the time of the offense through the guidelines established by the American Psychiatric Association concerning the proper diagnosis of PMDD. The judge shall not consider this testimony if the crime involved premeditation.*

**Background:** *Under § 5K2.0, the trial court may impose a sentence outside the range established by the actual guideline if it finds that a mitigating circumstance exists that was not adequately taken into consideration by the Sentencing Commission.<sup>192</sup> A woman who commits a spontaneous crime while suffering from PMDD represents such a case. Under § 3B1.2, the guidelines permit a downward adjustment for those defendants who played a minor or minimal role in the offense.<sup>193</sup> This provision is based on the notion that a minor or minimal participant is less culpable than one who played a major role in the offense.<sup>194</sup> A woman who suffers from PMDD at the time she committed a spontaneous crime is substantially less culpable than a woman who did not suffer from this disorder. A reduction of 2 (two) is chosen because, even though the woman may not be considered a minimal participant qualifying for a*

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<sup>192</sup> FEDERAL SENTENCING GUIDELINE MANUAL, *supra* note 186, at 245. The committee included this provision because circumstances that warrant departure from the guidelines cannot be comprehensively listed and analyzed in advance. *Id.* The decision whether and to what extent a departure should be made can only be determined by the court at the time of sentencing. *Id.*

<sup>193</sup> *Id.* at 178. If the defendant was a minimal participant in the criminal act, the base offense level is decreased by four. *Id.* If the defendant was a minor participant in the criminal act, the base offense level is decreased by two. *Id.*

<sup>194</sup> *Id.*

*reduction of 4 (four), she may be likened to a minor participant, who under the guidelines, may qualify for a reduction of 2 (two).<sup>195</sup> Likewise, a woman who agrees to treatment should qualify for a reduction of 2 (two) because she has accepted responsibility by agreeing that she has a problem and that she must be treated. This is based on the Sentencing Commission's notion that a defendant who clearly demonstrates a recognition and affirmative acceptance of personal responsibility for the offense of conviction should receive an offense level reduction of 2 (two).<sup>196</sup>*

Applying these guidelines to Karen's case, her offense would have a base offense level of 15 (fifteen). Because she has no prior convictions, her criminal history number would be 0 (zero). Therefore, the range would not change based on this factor. Assuming that experts convinced the judge that Karen suffered from PMDD at the time she committed the offense, and that she agrees to treatment, the new offense level would be 11 (eleven). According to the sentencing table, Karen's sentence may be reduced from a maximum of two years to a minimum of eight months. In a case such as this, Karen would still be punished for her wrongdoing. Because of her legitimate illness, Karen has less culpability, thus reducing her punishment for the criminal act. More importantly, she would also receive treatment.

## VII. CONCLUSION

Some women experience severe premenstrual symptoms that adversely affect their lives, causing some of these sufferers to act in ways that they do not at other times of the month. These severe symptoms may even lead these women to commit crimes. Some women have unsuccessfully tried to use their disorder as a defense in American criminal courts. American courts may be reluctant to accept severe PMS as a criminal defense because of its possibility of abuse, the uncertainty about the disorder in the medical community, and the possible harmful effects that its use may have on women. However, courts should recognize the existence of severe PMS, PMDD, as a mitigating factor in sentencing. By requiring sufficient expert testimony, courts may reduce the possibility of abuse. More lenient sentencing ensures not only that women are being punished for their crimes but also that they receive treatment for the disorder that plagues their lives. Thus, the state only

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<sup>195</sup> See FEDERAL SENTENCING GUIDELINE MANUAL, *supra* note 186, at 178.

<sup>196</sup> *Id.* at 195. If a defendant who accepts personal responsibility through a plea bargain, then evidence of PMDD may still be introduced at the sentencing phase.

**punishes these women in proportion to their culpability, taking their unique circumstances into consideration.**

**-Nicole R. Grose**