THE BODY AS EXCUSE

BIOLOGY, SEX AND CRIME: INTERSECTION OF SCIENCE, GENDER AND LAW

by

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Present Canadian legislation provides for only one gender-specific "defence" which appears in the Criminal Code as the crime of infanticide. English law recognizes severe Premenstrual Syndrome (PMS) as a mitigating factor in charges of murder. No common law country has yet accepted PMS as a full defence. Feminists have criticized this type of gender-based defence on the ground that (1) it relies on unsubstantiated theories of biological determinism and perpetuates the negative stereotyping of all women; and (2) legal recognition of conditions like PMS can be used as a sword against women.

This study tests the thesis that, unless law reformers deliberately take into account the nature and tenacity of sexual mythology, gender-specific additions to criminal defences will merely perpetuate gender bias and sexual inequality.

As preparation for legal analysis, a number of myths related to the female and male human bodies and to disease are compared and contrasted. This study examines the notion of woman as the victim of postpartum, premenstrual and menopausal "raging hormones" that force her into behaviour that is characterized as either criminal or sick. It compares her with the "ideal" man and with the man who deviates from this ideal for gender-specific reasons such as sexual impotence, abnormal chromosomes or pedophilia. Epilepsy, a disease common to both sexes, is used as a non-gender-specific comparison.
The medicalization of gender-specific disorders in both men and women are examined, taking into account the influence of "scientific" language formulated mainly by men. This is compared with equivalent histories of epilepsy and diabetes.

Criminological theories based solely on either biological or environmental factors are criticized, and the role of the "expert witness" is discussed. Cases that attempt to utilize biological defences are analyzed and law reform proposed.

There is strong evidence for the existence of biological conditions in both sexes that contribute to states of mind that should entitle the sufferer to legitimate defences. These should be incorporated within general defences rather than separate categories. However, until genuine disorders are separated from benign conditions experienced by most people, courts should exercise caution in implementing such defences.
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CHAPTER 1 - INTRODUCTION

"[T]o inquire about what may be, is the best way to inquire about what is." ¹

Imagine the following scenarios:

1. Maxine (30) has been arrested at the scene for the stabbing death of her live-in boyfriend. Two days later, while in custody, she starts to menstruate.

2. Gina (26) is under police guard in hospital after deliberately driving over a cliff. Her one-month-old daughter, her 18-month-old son and her husband have died in the crash.

3. Cheryl (15), whose parents are members of a strict fundamentalist sect, is undergoing psychiatric examination after delivering her baby in the bathroom and allowing him to drown in the toilet.

4. Haruko (49), a well-off married woman who does not work outside the home, has been charged with shoplifting after being caught leaving a store with a $10 scarf.

5. Stavros (35) is in custody after strangling a woman he picked up in a bar. He says he "blackened out" in a fit of rage when she taunted him about his impotence.

6. Mike (22) is under arrest after a brutal sexual assault on an eight year old boy. Scientific tests reveal that he carries the XYY chromosome and, two days after the crime, he had abnormally high testosterone levels.

7. Marie (37) has been charged with criminal negligence after severely injuring a pedestrian by driving over him. She says she remembers nothing about the incident because she had an epileptic seizure.

8. Kurt (28) is being questioned about his fatal stabbing of a co-worker. Like Marie, he says he can remember nothing because he was suffering from the effects of an excess of insulin that he has to take to control diabetes.

What should a prosecutor charge these people with and how should counsel defend them? Should either counsel rely on sex differences when making their decisions? I have deliberately minimized the facts at this stage in order to draw attention to this question of

sex. Patterns 1 to 4 deal with that rare phenomenon, female crime.\(^2\) Under present Canadian law, the prosecutor may charge Gina and Cheryl with the gender specific crime of infanticide, an alternative to a murder charge when a mother kills her newborn child while her mind is disturbed from the effects of childbirth or lactation.\(^3\) However, there is no similar section with respect to the deaths of Gina’s husband and son. The prosecutor may charge her with their murders.

Maxine may argue that she lacked the mental capacity to commit murder because she was suffering from premenstrual syndrome (PMS). Haruko may claim she was suffering from menopausal depression and resulting mental confusion. However, the prosecution could rebut this argument by introducing evidence that, even though Western women might have this disorder, Japanese women do not suffer from these symptoms.\(^4\)

Stavros may attempt to defend a murder charge by arguing that in his macho culture (Greek) potency is of such paramount importance to self esteem that the insults he received amounted to extreme provocation. Mike may invoke the human rights legislation to argue that it is discriminatory to have a sex specific crime like infanticide and no similar provision for men whose mental functions might be impaired by hormone imbalance or genetic factors.

Marie may decide to plead guilty because her lawyer has told her that, if she relies on her epilepsy for a defence she will be found not guilty but insane. Kurt’s lawyer says he may

\(^2\) I say "rare" because crime statistics continue to show that the vast majority of crimes are committed by men. Women commit only 10% of violent crimes (see infra).

\(^3\) Section 233 of the Criminal Code of Canada, R.S.C. 1985, c. C-46. (I will discuss this section in detail infra.)

\(^4\) I will discuss cultural differences in experience of premenstrual change and menopause in Chapter 4.
have a chance of acquittal if he relies on automatism because some courts have held that it is an external source (insulin) that is responsible for his blackout, not a disease of the mind that would attract a finding of insanity.

What would be a just outcome in each of these cases? Should defendants be allowed to rely on gender-based defences? Are such defences in keeping with the objectives of the feminist movement which, in the long term, seeks an end to patriarchy and, in the short term, an end to the negative stereotyping of women which has contributed to their subordination? This study will attempt to answer these questions. Its main focus will be on issues pertaining to women. However, for comparison, I will also discuss issues that are, as far as possible, peculiar to men. As a non-gendered control subject I will deal with the topics of epilepsy and, to a lesser degree, diabetes since both of these conditions have been the subject of criminal defences.5

First of all I will look at the power of gender-based myths and stereotypes to influence conscious and unconscious attitudes towards the actions of women and men. In particular, I will discuss the type of stereotyping that characterizes certain behavioural patterns as symptoms of disease; for example, cyclical mood changes in women. In the case of epilepsy I will show how ancient myths about that disease still affect opinions about sufferers of the disorder - both in the community at large, in the doctor's office and in the courts.6

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5 I have become more and more conscious while researching this study of the impossibility of finding a completely gender-neutral topic. For example, some medical research has noted the phenomena of premenstrual seizures and epileptic and diabetic impotence. However, the law has not, overtly at least, recognized gender differences when the accused has relied solely on the mental effects of epilepsy and diabetes.

6 Diabetes, which was fatal physical disease until the discovery of insulin in the 1920s, seems to be free of ancient myth and superstition.
Next I will discuss the general process of medicalization of certain behaviour that Canadian society considers to be deviant, and then the specific medicalization of various signs presented by men and women. Before doing this, however, I will demonstrate how the absence of a female voice in medical science has allowed the language of scientific research to become imbued with male values; for example, the myth of the "passive" egg and the "active" sperm as extensions of the myth of the "passive" female and the "active" male. The power of this "masculine" language is at the heart of this study because law relies so heavily on words, both written and spoken. When dealing with defences pertaining to the human body the law not only relies on its own language but on the language of science as expressed by expert witnesses. Thus one form of stereotyping reinforces another.

After comparing the medicalization of certain women's and men's concerns and the nature of the medicalization of epilepsy, I will concentrate upon medical and psychological explanations for the incidence of crime, especially violent crime: for instance, the idea that some women are violent because of periodic deficiency in progesterone; or that some men are violent because of high testosterone levels; or that people with epilepsy are violent because of chemical imbalance in the temporal lobe of the brain.

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7 I use the word "sign" to denote physical and mental changes experienced by everyone, both women and men, well and sick. The word "symptom" has a more negative connotation as it is usually used in connection with illness.

8 I call this language "masculine" because it is the language of patriarchy. Until recently, women's voices have been effectively silenced. Even if the voices of women had power when they were alive, they are either unremembered by historians or have been translated by male memory. I believe that, in our society, women have no language that is peculiarly theirs. They have had to use the words of the vocal majority, so that those historical works by women that have managed to survive have been forced to use this masculine language. By this I do not merely mean words like "chairman," "mankind" or "manhole cover" but the whole formulation of concepts, conversation and other communication between human beings.
Armed with the information gathered from several disciples, I will discuss what happens in court when defences such as PMS and postpartum psychosis are raised. Finally, I will examine feminist concerns about the use of gender based defences, will reach some conclusions about the reality of the dangers inherent in such defences, and will present some suggestions for future changes in the law.

A moment ago I asked what would be a just result in the cases illustrated above. This depends on the definition of justice. Criminal law and feminism may not necessarily have the same understanding of this concept, since criminal law is the product of a hierarchical system and feminism seeks to defeat patriarchal hierarchy. I believe that "justice" should be defined in concrete practical terms that relate to the lives of real people and real societies, not in abstract theoretical terms that might be applicable in some utopia. But if we stick solely to "what is" without considering what "should be," we may be restricted to the alleviation of symptoms instead of removing the cause of society's sickness. To analogize with medicine: when we treat symptoms without knowledge of etiology, the side effects of the treatment often create unforeseen new diseases. The treatment then becomes the disease. Once we

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9 I use the term "justice" in a wide sense that incorporates the concept of "care." I am unwilling to share the view of some modern writers that justice and care must be separate concepts. For example, see Annette C. Baier, "The Need for More than Justice," in Marshe Hanen & Kai Nielsen, eds., Science, Morality & Feminist Theory (Calgary, Alberta: University of Calgary Press, 1987) at 41. (This book is also cited as Supplementary Volume 13, Canadian Journal of Philosophy.) Baier, at 47, describes the "Kantian version of a society with its first virtue justice, construed as respect for equal rights ..." As she (and Carol Gilligan whom she cites) correctly observe, this definition of justice does not provide for emotional needs for attachment and interrelationships among human beings. It does not incorporate the idea of care. I would argue that there can be no justice without care. It is the definition that is wrong, not the overall concept of justice. For more discussion on this topic see Kathleen Daly, "Feminist Questions About Justice" (1989) 17 International Journal of Sociology of Law 1.
identify etiology we may find that radical surgery or genetic engineering is necessary to effect a permanent cure. ¹⁰

In women’s experience, many apparent gains won at great cost within the legal system result in overbalancing deficits in other areas of their lives. For example, movement towards equal opportunity in the work place has not relieved the majority of women from the burden of most parenting and domestic chores. "Proper" roles for women may have expanded but there has been little corresponding practical expansion in "proper" roles for men. When there has been such expansion, this too has worked to women’s disadvantage, especially when formulated in "rights" language. This grants men the right in principle to expand their traditional roles without expanding the practical obligations that should accompany these rights. In present society acquisition of a theoretical right does not necessarily lead to male participation in traditionally female chores.

The male backlash against women’s claims to equal treatment has resulted in loss of child custody for many women.¹¹ The arguments are not framed in language that makes a privilege of child care and domestic chores. There is little indication that the majority of men wish to do housework in the same way that many women wish to do paid work. Within patriarchy, many men seek to encroach upon women’s rights without sacrificing their images

¹⁰ Although I realise that the term "genetic engineering" might belong to a masculine metaphor and should be avoided.

¹¹ For example, see Susan Boyd, "Child Custody, Ideologies and Employment" (1989) 3 Can. J. Women Law 111.
as "real" men. As one male writer put it: "For there to be true equality the core of
[man's] being must love justice more than manhood."  

For justice to be done, men and women must have equal access to a legal system that is free from gender bias. Equality should not be equated with sameness; those who strive for gender equality must take into account existing gender differences, some of which may be due to inherent traits, peculiar to one sex or the other, and others that may be externally acquired products of a male-dominated system. Feminist writers have observed in a variety of contexts that gender equality does not necessarily result from identical treatment of men and women. The Supreme Court of Canada recognized this in R. v. Lavallee when it extended the concept of self-defence to a homicide committed by a woman suffering from the "battered wife syndrome." I should, however, acknowledge that the principles applied in Lavallee could well be adapted for the defence of a man in a similar situation; for example, a son whose father has abused him over a number of years. This points out the danger of creating a defence deliberately designed to be exclusive to one sex. Such a defence would preclude adaptation to include analogous fact patterns applicable to the other sex and would run the risk of denying equality before and under the law.

There are problems in distinguishing between inherent and culturally-acquired differences. A search for the former may lead down the unreliable path to biological determinism; a search for the latter is complicated by the multiplicity of factors that

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12 See infra, Chapter 2, on male stereotyping.


contribute to culture. Such a dualistic approach may fail to allow for the fact that the very
definition of "inherent" is likely the product of thought patterns that result from social and
cultural bias. Heisenberg's Uncertainty Principle\textsuperscript{15} which explains the effect of the observer
upon the observed, applies to observation of human behaviour as much as it does to physics.

Thought patterns are expressed and communicated by language. Language incorporates
bias and perpetuates myths and stereotypes.

Although the words we use may only represent linguistic conventions, in terms of
relationship they serve to reinforce behavioral stereotypes...\textsuperscript{[L]inguistic customs
powerfully reinforce the polarity between masculine and feminine, thus strengthening
sex-typed behavior [and thought.]}\textsuperscript{16}

Words are mere symbols of reality, and therefore reflect only the reality of the particular
speaker who uses them. However, words also \textit{construct} their own reality and, when a
dominant sex or class controls the meaning and use of words, subordinate sex or classes must
conform their lives to a system based on distortion of truth. Language in a patriarchal society
is mainly the product of male thought.

Control of the formulation and use of language may be partially responsible for the
tenacity of patriarchy and the disempowerment of women. Language is a major tool for the
maintenance of dominance since it defines what is normal and what is abnormal, sometimes
in social conversation and sometimes in formal written laws. In this sense normal is equated
with good and abnormal with bad. Language assists males in controlling the world view. It is
much more efficient than naked physical aggression, as it solicits willing recruits among

\textsuperscript{15} For a good non-mathematical explanation of this principle, see Stephen W. Hawking, \textit{A
Brief History of Time} (Bantam Books, 1988), Chapter 4.

\textsuperscript{16} Loren E. Pedersen, \textit{Dark Hearts: The Unconscious Forces that Shape Men's Lives} (Boston
women who subscribe to the myth of inferiority because of life-long cultural or religious indoctrination.

Those who dominate seldom see the need for change. Secure domination produces an "I'm alright, Jack" mentality and maintenance of the status quo. It is only in times of threat that those in power are forced into self-examination. Thus men react to changes in female gender roles rather than initiate changes in male roles. Michael Kimmel describes the situation as follows:

Men, as a group, have historically exhibited a smug satisfaction with existing gender relations. In fact, ... men have, as a group, benefited from the sex-role paradigm that has governed behavioral science’s treatment of gender, as it uses masculinity as the normative standard of reference and maximizes the distance between the two genders while minimizing the extent to which these definitions reproduce existing power relations, vary historically and therefore are open to challenge.17

Kimmel18 has drawn parallels between male response to feminism in the nineteenth with those in the twentieth century. He notes that men: 1) either retreat into traditional male roles (antifeminism); 2) vigorously assert a renewed masculinity (pro-male); or 3) support feminist objectives in the belief that they are beneficial to both women and men (pro-feminist).19 He advocates the promotion of men’s studies along the lines of present women’s studies.

Before researching and writing about gender-based defences it would be helpful to understand fully the current meaning of gender itself as well as the myths and stereotypes that


19 Ibid.
surround this value-laden word. However, the field of gender theory is too broad to encompass in its entirety in a study whose principal focus is the determination of a specific legal question. Conversely, a researcher who concentrates solely on the discipline of law will inevitably retrace the well-worn path of traditional legal thinking - a path created and maintained by centuries of patriarchy. Therefore, in preparation for an analysis of gender-based criminal defences, the first chapters of this study will draw from several disciplines, including biology, psychology, sociology and anthropology, for information and opinion about gender-based myths and stereotypes. The main focus will be on stereotypes associated with the body.

To avoid the traps of unconscious cultural bias, I will make use of some of the deconstructionist tools of Postmodernism. Hare-Mustin and Marecek outline the basis of this

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20 In dealing with questions of sex and gender it is very easy to confuse the two. I have found the following helpful in separating various related concepts.

An individual's *sexual identity* has the following distinct components: *biological sex* (whether one is male or female at birth); *gender identity* (one’s basic conviction of being male or female); *social sex role* (extent of conformity to physical and psychological characteristics culturally associated with males and females); and *sexual orientation*, which includes *sexual behavior* (patterns of erotic body contact with others), patterns of *interpersonal affection* (associations involving various degrees of trust such as with friends, lovers, and marital partners), *erotic fantasy structure* (sexually arousing patterns of mental images of one or more persons engaged in physical sexual activity or in affectional relationships), and *arousal cue-response patterns* (sensory cues which stimulate or inhibit erotic arousal).

approach in their reply to criticisms of an earlier (1988) paper, "The meaning of difference: Gender theory, postmodernism, and psychology." 21 They point out that "[d]isciplines often put boundaries around knowledge; that is, they "discipline" thought. Breaking down these boundaries is an important aspect of interdisciplinary work.22

Practitioners of disciplines such as medicine and law are particularly prone to remain trapped within what they define as their own, and often exclusive, jurisdiction. The danger of this type of blinkered thought increases when medicine and law attempt to communicate with each other; for instance, through expert testimony in court. The meaning of a term in law is not necessarily the same in medicine. This problem may not be so great when each side recognizes that it has interpretation differences. However, when both sides assume they are speaking the same language, misunderstanding and distortion of "facts" may well result.

A researcher who remains confined within the boundaries of law or medicine runs the risk of confusing what are really assumptions with given "truth." "[P]aradoxes in the current constructions of [law, medicine and] gender impel us to go beyond [traditional] constructions." 23 Before recommending a new law, it is necessary to deconstruct existing law. Since postmodern theory dictates that there can be no "right" view, the ultimate objective must be to reach a solution that is "just" for both men and women. This may well beg the question, since it forces a return to the question: "What is justice?" - the meaning of

21 Rachel Hare-Mustin & Jeanne Marek, "Thinking About Postmodernism and Gender Theory" (1989) 44(10) American Psychologist 1333, replying to criticisms of article in 43 American Psychologist 455.

22 Ibid at 1334.

23 Ibid at 1333.
which, in turn, depends upon the biased perspectives of those who deliver and those who receive the products of the legal system.

In this study, I will use as a guideline the broad definition of deconstruction formulated by Hare-Mustin and Marecek:

Deconstruction is a project of demystification that makes visible what is required to maintain hierarchy and opposition.\(^{24}\)

Feminist deconstruction concentrates, naturally, on issues of particular interest to women. Feminists pay little attention to issues that are usually perceived to be of special concern to men. The reason may be that, in women’s eyes, these concerns are minor compared to the ongoing subordination of women which creates concrete disadvantage to women in all areas of life. But "to pretend that men’s pain is irrelevant to women is understandable, but unwise. It will not result in equality, much less in intimacy."\(^{25}\) Some men’s issues should be of interest to women. Not only do their effects impinge on women but they are also a product of patriarchy. It is impossible to understand fully the meaning of "feminine" without studying the meaning of "masculine."

Masculinity and femininity are relational constructs; the definition of either depends upon the definition of the other. Although "male" and "female" may have some universal characteristics (and even here the research on biological dimorphism suggests a certain fluidity), one cannot understand the social construction of either masculinity or femininity without reference to the other.

Further, the sex-role paradigm is based upon the traits associated with the role... rather than their enactments... In addition, the sex-role paradigm minimizes the extent to which gender relations are based on power. Not only do men as a group exert power over women as a group, but the historically

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\(^{24}\) Ibid.

derived definitions of masculinity and femininity reproduce these power relations... by undervaluing the historical and social bases for gender relations, then, the sex-role paradigm reproduces the very problems it seeks to understand. 26

A central topic of this study will be the contribution of myth and stereotype to the idea of criminal defences that are, or would be, exclusively open to women; that is, defences based upon changes to a woman's mental and physical state apparently caused by childbirth, menstruation and menopause. In an attempt to achieve greater balance I will examine what I have identified as the closest male equivalents to female problems related to reproductive and sexual functions; namely, impotence and pedophilia. 27 I will also refer to male problems associated with chromosomal abnormalities. For comparison I will conclude by studying mythology and "facts" surrounding an apparently gender-neutral topic, epilepsy. Both epilepsy and sexual dysfunction have been relevant in law: the former in the area of mental competence and capacity, especially with respect to driving offenses and crimes of violence; the latter in the area of marriage law and, indirectly, criminal law.

Critics may ask why, in an attempt to answer questions pertaining to criminal law, I spend time on impotence when I have been unable to identify any recognizable body of

26 Kimmel, supra note 17 at 520-521.

27 Although child sexual abuse, and particularly pedophilia, need not be gender specific, criminal offenders tend to be overwhelmingly male. Pedophilia, in medical literature, is viewed as an exclusively male disorder. I might also have chosen "homosexual panic" disorder as it has been the source of a legal defence in the U.S. According to psychiatrists and psychologists who have testified for the defence in murder trials, this disorder manifests itself in latent homosexuals who react with uncontrollable insane violence to sexual advances by overt homosexuals. There are obvious similarities to the PMS defence and I will refer to them where especially relevant. However, the topic of mythology and stereotyping of homosexuals is too large to include in a study whose principal focus is on concerns of women.
criminal law that deals with this topic. How can I create balance in a chapter about criminal defences when impotence almost never surfaces as a defence issue? Would it not be easier to concentrate exclusively on male sexual deviance, a subject well researched and reported by biomedical, psychological and criminological authorities?

Having progressed through myths of medicalization of the male body, must I abandon the topic at the focal point of the study? On reflection, I believe that the answer is "no." I believe that these critics fall into the trap I have described above; that is, confinement by artificially created categories and compartments created by the legal system. Just as it is necessary to consider the impact of disciplines outside law, it is also necessary to cross over boundaries set within law. Surely it is just as impossible to deconstruct criminal defences without some reference to other legal categories as it is to deconstruct law as a whole without reference to other disciplines. Even if impotence plays no direct part in formal criminal laws, it is an issue that is central to male sexuality and, therefore, to all laws formulated by "male supremacists."

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28 Since sexual potency is such a vital component of masculinity as presently defined, is there any significance in the fact that men who deviate from the potency norm seldom expressly appear in criminal case law? Since stereotypical images of men and women are active and passive respectively, perhaps it should not be surprising that, in criminal law, male sexuality is more connected with perpetration of crimes of aggression (rape, physical abuse, etc.) than with elements of criminal defences. Male sexuality contributes to commission of crime (active); female sexuality contributes to defence against conviction (passive).

29 Stoltenberg, supra note 13, equates patriarchy with male supremacy just as apartheid might be equated with white supremacy. Negative connotations associated with the use of such terminology are useful if they bring home to the reader the accuracy of such an analogy. Male supremacists are not all men. Many women support the existing system, just as many black Africans in privileged positions may support the maintenance of apartheid. In drawing this analogy, I am focusing on only one characteristic that is common to both race and gender; the exercise of power and control by one group of people over another. However, I do so with an awareness of the danger of oversimplified comparisons between these two complex issues.
Concentration solely on formal expressions of criminal law excludes examination of elements of human conduct that, while classified under another legal category, may be relevant to an analysis of criminal law. I believe that male sexuality and the myths and stereotypes surrounding it are important driving forces in patriarchy, and thus in criminal law. Stoltenberg has observed that the law and the phallus are both primary instruments of owning. We must understand the symbolism of the phallus - its meaning to men - in order to understand the basis of all law. Thus male sexuality and perceived defects in sexuality are relevant to the definition, analysis, and creation of any law that affects women. Since patriarchy defines appropriate female gender roles by reference to and contrast with appropriate male gender roles, the preceding argument is especially relevant to laws based on female gender.

However, I will also refer, with some caution, to male sexual deviance. Caution is necessary in order to avoid direct comparison between "normal" women and "abnormal" men, and to avoid the error that feminists accuse male writers of committing with respect to women; that is, characterizing a whole sex as deviant or sick. However, there are several striking parallels between, for example, PMS and pedophilia. Reaction to both is based, to a large extent, on unconscious mythological perceptions of gender and normality. Both have been, or are in the process of being, medicalized so that a perpetrator who comes under the medical definition may now be "ill" rather than "criminal." Researchers in endocrinology have attempted to fit both into a biochemical model which makes hormones responsible for deviant behaviour. At the same time, researchers in other disciplines have attempted to identify psychological, social and environmental causes. Despite extensive work, the etiologies of both are still unknown; a cure for both remains elusive.
In both cases the law must grapple with the results, or lack of them, of this research. It must decide whether women should be entitled to a defence based on gender differences. It must decide whether changes in the laws of evidence are necessary to take into account the newly perceived reality of child abuse; changes that might seriously impinge upon the rights of an accused to a full defence.

In the next chapter I will discuss the stereotyping of women and men through characterizing various differences as "disease." PMS is part of a continuation of a centuries old pattern of deeming all women to be aberrant in some way or another. In the case of men, recent focus by researchers and the media on male violence and sexual deviance is creating a new phenomenon - the implication in the minds of many that all men are potential sex offenders. The law must take into account these old and new stereotypes. It must be conscious of the extent to which it perpetuates or is driven by them.
CHAPTER 2 - MYTHS AND STEREOTYPES
TRAITS AND BEHAVIOUR AS DISEASE

I. INTRODUCTION - THE POWER OF GENDER-BASED MYTH AND STEREOTYPES

Unexamined myths, wherever they survive, have a subterranean potency; they affect our thinking in ways we are not aware of, and to the extent that we lack awareness, our capacity to resist their influence is undermined. 

It may seem trite to say that, although biologists classify men and women as animals, the possession of a brain cortex has led to more than mere physical differences between homo sapiens and what evolutionists and many religionists term "lower" animals. However, this obvious fact is one that much biologically based research overlooks. Those who confine their studies to physical "abnormalities," - hormone changes and the like - often ignore or make only passing reference to psychological or societal influences. Thus they extrapolate, with few qualifications, results of animal studies to human beings.

The human cortex has somehow led to the development of language and the ability to share and store vast amounts of information. The advent of the computer has dramatically increased this ability. But, as pointed out in Chapter 1, the bulk of this information has been controlled and stored by men. Information gathered by women has rarely filtered through to society at large unless it has been approved or assimilated by men as their own. Even when it does, it is often the information of women who do not realise they are using "masculine" language.

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30 Evelyn Fox Keller, Reflections on Gender and Science (New Haven and London: Yale University Press, 1985) at 76.
As Gray L. Dorsey observes, culture, not natural processes, organizes and regulates society. Unlike most other animal species, other than their hands, humans have no built-in tools or weapons, such as claws or stings, for adaptation or specialization. The predominant control of sexual behaviour is not seasonally determined by nature for breeding purposes. Instead, human conduct largely depends upon the implementation of shared ideas and beliefs. Dorsey argues that these ideas must meet two criteria: "they must hold the promise of facilitating satisfaction of perceived needs, and they must be consistent with the current understanding of reality." The negative side of this argument is his acknowledgement that ideas which meet these two criteria and which pervasively seep into the consciousness of a people become basic beliefs in that they constitute the reality that must be reckoned with, like it or not.

Dorsey confines his attention to human consciousness. Scholars from such fields as psychoanalysis and psychology would argue that the more dangerous ideas are those that remain imbedded in the individual and collective unconscious. The outward stories and legends of


32 These ideas run counter to the Freudian maxim: "anatomy is destiny." This neat, easily remembered phrase, still holds sway with many researchers of human sexuality despite the obvious cultural overlay of gender.

33 Dorsey, supra note 31 at 5.

34 Ibid.

35 See, for example, Pedersen, supra note 16, who believes that much of the negative impact of male behaviour is due to unconscious suppression of the *anima*, the feminine side of the male psyche. He states at 22:

In trying to understand some of the deeper aspects of a man's relationship to women we need to understand that his conscious ideas of women represent only one facet of what he experiences with actual women... Whether or not a man is conscious of it, the inner struggle with the masculine/feminine polarity is one of
myth are present in the consciousness of a people but the reality or mindset that they represent comes from the collective unconscious. The mythical tales of Pandora and Eve tell the conscious mind that the curiosity of these women introduced evil into the world. Hidden in the unconscious is the misogynous belief that all women, by their beguiling sexuality, are instruments of the devil designed to transform male order and virility to female chaos and emasculation. According to a number of writers, these myths are products of male fears of women, products born during the ancient transition from matriarchal to patriarchal culture and maintained by distorting matriarchal reality.36

Myths are a vehicle for the projection of stereotypes. Anita Cava, in a recent paper which explores the concept of stereotyping and its application in a court setting, quotes the following two definitions of "stereotype"; the first from Webster’s dictionary and the second from A

*Comprehensive Dictionary of Psychological and Psychoanalytic Terms.* 37

1. [A]n unvarying form or pattern, fixed or conventional expression, notion, character, mental pattern, etc. having no individuality, as though cast from a mold.

36 See, for example, Jamake Highwater in *Myth & Sexuality* (Markham, Ont: New American Library, Penguin Books Canada Ltd., 1990) in his chapter "the Body as Man"; Joseph Campbell in *The Masks of God: Vol. III, Occidental Mythology* (New York: Viking Press, 1964) who believed that patriarchal myths represent an attempt to deny the essentially matriarchal character of men and women; J.C. Smith, *The Neurotic Foundation of Social Order* (New York & London: New York University Press, 1990) who believes that patriarchy rests on misogyny which is a "necessary condition for the creation and maintenance of masculinity as we know it." Again, misogyny originates in male fear of emasculation by and fear of dependency on women. (For example, the Delilah myth).

2. A relatively rigid and oversimplified or biased perception or conception of an aspect of reality, especially of persons or social groups, e.g., the perception of "bankers" - in general and without discrimination - as invariably cold-hearted in business dealings.

It is possible to view stereotyping as a neutral form of generalizing, a way of making thought more manageable and decision-making more efficient. However, the second definition indicates an element of bias or prejudice in the formulation of stereotypes. It is in this second sense that I will be using the word. In particular, I would adopt the following: "Sex-role stereotypes do not describe how women and men actually differ, but how society thinks they do."\(^{38}\)

Social orders presume or rest on mythic structures from which the belief in the legitimacy of that order is derived. Therefore, the relationship between social order and myth is fundamental to the understanding of culture and human behaviour... To the extent that the mythic structure is woven into the cultural fabric, it becomes a part of the cultural heritage of each person born into that culture.\(^{39}\)

Highwater stresses the importance and pervasiveness of myth as follows:

Myth, in its deep structure as well as in its superficial content, is about this compound relation between body/mind and word/world. [Myth] penetrates ... *everything* we do, all the sense we make - even in the most narrowly specialized branch[es] of science [and law].\(^{40}\)

Descartes is famous for his saying: "I think, therefore I am." But, if our reality is shaped by our cultural mythic structures which, in turn are shaped by our collective unconscious, our


\(^{39}\) J.C. Smith, supra note 36 at 51.

\(^{40}\) Highwater, supra note 36 at 13 citing David Maclagan *Creation Myths* (London: Thames and Hudson, 1977)
unconsidered thinking does little to tell us who we are or why we are trapped in a society that is unable to control violence, much of which is perpetrated by men and directed at women.

Unless we are able to recognize and combat the bias created in all of us by the power of myth and stereotypes, any changes we propose to make to rules of law will be straight-jacketed by hierarchical thinking. Any theories we formulate will fail to identify or address the real causes of crime. Criminologists write about criminal "deviance." But deviance presupposes a standard of normality. In present society patriarchy defines normality and since women are measured against the standard of the normal male, woman can be nothing but abnormal. To most women this is a ludicrously illogical proposition.

If myth is so deeply imbedded in our collective psyches, how can we change our world view in order to assess the effects of patriarchal ideology on the reasoning behind criminal law. Must we wait for the proverbial "paradigmatic shift" or, by analysis and debate can we cause such a shift by the weight of our opinion. J.C. Smith argues that we cannot cure the ills of patriarchy unless we kill patriarchy itself; we must consciously choose to adopt a matriarchal mythic system. But first we must be able to identify the disease. Smith suggests that

[w]e can use mythic analysis as a method for deconstructing history, culture, and the belief systems and institutions which give history and culture their particular forms. The purpose of such deconstruction is to strip away illusion and come close to reality. Theories about myth, and the forms of analysis which can be developed from such theories, can furnish us with powerful tools to deepen our understanding of the human condition.41

Gender-based myths and beliefs about demonic possession are especially powerful. Changes in other mythic systems, for example, from imperialism to Marxism, have failed to

41 Supra note 36, at 69.
stamp out misogyny. Changes in medical knowledge about epilepsy have failed to stamp out prejudicial notions about insane possession.

The rest of this chapter will discuss common myths and stereotypes about women, men, and victims of epilepsy. It will pay particular attention to "diseases" of women and men that are most closely identified with biological and gender roles.

II. WOMEN

A. MYTHIC DEFINITIONS AND DESCRIPTIONS OF "NORMAL" WOMAN

There is no rational basis for the myth of male superiority which underlies the world's present cultural and social systems. Although numerous writers and scholars have recognized that patriarchy is unnatural, even pathological 42, it still continues to rule the way most world societies live their lives. The creation of gender and sexual stereotypes are necessary for the maintenance of male dominance; and, since patriarchy has its roots firmly planted in misogyny, female stereotypes are expressions of male fears, prejudices and other negative attitudes about women. Even those stereotypes that may appear to be "positive" - such as motherhood and nurturing myths - place women in a position of inferiority.

Control of media of communication is essential for the perpetuation of any system. Women have had little input into definition and characterization of any human concepts, let alone

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42. For example, see Marilyn French in Beyond Power: On Women, Men, and Morals (New York: Ballentine Books, 1985) at 97: "Because patriarchy is at bottom unnatural, it cannot survive without tradition and institutionalization"; and J.C. Smith, supra note 36, who states that male dominance persists because male pathology and neuroses are more powerful than female neuroses.
those pertaining to themselves. Men, via philosophers, the church, sexologists and, in modern times, physicians and psychiatrists, have interpreted women for society, regardless of women’s reality. Simone de Beauvoir recognized this in 1952 when she wrote:

Representation of the world, like the world itself, is the work of men; they describe it from their own point of view, which they confuse with the absolute truth.43

At various times throughout history women have been called, irrational, evil, impure, weak, inferior ... ad infinitum.44

Plato associated femininity with irrationality, chaos and the physical body, whereas he associated masculinity with reason, order and pure mind. The myths of Pandora and Eve pinpointed women as the source of evil in the world. Freud, by assuming that the male is the norm, inferred that women are abnormal. "Benign" myths converted "good" women into Madonnas. Thus the idea of the maternal "instinct" ensured that women would be content to stay at home to rear children (or be plagued with guilt were they not so content).


44 The following examples illustrate some of these attitudes:

- We should look upon the female state as being as it were a deformity, though one which occurs in the ordinary course of nature. (Aristotle)

- The woman in us still prosecutes a deceit like that begun in the Garden; and our misunderstandings are wedded to an Eve, as fatal as the Mother of our Miseries. (Joseph Glanvill, 1661)

- Woman represents a state of arrested development, approximating the primitive. (Patrick, 1895)

These examples might be brushed off as mere anachronisms were it not for the legacy they have left modern women. Despite surveys that prove the opposite, men - and many women - believe that women as a group, for biological reasons, are unable to think logically, and are designed by nature for the purpose of nurturing men and children.

B. MYTHS ASSOCIATED WITH WOMEN'S REPRODUCTIVE FUNCTIONS

Two myths are at war in the stereotyping of women's reproductive functions: (1) the myth that women are essentially evil and weak and must therefore suffer the consequences of this "natural" state by submitting to the male will; and (2) the myth that woman the mother is sacred and that any deviance from "natural" maternal behaviour (as defined by men) must be inherently abnormal or sick.

Menstruation has long been considered an outward sign of female inferiority. Hippocrates believed that menstrual blood was toxic because of the essential evil of women, while Galen, in the second century A.D., thought that it was the discharge of humours "heaped up" within the body due to "living continuously at home, and not being used to hard labour." Thus traditional upper and middle class men forced their women to stay at home and then blamed their "idleness" for the existence of menstruation. It is easy to see the progression from Galen's belief that the body reacts in weakness because of women's inactivity to the idea that women must remain inactive because they are weak.  

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46 Of course, poor working women did not have the luxury of remaining inactive. Most of the advice and commands about resting and participating in only gentle pursuits was given to upper and middle class women who, presumably, had enough money to call in a doctor for less than life-threatening events. This was particularly true in Victorian times. For further reference
Judeo-Christian theology equated woman's body with sin. As punishment for the fall of Eve, women had to "bring forth in pain." This led some believers to frown on any efforts to alleviate the pain of childbirth as being interference with God's will. Menstruation was viewed as a "sickness" and a "time of uncleanness" and men were forbidden to "come near to a woman in her impurity." 47

This latter belief is common in most societies today and has led to many customs based on sexual taboos, from prohibition of hair washing to segregation of women in menstrual huts to avoid contaminating men. Karen Erikson observes that

these rituals are implicit mechanisms by which political claims over women and other men may be demonstrated. Menstrual segregation and the pollution beliefs they express are interpreted as demonstrations of "ritual disinterest" in a man's most valuable asset - a woman's demonstrated ability to continue reproducing offspring which will add to his own prestige, wealth, and power.48

These ideas are not relics of the past. A recent survey of menstrual beliefs and practices found that in third world countries at least one third of all women believed menstruation to be "dirty" in the sense of "sexual pollution." This concept "implies that male contact with women's sexual organs will lead to grave physical danger, moral contamination, and supernatural

to class differences in medicalization, see Chapter 3.


sanctions. Almost all third world women agreed that sexual intercourse should be avoided during menstruation; the equivalent figure for the U.K. and U.S. was 50%. Similar taboos apply to post partum bleeding.

Surveys conducted in the U.S. in the 1970s and 1980s have shown that 89% of men and 66% of women believe that menstruating women do not perform well at work, and almost everyone of both sexes believes that women are more emotional during menstruation. ("Emotional" having a negative connotation.) 39% of men and 25% of women agreed that menstruation affects a woman's ability to think despite the lack of any scientific basis for this opinion. Negative beliefs and adherence to taboos were greater in those who believed most strongly in the "traditional" family and who attended fundamentalist churches - both bastions of patriarchy.

C. MYTHS ASSOCIATED WITH "ABNORMAL" "DISEASED" WOMEN

Maternal myths have been used to keep women in their "proper place" - the home. "It is a cast iron guarantee that the more motherhood is idealized, the more women are enslaved by

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49 Ibid., Ginsberg at 176. These myths may have been originated by men out of fear of women's differences or out of a desire to keep women separate and inferior. On the other hand, they may equally have been originated by women to provide a temporary escape from non-voluntary intercourse or a respite from their role as caregivers.

50 For a study of cognitive and psychophysiological responses during the paramenstruum, see Barbara Sommer, "How Does Menstruation Affect Cognitive Competence and Psychophysiological Response?" (1983) 8 Women & Health 53.

51 Ginsberg, supra note 48 at 176-177. A 1983 study concluded that wives had three reasons for adhering to traditional menstrual sex taboos: (1) their motherhood status; (2) their own beliefs in the importance of patriarchal families and sexual chastity for women; and (3) their husband's belief in patriarchal familism. On the other hand, their wife's beliefs were not a factor in determining husbands' adherence to taboos. The strength of their own belief in patriarchal familism and their social class background were the most important factors for men.
The belief in a biologically determined maternal instinct persists despite evidence of infanticide, abandonment and child abuse perpetrated by mothers. Therefore, instead of considering that social and environmental factors may be in part to blame for these actions, adherents to the maternal myth look for faults within the woman such as mental or physical illness. Earlier societies may have been closer to reality when they gave tacit recognition to the economic and social plight of single mothers. Constance Backhouse, in a study of infanticide in nineteenth century Canada, observes that "male judges and male jurors exhibited remarkable lenience when faced with women who were accused of infanticide." Most were acquitted despite overwhelming evidence of guilt. This was due in part to the lack of value placed at that time on newborn children (especially bastards) and in part to the recognition that it would be impossible for single mothers (and most accused were single and poor) to raise a child without resorting to prostitution or the work house. Punishment by execution was an unacceptable alternative.

Now that society places more value on the life of a child and women are better able to control conception, people as a whole tend to view infanticide as a pathological act by a deranged mother. Societal and economic pressures are not taken into account despite the fact that single

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52 Vivienne Welburne, Post Natal Depression (Fontana, 1980).

53 Elisabeth Badinter, who studied four centuries of motherhood and childcare in France, calls the "maternal instinct" into question. "She demonstrates that far from being innate, immutable, and biologically determined, mother love is a culturally conditioned phenomenon." Her study shows that in a sample year out of 21,000 infants born in Paris less than 2,000 were kept at home. The rest were sent to wet nurses and baby farms in the country. Over half of these die before they were two years old. This phenomenon was not confined to France or to the eighteenth century. [Elisabeth Badinter, Mother Love: Myth and Reality (MacMillan, 1980) quoting from dust jacket.]

and poor mothers may still suffer from unbearable stress. It is more in keeping with the maternal myth to blame aberrant hormones.

Although there are some cross-cultural variations in attitude towards certain aspects of childbirth and menstruation, myths, in general, are fairly consistent. In contrast, reactions to menopause differ markedly from culture to culture. Those women whose lives have been closely circumscribed, for example, Moslem and Hindu women, see menopause as a time of liberation. Those women who have fallen for the "youth is everything" beliefs of modern Western society view menopause as a time of mourning. As Cheryl Bowles observes:

[In any given culture the status and activities dictated by societal norms as constituting the woman’s role during her fertile years becomes reversed at menopause. 55

It is not surprising that Western women feel this way. A review of the literature reveals that in our culture menopausal women have been regarded as "deficient, diseased, hopeless, confused, despairing, depressed, sexual castrates." 56 The subject of menopause is still shrouded in mystery; however, women who participated in the feminist movement of the 1970s and are now reaching menopause are beginning to speak out and exchange information. As Ruth Formanek says:


The absence of discussion about menopause kept it shrouded in obscurity, while hearsay, speculation, and reasoning by analogy kept misconceptions based on ancient ideas alive.\textsuperscript{57}

Some of these misconceptions were literally fatal to women. In the Middle Ages the image of the older woman was that of the ancient crone, a symbol of evil. Many older women who used their skills as healers and midwives were burned as witches. Instead of honouring them for their wisdom, the Catholic church considered them a threat to its male-dominated system. Although outward manifestations now take a less drastic form, similar attitudes prevail today within the medical profession under the guise of "the best interests of the patient" resulting in hysterectomies and caesarian sections that are not always necessary for a woman or baby's overall health.

Misconceptions were particularly rampant in the nineteenth century but were in keeping with general ignorance about women's bodies. Dr. Edward John Tilt, a well known Victorian gynecologist and President of the Obstetrical Society of London, considered menopause a time when women suffer a gradual "loss of feminine grace" and are susceptible to mental diseases such as "morbid irrationality," "minor forms of hysteria," "melancholia, impulses to drink spirits, to steal, and perhaps, to murder."\textsuperscript{58}

Freud saw menopause as yet another source of neuroses and reinforced Tilt's views when he stated that menopausal women often "become quarrelsome and obstinate, petty and stingy,


\textsuperscript{58} Delaney & Toth, supra note 45 at 220. Germaine Greer takes a kinder view of Dr. Tilt in The Change (Alfred A. Knopf Canada, 1992)
show typical sadistic and anal erotic features which they did not show before." 59 None of these "experts" considered that the symptoms they described might be caused by the emptiness of the type of existence forced upon middle aged women who were facing the end of motherhood, the only role valued by their society.

These negative attitudes are in strong contrast to those of some third world women who move from a period of social constraint into one of freedom, respect, and power. Reproductive capacity is not their only value to society; menopausal women are valued for their knowledge and for their capacities as "confidants, advisors, decision-makers and leaders of extended family and community." 60 Although third world women suffer many of the same physical complaints as Western women, they seem to avoid major depression. This indicates that many emotional symptoms may originate from social and cultural pressures rather than from physical changes. 61

D. NEGATIVE EFFECTS ON WOMEN OF SEXUAL STEREOTYPING

The above discussion describes the nature of sexual stereotyping of women but mentions only a few of its practical effects, and those mainly in the context of medicine. It may be thought that most of these negative attitudes have died now that women are entering the work force and participating in public life. However, most of them linger on in even more insidious form because they are less obvious and do not always directly discriminate against women.

59 Ibid. at 220.

60 Cobb (1990) supra note 57 at 16.

61 For example, see Bowles, supra note 55, who notes that Japanese women do not report the same menopausal symptoms as Western women. This does not mean that they do not experience changes, rather that they do not perceive those experiences as medical events.
Stereotyping is part of the objectification of women. It means that women are viewed as a single homogeneous class, all having the same positive and negative qualities. It means that when the media report on subjects such as PMS they are less than precise. They use vague all-encompassing headlines like "Coping with Eve's Curse: Doctors Are Finally Treating Menstrual Miseries"; they use vague generalized phrases like "about half of all women of child-bearing age [suffer] monthly misery that causes intense physical and mental discomfort;" or "many women ... become lethargic, irritable and depressed."

Characteristically, the media image of PMS involves the following: a focus on physical symptoms and negative moods, a discussion of associated undesirable behaviors, and identification of biological causes and/or treatments of the negative moods and behaviors. 62

Using an all-encompassing word like the "media" draws attention away from the fact that some of the most extreme writers are women. For example, in September 1991, Cynthia Helmel in a presumed attempt to be humorous, wrote an article for Cosmopolitan magazine entitled "PMS and Epaulets." The following paragraph is worth reproducing in its entirety:

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62 Mary Brown Parlee, "Media Treatment of Premenstrual Syndrome" in Ginsberg, supra note 48 at 192. Parlee observes that journalists share a network of like-minded experts in different scientific fields, with the result that they tend to repeat the views of a small number of high profile scientists and present unbalanced articles. Magazine quotes are cited by Parlee and come from "Time" July 27, 1981.

Other writers report such headlines as:

"Monthly Miseries save Murdering Mistress"

"Raging Female Hormones in the Courts"

"Women's violence blamed on Period"

Mark off on your calendar the day you will become insane. When that day arrives, you are officially on PMS watch. Call a nonpremenstrual friend to make decisions for you, because if she doesn't decide, you'll have Ring Dings and Valium.63

This article goes beyond mere implications of irrationality. It exaggerates to make a point, and the point is that women are irrational every month. The author states: "I want to be wild and free as the wind. I have PMS. I am insane. Really bonkers." Because of this, she has uncontrollable urges to wear unmatched clothing. However, she forces herself to heed a security's guard's command to "[g]o home and put on a navy suit." Her manifestation of "madness" may be trivial but her message adds to the harm done to women. She is really saying that it is insane for a woman to want to be "free and wild as the wind" and that the only way to overcome this insanity is to place yourself under someone else's control or to deaden your impulses with drugs. 64


64 Stevi Jackson points out the dangers for a woman whose symptoms are labelled "PMS":

A diagnosis of [PMS] exerts strong pressure on a woman to conform to others' wishes and expectations; any rebellious impulses are taken as symptomatic of her illness; any real problems in her life are interpreted as little more than delusions.

Another illustration appeared in a "Cathy" column, soon after the Thomas-Hill hearings in the U.S. Senate:

This, perhaps unintentionally, downplays the seriousness of issues of sexual harassment in the workplace and, in addition, reinforces the stereotype of the PMS victim unable to listen or respond calmly. These examples highlight the fact that women themselves often do more than men to perpetuate negative impressions of their own sex. Some feminists might brush them off as handmaids of patriarchy, but I believe that many of these women writers may think that they are serving a woman’s cause. They are drawing attention to a real problem that has often been dismissed as a figment of irrational imagination but, in so doing, they are assuming that "it is all in the hormones."

It is not altogether surprising that the media use vague terminology when self-described "experts" in supposedly technical papers use descriptions like: "Many women are affected so severely by their symptoms [of PMS] that they sometimes are incompetent to make decisions;" and "it is common knowledge that PMS can be responsible for illogical or irrational behavior,
including criminal acts." 65 (emphasis added) Until paternalistic physicians change their attitudes, it is inevitable that the media will continue to perpetuate menstrual myths. Even though much of what they say may be accurate, their slanted presentation is damaging to women as a whole. Among other things, it affects women's access to areas of society presently open to and controlled by men.

For example, stereotyping can have a profound effect on women in the workplace. In the case of working mothers, despite the job security offered by maternity leave and unemployment insurance benefits, they may feel insecure because many employers believe that divided loyalty will make mothers unreliable on the job. Women themselves are conditioned to believe that their babies may suffer if left with sitters. Therefore, if they have to work for financial reasons or wish to work for personal reasons, they are constant victims of culturally imposed guilt. If they put job before family they are perceived to be unnatural mothers; if they put family before job they are seen as unsuitable promotion material.

Society in general does not tend to harbour negative notions about a woman's post partum mental condition unless she becomes suicidal, depressed or harms her baby. To the contrary, people talk about "the blessed event," and "the bundle of joy" assuming that all mothers are overwhelmed with delight at the birth of a new baby and somehow know what to do instinctively. If they fail to cope, mothers blame themselves for being unnatural. If they become depressed society may label them inadequate or "sick." Medicine may agree with these opinions

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65 Thomas L. Riley, "Premenstrual Syndrome as a Legal Defense" (1986) 9 Hamline L.J. 193, pages 199 and 193 respectively. Riley takes a paternalistic approach throughout and is a strong advocate for the use of PMS as a defence. He constantly uses negative terminology such as "disease" and "afflicted" and appears to agree with Krafft-Ebing's 1902 opinion that courts should give special consideration to uncontrollable menstrual symptoms. Riley jealously guards expert jurisdiction over this "disease" and believes that treatment should not be left to PMS clinics with "figurehead" physicians.
by responding in two ways. It may either treat them as just another weak female and send them away with a prescription for antidepressants or tranquilizers; or it may consider them victims of their biology and treat them for the "disease" of post partum depression. Neither approach takes heed of their particular environmental or social circumstances; instead each adopts a paternalistic attitude based on stereotypes.

If a woman kills her newborn baby, a Canadian or English prosecutor may choose to charge her with infanticide rather than murder if the circumstances and her mental state so warrants. However, if she commits a lesser crime, her mental condition may not be a complete or partial defence unless it is so extreme as to constitute legal insanity or to preclude requisite mens rea. Just as there is no consistency among medical experts, there appears to be no consistency in legal reasoning with respect to the use of women's problems as a defence to criminal charges. This may be due, in part, to the application of inconsistent stereotypes; for example, the raging virago versus the mild madonna.

It is not only mothers who may suffer in the workplace from the negative effects of stereotyping. There is a popular misconception that women as a whole will be absent from work more often than men because they are the victims of menstrual problems. Before PMS became fashionable, it was thought that absences would occur only during menstruation. Now there is an expectation that there will be additional absences during the premenstruum. Unfortunately,

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66 Discussed in detail infra.

67 Susan Bell, "Premenstrual Syndrome and the Medicalization of Menopause" at 153 of Ginsberg & Carter, supra note 48, cites studies which purport to show that PMS causes huge monetary loss in the employment field; for example, a 1984 report in the New England Journal identified PMS as a "serious public health problem, which results in decreased productivity and increased absenteeism among women with severe premenstrual syndrome." A 1969 U.S. study estimated that absenteeism due to PMS caused losses of $5 billion. Bell observes at 168 that:
some women contribute to these notions by using PMS as an excuse for irritability and a lack of enthusiasm for unrewarding work; or because they believe that this may a more acceptable reason for absence than a child's dental appointment. There is no doubt that a few women genuinely suffer debilitating symptoms but these few are not well served by women who may delude themselves into believing that PMS, and not cultural or social stress, is responsible for their malaise.

Stereotyping of women may be even more damaging to those who seek work during their menopausal years. They fall victim to outdated "cultural norms about the "proper" role of aging women" in which medical experts prescribe "social and helpful activities, such as reading, resting, and engaging in socially appropriate ways" as a way to "grow old gracefully." Just as

Not only is medicine expressing the notions and categories of sexist society - that their biology determines women's performance - but in these discussions, medicine is claiming that this performance can be controlled by medicine and that medicine can do this on an individual basis by diagnosing and treating individual women. Implicitly, these discussions assume that the problems are individual, and that they can be solved individually: the biochemical model underlies medical opinion about productivity. Further, these discussions give scientific credibility to sexist notions about differences between men and women."

This is only one example of a whole range of medicalization discussed in Chapters 3 and 4.

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Parlee, supra note 62 at 194, notes that, as PMS becomes publicized as a disease, it may then be more socially acceptable as an excuse for absence than, for instance, child care problems. Since the only reasons for absence come from the employee herself, it is impossible to determine whether there is, in fact, a causal relationship between menstrual problems and absenteeism.

Ibid. Parlee discusses the sociological labelling theory to which the media contribute by portraying women as unreliable workers and/or as "mad," "bad," "criminal," or "sick." The "media plays an important role in shaping public discourse … on a socially sensitive topic … [that is], how female reproductive processes - biological, relatively unchangeable givens - might negatively affect women's performance in the world of paid work and might also cause them to act in ways traditionally associated with the troublesome or "not normal" individuals in society." (at 201)
with PMS and post partum depression, medicine appears to serve "women by legitimating their depression." 70

This approach fails completely to take into account the reality of the lives of most middle-aged women many of whom, because of divorce, are thrust untrained upon the workplace during their forties and fifties. Employers who subscribe to stereotypes about the proper role for menopausal women, or to misconceptions about their loss of mental function and ability to learn, will be reluctant to risk employing them. Menopausal women also suffer from the myths about absenteeism described above.

Other possible effects of the "irrational," "diseased" model are the continuation of the denial of positions of social and political power to women; the justification of violent assaults upon women; and its use against women in custody and divorce battles. I will discuss feminist concerns about some of these effects after I summarize the nature of women's illnesses and their use to date as criminal defences.

Before continuing with the next section of this paper, however, I wish to comment briefly on the negative effect that medical stereotyping may have on men. By assuming that the male body is "normal" and thus designating the female body as "abnormal," medical research virtually ignores the existence of and possible problems resulting from male cycles. Researchers choose topics that tend to reinforce stereotypes, maybe because funding is more available for such subjects. Would the recognition of male hormone/mood cycles be helpful to women as a

70 Bell, supra note 67 at 162. As she points out, this advice was designed for middle- and upper-class women of the 1930s, not for today's working woman. However, images of older women sitting at home bemoaning their lost children and their lost looks still occasionally persist within the medical profession. (See discussion in Chapter 4)
demonstration of biological equality, or would men merely grasp male cycles as an excuse for their own criminal behaviour and violent tendencies towards women?  

As I stated above, many physical symptoms may originate from social and cultural pressures. I believe that many of these pressures stem from the drive to conform to conduct that patriarchy deems appropriate and, in some cases, mandatory for "normal" women. It is "normal" men who set these codes of conduct to which women consciously or unconsciously subscribe. The next question to ask is "what constitutes a "normal" man?"

III. MEN 
A. MYTHIC DEFINITIONS AND DESCRIPTIONS OF "REAL" MEN

Anthony Simpson, a legal historian, has written about the concept of the "real man" as it developed from the "ethos of masculinity" that arose during the late eighteenth and nineteenth centuries.

A "real man" is in control of his own life, and perhaps the lives of others, and makes decisions based on his own feelings and beliefs, and not according to

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71 Tannis MacBeth & Jessica McFarlane of the psychology department at the University of British Columbia found in a recent (to be published) study of 60 women and 10 men, randomly chosen from the community, that 7 men experienced cyclicity. A significant number of women who said that they suffered from PMS were actually experiencing cyclical variations similar to the men; that is, changes did not consistently appear premenstrually. These women could be distinguished from those who did experience premenstrual changes. ("Premenstrual Syndrome in Context: The Results of a Longitudinal Study," reported in a workshop at the first "Women's Health Across the Lifespan Conference," October 16-18, 1992, University of British Columbia.

Other authors have commented on the existence of male cycles. Karen McArthur in an article about the use of PMS as a defence, "Through Her Looking Glass: PMS on trial" (1989) 47 University of Toronto Faculty of Law Review 825, cites the following articles: Z. Hilton "Against Using PMS in Criminal Court Cases" (1987) 10 Justice of the Peace at 152; R. Hersey "Emotional Cycles in Men" (1931) 77 Journal of Mental Science at 151; C. Luce Biological Rhythms in Psychiatry and Medicine, (Dover Press, New York, 1970) at 110-111; F. Parlee "The Rhythms of Men's Lives" Psychology Today, April 1978 at p. 82; E. Ramsay "Men's Cycles (They do have them too, you know)" Ms 8, Spring 1972 at pp. 11-12.
outside constraints … [M]aleness as a special quality cannot be demonstrated unless there are those whose inferiority is shown in comparison. 72

Thus, under this definition, the male must control and the female, the child and the deficient male must be controlled.

Male stereotypes are often described as polar opposites of female stereotypes. This is generally, but not always, the case. Male stereotyping may range from attributes such as rationality, intellectual acumen, and mathematical ability to aggression, vigour, and competitiveness.

What distinguishes male from female stereotypes is not necessarily their opposing characteristics but the fact that the majority of men and women consider the characteristics of the dominant group to be normal and desirable for those who exercise political power - namely, men. Characteristics that are abnormal in the dominant group may be appropriate for subordinate groups. In patriarchy, those in power create a hierarchy of roles for all levels of society. They also formulate the attributes necessary for the most efficient fulfilment of these roles.

For example, if men choose to exercise power in the public sphere and delegate authority in the private sphere to women, there is no point in rewarding outgoing women who are interested in successful careers. Instead, they create a husband-wife relationship that is the union of opposites:

<table>
<thead>
<tr>
<th>WIFE</th>
<th>HUSBAND</th>
</tr>
</thead>
<tbody>
<tr>
<td>family oriented</td>
<td>success oriented</td>
</tr>
<tr>
<td>pure</td>
<td>worldly</td>
</tr>
<tr>
<td>gentle</td>
<td>aggressive</td>
</tr>
<tr>
<td>moral</td>
<td>pragmatic</td>
</tr>
<tr>
<td>emotional</td>
<td>rational</td>
</tr>
</tbody>
</table>

On the other hand, in times of war or economic necessity, the above "wifely" characteristics may hinder rather than help the efficient operation of society. War requires the male macho stereotype but it cannot support the female shrinking violet. Working class economy requires the male breadwinner stereotype but cannot support the weak female angel. In extraordinary times different myths come into play. Gender stereotypes are no longer opposite but complementary. Hera becomes Artemis; Aphrodite becomes Athena. Women may participate in public life but only as long as they are content to remain helpers but not leaders. The core of male stereotypes tends to stay much the same; female stereotypes change according to men's needs.

What are the most prevalent male stereotypes? What defines a "real man?" How much does this definition depend upon anatomical differences? In other words, is the possession of a functioning penis absolutely essential for a man to remain within the dominant group of society? And, as Freud might have asked, must the absence of a penis in woman always relegate her to a position of supplication and inferiority?

Writers are only now beginning to react to the large volume of feminist literature about women by studying sociocultural male role norms. It appears that previously the "normal" male was not a worthwhile subject for study except as an objective to be strived for by less fortunate men smitten by mental or physical handicaps which rendered them unfit to be tough, strong and

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63 Gerzon, supra note 25 at 128. See also Pedersen, supra note 16, at 182, where he lists a continuum of attributes for both men and women that are generally perceived to be positive or negative. Men's range from aggressive, courageous and independent to bull-headed, presumptuous and violent; women's from affectionate, sensitive and gentle to bitchy, fickle and wily.
virile. Deviants from the role norm were, and often still are, relegated to inferior subgroups ("others") composed of abnormal and diseased males and women. As Pedersen points out: "Masculinity has left its imprint, if not footprint, on science and philosophy in its attempt to study everything but itself." 64

In a recent study, Thompson and Pleck used the term "male role"

to refer to the social norms that prescribe and proscribe what men should feel and do. It is a sensitizing concept that summarizes the general social expectations men face ... 65

The authors identified a threefold structure for traditional male role norms: (1) men's need to achieve status and respect; (2) their need to be mentally, emotionally and physically tough, self-reliant and self-contained; and (3) an antifemininity factor (need to cultivate incompetence in "feminine" activities.) 66

Has this structure remained constant throughout history? We can all picture the "knock 'em down, drag 'em out" stereotypes of the caveman subjugating his woman but does this accurately portray pre-historic reality? Those who have charted the existence of ancient matriarchal societies might argue that this description is a distortion created out of male wishful thinking, a backdating of such myths as the Rape of the Sabine Women.

64 Ibid. at 3. Other writers have speculated that "Men have generally remained untheorized, since they have not been seen as requiring an explanation." - Caroline Ramazanoglu, "What Can You Do With a Man? Feminism and the Critical Appraisal of Masculinity" (1992) 15 Women's Studies Int. Forum 339 at 340.


66 Ibid. Their subject group, four hundred white middle to upper class college age men, did not fully endorse these traditional male roles, indicating that attitudes may be gradually changing - at least within what we perceive as the privileged classes. It is unfortunate that the authors did not question an equivalent group of women.
Out of the Greek myths that enacted the defeat of matriarchy by patriarchy came the Hellenic image of the ideal man, the possessor of arete - "a physical and temperamental idealization of males which is endlessly recapitulated in the visual arts of the Hellenic world." 67 Only free-born Greek males could aspire to arete. Women were disqualified as being not truly human. The symbol of arete was the phallus; the ideal man possessed physical beauty and strength, nobility of mind and sexual power which, unless required for procreation, was reserved for young boys who played the submissive role. Although the Ancient Greeks considered homoeroticism to be normal, they respected only the dominant male adult. The effeminate adult male was an object of scorn.

There is evidence that some aspects of arete persist today. Mishkind et al. (1986) investigated how men's perceptions of bodily image relate to their concepts of masculinity.68 They found that the stereotypical notion that "what is beautiful is good" applies today even among pre-schoolers and that

the muscular mesomorph is the ideal because it is intimately tied to cultural views of masculinity and the male sex role, which prescribes that men be powerful, strong, efficacious - even domineering and destructive. 69

Men perceive physical attractiveness and potency to be "virtually equivalent." 70 Other researchers confirm the existence of the opposite assumption; that ugliness and lack of stature imply a lack of power. For example, Gilmore (1990) notes that bigness is the measure of the

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67 Highwater, supra note 36 at 80.


69 Ibid. at 549.

70 Ibid.
man in many cultures, including North American, and that "[o]ur own prejudice against short men is built into courtship, the chances of finding a job, and even language, where a rich vocabulary of abuse impugns the short man." 71 The requirement of physical beauty also influences men's definition of the ideal woman. 72

In a cross-cultural study of the concepts of masculinity, Gilmore concluded that men are innately not so different from women. In order to behave like "real men" they must receive motivation to become assertive. Male assertiveness is essential for survival of the patriarchal social unit. Thus male ideologies are adaptations to social environment, principally physical survival needs. Gilmore identified three key male functions: (1) impregnation of women; (2) protection of dependants from danger; (3) provisioning of kith and kin. 73

These functions do not come naturally to men; "manhood is a kind of male procreation." 74 Society must force young boys into manhood by means of initiation rites which are often sexual, violent and painful; for example, fellatio, beating, flailing and ritual circumcision. Many of these initiations involve the spilling of blood, often, like menstrual fluid, thought to have healing


72 See, for example, Deborah A. Stiles, "The Ideal Man or Woman as described by Young Adolescents in Iceland and the United States" (1987) 17 Sex Roles 313.

73 This theory takes no account of the long survival of matriarchal societies in which the macho tradition was unnecessary.

74 Gilmore, supra note 71 at 223.
properties. Some writers have interpreted this as a form of male menstruation that is perceived to be superior to that of women because men must achieve this state while to women it comes naturally - part of the men-culture, woman-nature debate.

In contrast to femininity which is an inherent part of women, masculinity must be created; and once created, it must be maintained by constant displays of manliness. The penalties for failing to live up to society's requirements range from name-calling (usually a derogatory comparison with woman) to ostracism by women as well as other men.

There is a constantly recurring notion that real manhood is different from simple anatomical maleness, that it is not a natural condition that comes about spontaneously through biological maturation but rather is a precarious or artificial state that boys must win against powerful odds... [This notion] is found at all levels of sociocultural development regardless of what other alternative roles are recognized. It is found among the simplest hunters and fishermen, among peasants and sophisticated urbanized peoples; it is found in all continents and environments. It is found among both warrior peoples and those who have never killed in anger.

Gilmore calls this part of the "gratuitous agonies of man-playing." Again there is the active-male/passive-female dichotomy. Girls passively wait and nature transforms them into women. Boys' change of status is impossible without purposive

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75 See Pedersen, supra note 16 at 92 who states that primitive peoples believed that both menstrual and subincision blood had magical properties when used in healing rituals.


77 Gilmore, supra note 71 at 11.

78 Ibid. at 20.

79 Gerson seems to assume a smooth transition from child to adult for girls in the cultures he studies. This does not mean that there are no initiation rites for young girls. However, these generally do not occur until menstruation begins. One exception is female circumcision ranging from incision of the skin around the clitoris to major mutilation. According to recent newspaper reports, for example, the Vancouver Sun, January 27, 1992, this practice is still widely prevalent.
conscious action and assistance from the male brotherhood. In order to become a "real man" disciplined exercise of the will is paramount. In Chapter 4, I will discuss nineteenth century ideas about disorders of the will that robbed sufferers of their manhood. Not surprisingly, there was no corresponding female disorder of "will-lessness"; an active will was considered to be unnatural and undesirable in women.

Theories abound about the nature of the male will. Many rest upon the idea of fear of regression to the feminine or to dependency on the female. In macho societies, real men cannot or dare not assist in child care. Boys spend their early years almost entirely in the company of women - mother, aunts, sisters. They see men from afar but have little opportunity to learn "male" skills until they undergo some form of initiation into manhood. Overnight, boys must switch from being nurtured to being protector and provider. Any overt actions that their culture would normally attribute to women are suddenly forbidden in order to discourage attempts to escape from adult responsibilities by returning to the shelter of mother. Girls and women reinforce the macho ideal by rejecting and jeering at men who fall short of it.

Gilmore states that in macho societies there is

no greater fear among men than the loss of ... personal autonomy to a dominant woman ... because it turns wife into mother, subverts both the man and the family unit, sending both down to corruption and defeat. ⁸⁰

in Africa and occurs in first world countries when immigrants from Africa can find a doctor to perform the operation. The object of circumcision is only indirectly the creation of a ritual passage into womanhood. Its main purpose is the creation of a physical and psychological chastity belt. It is also designed to maximize male, and minimize female, sexual pleasure.

⁸⁰ Ibid at 50-51.
If Gilmore is correct that there is a cross-cultural and cross-temporal continuity in male myths and stereotypes despite periodic overlays of apparent change, then it appears that the most tenacious myths are based on fear and tied to survival.

Not all societies adhere to the macho stereotype; for example, the Kung bushmen of Africa. A small number are androgynous and believe in gender equality. But even those have some kind of male initiation rite often in the form of a hunting requirement. The doctrine of *machismo* is at the other extreme and may seem outdated in modern society. However, it remains alive in John Wayne and Rambo myths; in the bar-room brawler and the wife assaulter. As one writer points out, box office receipts indicate that there must be a tremendous amount of unconscious support for these exaggerated hero myths that portray men as ultra macho and even sadistic. 81

Many men still strive to conform to the macho image. It portrays the ideal man as a heavy drinker who can hold his liquor; a big spender who is ostentatiously generous; a brave fighter who would never back down; a potent lover who fathers many children, preferably sons. In a society that values this image it is more important to be "good at being a man" than to be a "good man." 82 None of this can be done in private. The system demands public displays: "obsessional glory-seeking" or "social agrophilia." 83 Gerzon calls this the "paranoid cult of the tough guy." 84

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81 Ibid. at 99, discussing the hero in the film *Cobra* who murders at least forty seven people in the course of the plot.

82 Ibid. at 36.

83 Ibid. at 38.

84 Gerzon, supra note 25 at 116.
The lengthy persistence of this image of the ideal man indicates that it must have served some pressing societal needs at one time. Even when political and cultural systems have undergone massive change, this core concept of masculinity survives. The Ancient Greek ideal differs little from the hero of Arthurian legend. The first may stress rationality and homoeroticism while the second concentrates on spirituality and courtly love, but both maintain the idea that masculinity entails a constant quest. The same parallel appears between the philosophies of the Enlightenment and the poetic outpourings of the Age of Romance. Despite expressions of lofty sentiment, the reality of all of those societies involved brutality towards women, children, the sick, and towards men who did not meet the masculine standard.

Gerzon analyses a number of male hero myths from the frontiersman and soldier to the breadwinner and expert. If these stereotypes exhibited nothing but callous violence and pathological self-reliance, it might be easier to eliminate them in an era where environmental survival depends upon caring restraint and interconnection. However, all of these roles include elements of gentleness and compassion in certain circumstances. We see images of the soldier crying for his wounded buddy, the mafia capo mourning the loss of his mother, the cowboy singing love songs to his "girl." The most recent image is that of the father carrying his baby in a "snugglie." These are positive, even endearing images. We point to them as evidence that men can change. But of course individual men can change. Of course, not all men are aggressive tough guys. It is society's image of the ideal man that remains the same; and it is this image that must change before women can hope for equality.85 "Changing men is not simply about men

85 The notion of the ideal man "presents a public model of masculinity which may not be what most men are, but is very generally a model which is consented to." - Ramazanoglu, supra note 64 at 343.
developing new identities, but about the structural transformation of gendered power relations. 86

Nowadays many men are openly acknowledging that the traditional male role is unfulfilling but, as a collective, men refuse to let it go. Although some subscribe to the theory that men would benefit from change, the majority stick to the established stereotype that regards those who reject the traditional male roles as being deviants, wimps, pseudo-women - not "real men." Unfortunately some men are beginning to blame women for raising them to be traditional when women had little choice in the matter due to imposition or acceptance of prevailing cultural norms. Others, like Pedersen and Broude, locate part of the problem in "father-absence" and the lack of male guidance in the transition from boyhood to manhood. 87

As noted in the section on women, the media help to perpetuate gender stereotyping by portraying outdated male images. "Thus men today consume certain images of manhood even though the world from which they are derived may have disappeared ..." 88 This is untenable in a nuclear age where the masculine traits that society formerly praised could now lead to annihilation. "Our consciousness lags behind history, our self-awareness behind our weaponry." 89

86 Ibid. at 346.

87 Pedersen, supra note 16, Chapter 5. Gwen J. Broude, "Protest Masculinity: A Further Look at the Causes of the Concept" (1990) 18 Ethos 103. But what form should guidance take? Most of the societies that have retained initiation rites are male dominated. If initiation rites are helpful in the transition from childhood to adulthood, is it necessary that those of men differ in form and substance from those of women? Is gender differentiation a prerequisite for individuation?

88 Gerzon, supra note 25 at 5.

89 Ibid. at 45.
Despite women's fight for equality and despite their demonstrable competence at previously male jobs, ideal manhood still requires the existence of the subordinate woman to receive the fruit of his toil and the strength of his sex. Since manhood entails procreation, protection and production, sexual prowess and economic skills are closely linked. Under our present system there is a direct correlation between material and erotic achievement. Men must compete and take risks, pursue and capture. If power is lacking in the one, it seems that power in the other will decline or disappear. The language of sex becomes the language of business. A man with courage has "lots of balls." The winner of a business contest is the one with the "biggest dick" (meaning the greatest power). Public failure to grasp success leads to mental and physical emasculation since
to fail to excel in our society is a form of death. Success is so highly prized that anything short of it is believed to constitute total failure. The mythology of consumerism has created a vivid male analogy between economic success and sexual prowess, between social failure and the failure to achieve an erection and to consummate intercourse.

If this represents reality for men, impotence must mean much more than a mere physical handicap. Like the macho man, the "impotent" man is a mythological and cultural construct that is just as damaging to men and women as a whole as the myths about disordered females.

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90 Gilmore, supra note 71 at 85.


92 Highwater, supra note 36 at 193.
B. MYTHS ASSOCIATED WITH "ABNORMAL" "DISEASED" MEN

In the previous section I discussed stereotypical notions about the "real man," perhaps an extreme or idealized version of what society believes to be the "normal" man. What does society believe about the "abnormal" man? How does society define him? Do these definitions and treatments have anything in common with definitions and treatments of women? To review this topic in depth I would have to discuss homosexuals, transvestites, sex-offenders, excessively violent men, gentle non-aggressive men, as well as those suffering from medical/genetic/psychological "problems." In fact, I would have to return to the broad study of gender theory that I rejected in Chapter 1. Instead, I propose to focus on the last category as being most analogous to problems associated with female reproductive and sexual functions, and most threatening to men's sense of their own masculinity. I will also look at chromosomal abnormalities in men that have been associated with violence, and an example of sexual deviance, child sexual abuse.

(i) IMPOTENCE

Sexual competence is part - some would say the central part - of contemporary masculinity, whether we are discussing the traditional man, the modern man, or the "new" man... Psychologically ... male sexual performance may have as much or more to do with male gender role confirmation and homosocial status as with pleasure, intimacy or tension release. 93

93 Leonore Tiefer, "In Pursuit of the Perfect Penis: The Medicalization of Male Sexuality" (1986) 29(5) Amer. Behav. Scientist 599 at 580-581. Tiefer lists ten male sexual myths that have probably existed since ancient times:

1. Men's sexual apparatus and needs are simple, unlike women's.
2. Most men are ready, willing and able to perform as much sex as they can get.
3. There is suspicion that other men's experiences are better than one's own.
4. It is responsibility of man to teach and lead partner to experience pleasure and orgasm.
5. Sexual prowess is serious, task-oriented business; no place for experimentation, unpredictability, or play.
Thus deficiency in the penis means deficiency in the whole man. The very use of the word "impotent" reinforces this notion. It is similar to adjectives like pre-menstrual, menopausal, epileptic. The person becomes identified by the disorder.

I found three references to the semantics of impotence. The first two came from urologists who objected to its use on the ground of medical imprecision. One was concerned about descriptive accuracy rather than stigma; the other recognized that the issue is complicated "by the fact that it deals with an emotionally charged subject, at once tragic and comic." The third author traced the use in psychological abstracts of the terms "impotence" and "frigidity" and noted that the former has increased in use while the latter has disappeared.

6. Women prefer intercourse to other sexual activities, particularly "hard-driving" intercourse.
7. All really good and normal sex must end up with intercourse.
8. Any physical contact other than light touch is an invitation to foreplay and intercourse.
9. It is responsibility of man to satisfy both his partner and himself.
10. Sexual prowess is never permanently earned; must be reproven each time.

Many of these demands require, directly or indirectly, an erection.

94 It has been argues that it is possibly the very way that male sexuality is intertwined with sexual prowess that makes rape understandable. See P.M. Mazelan, "Stereotypes and Perceptions of the Victims of Rape" (1980) 5 Victimology 121 at 122.


from technical journals. It is interesting that some writers expressly deplore the use of the term but continue to use it anyway.

Feminists and other writers have accumulated a mass of information on female sexual mythology, especially in relation to what societies over the ages have considered to be pathological conditions. There is no similar body of knowledge about male pathology until the advent of medicalization in the late eighteenth and nineteenth centuries when impotence and homosexuality became "health" problems. With a few exceptions, anthropological and psychological literature is more interesting in what it does not say - especially in the indices to recent books cited in this study. None of these non-medical books lists "impotence" in its index. There is a significant gap between "illusion" or "imagery" and "incest." Even Foucault, in his wide ranging analysis of sexuality, leaves it out.

Modern self-help manuals point out that sexual impotence is the last sexual "taboo." Although they acknowledge the existence of social factors, they legitimate discussion of this topic by concentrating on medical "cures." By assuming the objective stance of science, these writers are able to sidestep the larger cultural issues. Instead of Spanish Fly and rhino horn, they offer prostheses and injections.

As discussed above, one of the principal indications of manhood is the ability to procreate. Thus myths about sexual impotence are closely interwoven with ancient ideas about generation. Hippocrates believed that both sexes produced sperm which united to form a new

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97 Mark L. Elliot, "The Use of "Impotence" and "Frigidity": Why has Impotence Survived?" (1985) 11(1) J. of Sex & Marital Therapy 51.

person, and that the brain was the organ that contributed the most to formation. Since the Ancient Greeks assumed that females were inferior beings, the male contribution was considered to be more important\(^9\) - especially since the brain was involved. Indeed, later writers such as Aristotle, thought that the female was a mere receptacle and that generation began by the active contact of male semen with menstrual blood. From the time of Galen until the Renaissance, physicians agreed that both sexes produced sperm but that generative power was reserved for the male - another illustration of the complete swing away from a primitive belief in women’s magical generative powers, and a denial of the sexual power of women.

Along with the glory of procreation, men had to assume the burden. If they played a major role in creating new generations, then failure to perform would be a disaster. Survival of the species - not mere survival of the fittest - was their responsibility. A sexually impotent man would be a burden on society - a consumer, not a producer. It may be that present attitudes and fears about impotence are, in part, the result of an early evolution of survival tactics in marginal tribal societies.

Paolo Zacchia, physician to the Vatican from 1644 until his death in 1659, made an extensive study of impotence and appeared before canonical courts as a forensic expert in nullity actions.\(^10\) His approach was the forerunner of the modern medical expert model and might

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\(^9\) For example, see discussion by Michel Foucault, *The Use of Pleasure: The History of Sexuality, Volume 2* (New York: Vintage Books, 1990) at 126 ff where he describes the Ancient Greek notion that it is the male act that "determines, regulates, stimulates, dominates ... [and] ensures the health of the female organs by ensuring that they function properly." (at 129)

\(^10\) A complete history of Zacchia’s work on impotence can be found in Joseph Bajada, *Sexual Impotence: The Contributions of Paolo Zacchia (1584-1659)* (Editrice Pontificia Universita Gregoriana, Roma, 1988). Zacchia also studied organic and functional impotence in women. (The term frigidity was, at that time, used to describe both male and female conditions. In fact, some canonists and doctors held that only men could be frigid since women were mere passive receptacles.) Zacchia was unusual in recognizing female sexuality and advising that
better be discussed in the context of medicalization. Contrary to his medical contemporaries, he believed that the female plays an active part in generation and that menstrual blood is essential to conception. This view retained credibility until well into the nineteenth century.

Zacchia is mentioned here because, despite his scientific approach, he retained some traditional ideas about *maleficium daemonis*. After excluding all natural causes he believed that sudden impotence in previously healthy men could be the result of intervention by the devil. Other doctors and laymen extended this to include intervention by witches who, they thought, could invoke curses to produce impotence in men and sterility in women. The biblical tale of Sampson and Delilah, told in the Book of Exodus, could be interpreted as an impotence myth. Many of these attitudes persisted into modern times and may still persist in some cultures today.

In the mid-nineteenth century, one physician was bemoaning medicine’s neglect of the subject of impotence and the benefit thus derived by "vile harpies who pray on this class of victims" and "charlatans who fattened upon the vices and fears of men." Because this problem happens only to "lesser" men and is also the subject matter of low comedy and jokes, it is understandable that sufferers would go in secret to assorted quacks and resort to obscure advice in pamphlets "for men only." As one writer puts it:

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husbands should be aware of it.

101 Ibid.


103 Ibid. at 1012.
When we fear something, we tend to keep silent about it, or we cover up our fear with a mask of disdain or contempt. Movies, jokes and popular culture reinforce such negative attitudes. 104

This applies equally to women's problems and epilepsy.

In summary, the term "impotence" carries with it a great deal of stigma and mythological baggage. Study of its mythology is hampered by the lack of non-medical literature on the topic. However, it is probably safe to infer the stereotype as being the underside of the "real man" myth discussed above.

(ii) CHROMOSOMAL ABNORMALITIES

Although this topic properly belongs in the following chapter on medicalization, I should note here that much of the research seems to have the objective of confirming yet another male stereotype: that there is something inherent in male biology that predisposes men to violence. Discovery of an extra Y (male) chromosome in some men has led to the quest for XYY men among the criminally violent in the expectation that subjects having even more of a bad thing will exhibit even more violent tendencies than XY men. There seems to be a need in present society to blame an external agency like god or biology for its ills. This makes it easier to escape examination of cultural and societal causes.

(iii) SEXUAL DEVIANCE - CHILD SEXUAL ABUSE

Sexual deviance differs from impotence and chromosomal abnormalities in that it is not gender specific. Women can and do abuse children sexually. However, as in the overall category

104 Irwin Goldstein and Larry Rothstein, The Potent Male, Los Angeles, Ca: Price Stern Sloan Ltd., 1990) at 1. (Popular informational publication.)
- crimes of violence - an overwhelming preponderance of perpetrators are men. Sexual abuse of children by men *appears* to be much more prevalent today than in the past. This increase may be due to a greater willingness on the part of victims to report abuse and willingness on the part of members of the justice system to believe these reports. Most people probably regard this as a stereotypically male crime, usually involving penetration. It may be that sexual abuse by women is more common than now supposed, but I doubt whether it encompasses more than a mere fraction of cases. Therefore, for the purposes of this study, I will assume that a pedophile is a man who is "sexually attracted by prepubescent children." I will also assume that incest is a sexual relationship between a father and his daughter.

It is only recently that the subject of incest and sexual abuse by men has come out in the open. What was previously referred to in whispers and often treated with disbelief has become the topic of talk shows and media columns - to such an extent that all men are becoming suspect. A few cases of abuse by women have come to light. So far they have been viewed with some amazement as isolated aberrations.

It is fairly easy to find myths associated with incest taboos; the story of Oedipus is likely the best known, especially since its incorporation into psychoanalytic theory. Identifying myths and stereotypes about sexual relationships between adults and non-related children is more

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105 Carol Smart calls this type of crime "sex-related" in contrast to "sex-specific" crimes that are exclusive to either men or women; for example, statutory rape and infanticide. *Women, Crime and Criminality* (London, Henley & Boston: Routledge & Kegal Paul, 1977), Chapter 1.

106 This definition is used by M. Ashley Ames & David A. Houston, "Legal, Social, and Biological Definitions of Pedophilia" (1990) 19 Archives of Sexual Behavior 333 at 334, to distinguish pedophilia from rape and incest. David Finkelhor & I.A. Lewis in "An Epidemiologic Approach to the Study of Child Molesting" (1988) 528 Ann. N.Y. Acad. Sci. 64 at 73, describe child sexual abuse as a "predominantly male behavior, [that] can also be plausibly analyzed as having its roots in the social construction of masculinity."
difficult - probably because such relationships have not always been viewed as immoral, much less criminal. Ames and Houston note that adult/child sex pairings ("particularly same-sex pairings") were at one time accepted practice in China, Japan, Africa, Turkey, Egypt and the Islamic areas of India. Araji and Finkelhor cite the ideas expressed in some feminist quarters that

pedophilia grows out of certain themes in normal male socialization that tends to make children "appropriate" objects of sexual interest. These themes include the value that male socialization puts on being dominant and the initiator in sexual relationships, as well as the value placed on partners who are youthful and subservient. Pedophilia occurs as a natural extension of some of these values.

As already discussed, ancient Greeks considered sexual relations between adult men and pubescent boys to be normal. However, they condemned those who raped or sold themselves for sex. There is little evidence that they sexually used really young children. The situation was similar in Rome, except that the Romans in the first century B.C. implicitly condemned the sexual abuse of young girls. However, what would be termed abuse in modern Western culture would be mere "use" in ancient times. Both Greece and Rome sanctioned marriages between older men and girls as young as ten. Class issues also enter the picture. Slaves, being property and non-persons, could be sex objects at any age. In fact, there is evidence that some

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107 Ibid.


110 Ibid.
slave children were specially raised for this purpose. Sons of freeborn Romans were protected from pederasty by the Scantian Law.\footnote{111}

Christians, believing homosexuality to be sinful, condemned these ancient practices but still allowed marriages of prepubescent girls. However, religious dogma, not unsurprisingly, did not eliminate child sex, for the medieval streets of Europe were "alive with children of both sexes acting as prostitutes."\footnote{112} Apparently little has changed. Two "gentlemen's travel guides" of the 1970s directed readers to sources of child sex in Europe\footnote{113} and there are similar sources of information about sexual opportunities in countries like Thailand. A recent U.S. report located at least 250 publications devoted to "graphic depiction of erotica using children from 3 to 5 years of age."\footnote{114}

It seems that three stereotypes exist in this area: (1) The "dirty old man" who discreetly buys child sex in foreign countries and who views kiddy porn in "adult" theatres or behind "plain brown wrappers"; (2) the "weak, passive, socially isolated and inept man who turns to children for sexual fulfilment"\footnote{115}; and (3) the "dangerous anonymous psychopath"\footnote{116} who mutilates and kills during an uncontrollable burst of sexual violence against children. I have already observed, while discussing infanticide, that until recently small children as a class were not highly valued

\footnotesize
\begin{enumerate}
  \item Ibid. at 460.
  \item Ames & Houston, supra note 106 at 334.
  \item Ibid.
  \item Ibid. at 334-335.
  \item Ibid. at 338.
\end{enumerate}
in Western societies. This may explain the tacit acceptance of behaviour that would be considered criminal today.  

The second stereotype either arises from medicalization or is an easy target for it. He represents a "sick" member of society who must be treated. However, he is also defined as criminal. In Chapter 4, I will examine the medicalization of adult/child sexual behaviour that at one time might have been considered normal; in particular, the emergence of a new medical category "pedophilia."  

IV. MYTHS AND STEREOTYPES SURROUNDING EPILEPSY

Because of its strange and varied behavioural symptoms, epilepsy has always been a source of awe, disgust or superstition. A study of its history shows an oscillation between belief in divine and demonic causes. It was only when people began to perceive it as a contagious disorder that it gained firm negative connotations and social stigma.

Much of the following discussion relies on information from Oswei Tempkin's comprehensive medical survey of epilepsy from the time of the Ancient Greeks until the beginning of modern medicine.  

He notes that the word "epilepsy" and "epileptic" are of Greek origin and have the same root as the verb epilambanein which means to "seize" or

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117 Previous societies have also defined "childhood" in ways different than today. For example, during and after the Industrial Revolution working class children as young as seven years old had jobs in factories. This might have affected attitudes towards sexual practices. In our society, "children" may be as old as eighteen for some legal purposes.

118 I wish to stress that violent sexual behaviour between men and children has never been condoned. Although the issue of consent does not seem to have been important in adult/child sex (contrast rape), the use of force has generally been condemned.

"attack." 120 The Hebrew word for epilepsy (nikhpe) means much the same as the Greek - to seize, to attack, to overcome with surprise. 121

The Sakikku (718 - 612 B.C.), a Babylonian medical diagnostic series containing the oldest written account of epilepsy so far discovered, describes it as the "falling disease." 122 It also lists the cause as the work of demons or ghosts, a belief maintained by many later cultures. The various names used throughout the centuries, as well as being descriptive, indicate to some extent the swings in attitude toward the disease. The Ancient Greeks called it the "sacred" or "divine" disease, thought by laypersons to be caused by the invasion of supernatural agencies - gods, demons, evil spirits. "Sacred" in this sense meant "awesome" and "taboo," making a sufferer from epilepsy untouchable.

To the ancients the epileptic was an object of horror and disgust and not a saint or prophet as has sometimes been contended. 123

However, Hippocrates rejected the superstitious beliefs current in his time and believed that epilepsy was hereditary, its cause lying in the brain. (This is similar to today's biological theories.) It was only to the extent that all disorders were visitations by the gods that epilepsy could be characterized as a "sacred" disease. That is, epilepsy was no different than any other

120 Ibid. at 21.


122 See J.V. Kinnier Wilson & E.H. Reynolds, "Translation and Analysis of a Cuneiform Text Forming Part of a Babylonian Treatise on Epilepsy" (1990) 34 Medical History 185, who found that the text accurately and comprehensively describes many aspects of epilepsy, including temporal lobe.

123 Temkin, supra note 119 at 9.
illness. Hippocrates coined the phrase the "great disease" retained until recently by the term "grand mal."

The Romans called the seizure morbus comitialis because attacks disturbed public assemblies. The disgrace attached to this caused sufferers to run and hide if they were lucky enough to have warning of an attack. The situation is little changed today. 124 The disease itself was morbus caducus - the falling sickness. The Romans were also among the first to regard epilepsy as contagious and would spit superstitiously to keep away the demon that had caused the disease. They also refused to eat from the same dishes, holding sufferers to be unclean.

The magic conception according to which epilepsy was a contagious disease was one of the factors which made the epileptic's life miserable and gave him a social stigma. For it was a disgraceful disease. 125

It is interesting to contrast these beliefs with those about female disorders which, although not contagious per se, were thought to have an adverse effect on men who came near menstruating women. The common element was the taboo of physical contact and the idea that both were unclean. Does a common fear underlie these taboos? Are both conditions a threat to the frailty of "normal" manhood?

This belief held into the Middle Ages and helped perpetuate the stigma, already carried by lepers, of "uncleanness." The notion that one could catch epilepsy from others was tenacious.

Although the idea of physical infection fell from favour, medicine replaced it with psychological

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125 Temkin supra note 119 at 9.
infection - the idea that observers of an epileptic seizure could themselves become epileptic, or that a pregnant woman exposed to a seizure could have an epileptic child. This is an illustration of how myths and stereotypes can outwardly change to conform with contemporary fashion but, at the same time, retain a base solidified by centuries of conditioning. 126

As Christianity gained hold, the idea of evil and sin crept in, just as it did with women’s problems. Epilepsy became the "falling evil" or the "demon" or "lunacy" - names coined by lay people. Physicians were challenged to distinguish between natural disease and demonic possession, just as Zacchia was in cases of impotence. Possession now became a sin, an indication of personal evil or a punishment for misconduct. Many of these beliefs originated in Judaism. For example, neither Jews nor catholics who had epilepsy were eligible for the priesthood. Epilepsy, leprosy and syphilis were grounds for expulsion from holy orders. No one with epilepsy could participate in the Eucharist.

The story in the Book of Matthew about the casting out of unclean spirits gave fuel to those who would argue against natural causes. Origen (254 A.D.) asserted that "this disease is obviously brought about by an unclean dumb and deaf spirit." 127 At one time the terms epilepsy and lunacy were almost interchangeable to the extent that a sufferer from epilepsy was one seized by "the disease of the moon." The common manifestation was the existence of periodic attacks. "The influence of the moon on epilepsy was taken as an established fact until the end of the seventeenth century." 128

126 Many analogies can be found in the area of women’s problems, discussed elsewhere in this study.

127 Quoted in Temkin, supra note 119 at 92.

128 Ibid. at 227.
In this way epilepsy became confused with mental disease, a misconception that persists today. St. Hildegard of Bingen, a famous physician of the twelfth century, and herself a sufferer from a form of epilepsy, identified two forms of the disease: (1) associated with wrath, causing madness; and (2) an affliction of those with easy morals which tired the body and caused it to fall down.

During the early Middle Ages, physicians attempted to classify different forms of epilepsy. They distinguished between "major" and "minor"; between "analepsy" - originating in the stomach - "catalepsy" - a disease with fever - and "epilepsy" - the form originating in the head. The frenzy of fever and the convulsions of epilepsy were often confused, just as later hysteria and epilepsy were confused.

By the time of the Renaissance the focus shifted from mere possession to include the machinations of witchcraft. In the 1580s the *Malleus Maleficarum* connected witches with all diseases, including epilepsy because "there is no infirmity, not even leprosy or epilepsy, which cannot be caused by witches, with God's permission." 129

Along with the fear of the evil of epilepsy ran the inconsistent belief that ecstasies experienced during seizures could lead to prophetic skills. On the one hand, the church believed that only those pure and healthy could be prophets, could be worthy to receive messages from God. On the other, there was a popular belief, surviving from pagan times, that sufferers could foretell the future. It is likely that these people were referring to forms of temporal lobe epilepsy that can induce ecstatic states and, sometimes, interictal (between seizures) religious or poetic mania. This manifestation became known as the "diviner's disease." As Temkin observes:

129 Edward L. Murphy, "The Saints of Epilepsy" (1959) 3 Med. Hist. 303.
The resulting differences of opinion were great, but the lack of consensus is hardly surprising in a time in which orthodox theology, Erasmian tolerance, religious rebellion, burning of witches, and the practice of magic and hermetic philosophies existed side by side. 130

Popular beliefs also arose about the association of epilepsy with genius. Writers drew attention to such people as Julius Caesar, Caligula, St. Paul 131, Mohammed (an idea promoted by Christians as negative propaganda), and Napoleon. 132 This ran counter to an equally strong belief that those with epilepsy were somehow mentally deficient, if not completely deranged. These contradictory beliefs hold sway today to some extent.

Every new philosophy muddied the waters of knowledge of epilepsy. By the time of Paracelsus and the alchemists (early sixteenth century), there was an urge to interpret diseases by cosmic analogies. Man the microcosm was thought to duplicate Heaven and Earth, the macrocosm. Instead of looking for cause and effect of disease, these doctors looked for cosmic similarities. For instance, an epileptic seizure was the equivalent of the genesis of thunder. Paracelsus also relied on astrology, alchemy and magical beliefs as well as allegorical analogies.

Epilepsy is compared to pride, and the pathology of the disease is brought into close parallel with the features of this vice. 133

By the end of the sixteenth century, the focus had returned to empirical observation and case histories. This period saw the rise in psychogenic diagnosis plus the recognition of the role

130 Temkin, supra note 119 at 161.


132 According to Murphy, supra note 129, 37 saints were associated with epilepsy, resulting in a profitable trade in "curative" bones and relics as well as pilgrimages to saints' tombs.

133 Temkin, supra note 119, at 179, discussing Paracelsus.
of head injuries. Anatomists suggested chemical irritation as a cause. By the late seventeenth century attention returned to natural causes. Now the difficulty was in distinguishing between epilepsy and hysteria, a puzzle that continued well into the nineteenth century, and which I will discuss in the next chapter. Temkin speculates that many cases diagnosed as hysteria may have been forms of temporal lobe epilepsy. 134

Although I chose epilepsy as a gender-neutral disorder, I have found that most diseases linked with brain power have also been linked with sexuality. Epilepsy is no different. By the eighteenth century the idea of demonic possession was on the wane. Sex was the new "demon." Prior to this, sexuality was an indirect factor; for example, exemplified by the use of blood in therapy. Menstrual blood was frequently used in therapy as well as blood from dead gladiators or from the heads of decapitated criminals. In fact the Ancient Greeks compared an epileptic seizure with the sexual act and recommended that those with epilepsy should abstain from sex. In extreme cases, doctors recommended castration as therapy, a technique to be revived centuries later.

Added to the menstrual myths described above, are those directly associated with epilepsy. Physicians in ancient times believed that good menses could prevent epilepsy in women and that amenorrhoea could cause it. Medieval doctors thought that a child begotten during the time of menstruation or from epileptic parents would itself suffer from incurable epilepsy. The Talmud advised that intercourse in the presence of a child or in the light could bring on epilepsy or cause the birth of an epileptic child. All of these ideas were compatible with prevailing views about the female body and about the sin of sexuality.

134 Ibid. at 224.
Like impotence, epilepsy was a bar to marriage in many societies and grounds for Jewish divorce or catholic annulment. According to a sixteenth century writer, it was customary to castrate men suffering from incurable diseases such as epilepsy. Epileptic women were isolated but if somehow they managed to become pregnant they were buried alive along with their babies.\textsuperscript{135}

As with hysteria, some forms of epilepsy were blamed on "vapours arising from the uterus."\textsuperscript{136} Called \textit{epilepsia uterina}, it differed from "true epilepsy" and was "peculiar to women of the hysteric temperament."\textsuperscript{137} This type of diagnosis marked the beginning of the type of medicalization described in the Chapter 4.

Late eighteenth century medical opinion about sexuality foreshadowed the wholesale wallowing in such matters that became common in the Victorian era. Doctors claimed that masturbation, sexual excess, and excessive continence could all cause epilepsy - just as they were later thought to cause insanity and impotence. Once again the insidious link between epilepsy and insanity becomes apparent through an obsessional focus on sexuality which

\[\ldots\text{had its origin not so much in rational pathology and critical observation as in the peculiar attitude of contemporary society toward matters of sex.}\textsuperscript{138}\]

How many of these myths survive today? Do they continue to have an impact on how society formulates and applies its laws? There is evidence that, in Third World countries, many myths prevail in their old form. For example, in Ethiopia, epilepsy is called the "spinning"

\textsuperscript{135} Ibid., citing Hector Boece (1536).

\textsuperscript{136} Ibid. at 185.

\textsuperscript{137} Ibid. at 225.

\textsuperscript{138} Ibid. at 232.
disease and is thought to be contagious. For a variety of reasons, the rate of epilepsy is often higher in developing than in developed nations and the stigma created by stereotyping has concrete effects in areas such as employment, housing and marriage.

People in rural communities in Africa perceive epilepsy as a feared and dreaded disease because of its alleged association with evil spirits and witchcraft. [Thus] a person with epilepsy in Africa suffers from social deprivation and prejudice ... and may even be ostracized by society.

This prejudice crosses gender and religious lines; men and women, Moslems and Christians, share similar beliefs. At first glance it may seem surprising that prejudice is just as high in families who have members with epilepsy as in the general population. However, studies in Britain have confirmed that those with handicaps are often less tolerant with others suffering from the same disorder than those who know little about it.

A number of researchers have documented "prejudice" in modern developed nations. They do not overtly talk about mythic influences but what else is prejudice but the "pre-judging" of a person or class of persons based on ideas of stereotypical attributes passed down through myth? Antonak and Rankin relate the stigma of epilepsy to that attached to other differences

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140 These attitudes are still common, although to a lesser extent, in developed nations. Rader et al. (infra note 147) note that people with epilepsy have greater problems gaining work as employers are afraid that they will be more accident prone than other workers. Gallhofer (infra note 142) found that only 50.7% of teachers questioned would approve of marriage of their child to someone with epilepsy.

141 Tekle-Haimont, supra note 139 at 206. Among the results of the study emerged the following: 75% would not employ someone with epilepsy; 67% would rent premises only under pressure; 50% would instruct their children to run away in the presence of an attack; only 26% would allow their children to marry someone with epilepsy.

142 Rader, Ritter & Schwibbe, supra note 124 at 330-331.
such as race, religion, or physical attractiveness. These differences could well include the female gender. The following observation could easily apply to female and male disorders: "For many people with epilepsy, society's attitude is more devastating than the disorder itself." The totality of discussion in this chapter leads me to suspect that, if society does not sometimes cause the disorder itself, it contributes to its perpetuation and misconception by a process of unconscious feedback of attitudes based on entrenched myth.

Antonak and Rankin note the continuing prevalence of negative attitudes toward epilepsy such as the idea that epilepsy is associated with "criminal tendencies, sexual deviance and insanity." As in the study on Ethiopia, they point to concrete disadvantages: eugenic marriage laws, insurance restrictions, exclusion from school and denial of employment opportunities. The reference to criminal tendencies may be an echo of Temkin's observation that some criminals would simulate epilepsy in order to escape obligations and criminal sanctions. There is no way to tell how many of these criminal tendencies were attributed to "epileptics" who were, in fact, skilful mimics. The question remains: did this stereotype originate with persons with epilepsy or with persons who, for the purpose of personal gain, exploited peoples' prejudices?

Antonak and Rankin call for educational programs "to dispel myths, correct misunderstandings, and change attitudes among medical professionals, educators, rehabilitation


144 Ibid. at 159, quoting from G.N. Wright, ed., "Rehabilitation and the Problem of Epilepsy," in Epilepsy Rehabilitation (Boston: Little-Brown, 1975) at 3.

145 Ibid. at 159.
counselors and employers." 146 The same rationale could apply to gender bias but, despite seemingly endless study groups and public debates, this idea is obviously easier to apply in theory than in fact, probably because we are dealing at the level of the collective unconscious. However, on a more hopeful note, these authors recognize a decrease in prejudice over the last twenty-five years.

Authors other than Antonak and Rankin also make the point that victims of epilepsy tend to live up (or down) to society’s expectations of them.147 Could this not be the same for victims of PMS who may act out in accordance with society’s negative expectations of premenstrual women? B. Gallhofer, in a study entitled "Epilepsy and its Prejudice" notes that "society will confront the epileptic child with a strong hierarchy of prejudices against all sorts of minorities." 148 He (assuming male gender from the use of the initial) discusses a number of instances in which epilepsy has been placed on a continuum of prejudice; for example, in comparison with other diseases, between insanity and diabetes and, in comparison with racial prejudice, in a worse position than immigrants from racial minorities. The mere fact that such comparisons are thought to be relevant or useful indicates the power of stereotyping attached to any group that falls outside the standard-setting norm of the healthy, middle class white male; be that group categorized by gender, race, class or - in the case of mental disorder, epilepsy and diabetes - disease.

146 Ibid.


148 Ibid. at 188.
Galloher did not confirm the above belief in criminal tendencies. Instead he found that the main handicap was social dependency which suggests that epilepsy has more in common with female gender stereotypes than male violence. Rader et al. also note what has been observed in many situations involving prejudice, that "behind the ostensible acceptance a considerable potential for objection is to be found when there is personal involvement." In other words, it is alright for epileptics to marry but not to marry "my daughter (or son)"; or, it is alright for women to be policemen, but not "my daughter (or wife)."

Interestingly, people with epilepsy have a more positive attitude toward their personal attributes despite the above finding that they are more prejudiced than "normal" people when it comes to things like employment and marriage.

Normal people are likely to attribute mostly negative qualities to epileptics such as: pedantic, fearful, selfish, dangerous, aggressive and moody; while epileptics [show] a more positive assessment.

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149 It is interesting to note that women (in general) have the same negative attitude to epilepsy as people suffering from various handicaps; for example, women, like those with epilepsy, expect negative consequences on the labour market from prospective rivals. (Rader et al., supra note 142 at 333)

150 Ibid.

151 Rader et al., supra note 124, at 327. The authors' use of words is significant. How do they define "normal" people? Note that they, like most authors, define subjects by their disease - "epileptics" - a practice that should be avoided as it turns these people into objects rather than individual human beings. (Compare the use of the word "impotent.")
Analogies may be drawn with attitudes toward menopause, which are more positive in peri- and post-menopausal women than in young women. This confirms that fear of the unknown and adherence to myth combine to shape attitudes. It is likely that they also combine to shape laws.

As in the past, researchers have attempted to relate epilepsy to abnormalities in sexuality and to the menstrual cycle. I will discuss the results of some of this research in Chapter 4. However, I believe it is appropriate to the study of the effects of myths and stereotypes to mention that there appears to be an unconscious wish among some researchers to find that epilepsy is associated with, or causes, impotence. Is this a case of one set of prejudices feeding off another, or is it the outcome of medicalization in general and the nineteenth century obsession with sexuality in particular?

With respect to PMS, a number of researchers have noted that in some women seizures tend to occur premenstrually; one study speculates that some cyclical abnormal behaviour might be due to a combination of premenstrual hormone changes and a predisposition to suffer from temporal lobe epilepsy. However, Louise Lander mentions that at least one psychiatrist has suggested that the extreme forms of PMS seen in criminal cases may, in fact, be due to a form of temporal lobe epilepsy.

Epilepsy, like PMS, is a protean disorder. It is probable that many different problems are subsumed under this heading. This may explain the inconsistency of some myths - saints and

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prophets versus sinners and madmen. Some authors refer to its various manifestations as "the epilepsies." Maybe, it would be more accurate to use that somewhat overworked nomenclature: "syndrome." A better defined and described classification of the disease would go a long way to assist lawmakers in establishing more just and flexible defences. Education about myths and prejudices would assist them in avoiding stereotypical responses to those charged with offenses.

V. CONCLUSION

The power and nature of myth have been a topic for lifetime study by a number of scholars, including philosophers, anthropologists and psychoanalysts. In this chapter I have tried to give an overview of the nature of myths and stereotypes relating to the sexual differences between men and women - especially "diseased" or "abnormal" men and women.

Myths are part of the conscious and unconscious heritage of all societies. They are larger than life metaphors for right and wrong, strength and weakness, sickness and health - "grand stereotypes" if you like. Stereotypes translate the heroic proportions of myth to generalized statements about proper and appropriate roles for human beings. In Western patriarchies, players of proper roles are arranged in hierarchies of power, with wealthy, healthy, sexually potent white men on top of the heap. They form the standard of excellence towards which all others must aspire but never attain.
The following flow chart illustrates one interpretation of this hierarchical structure.

Ideal normal man (standard of excellence) 

Normal woman
(conforms to stereotypes of patriarchy)

Diseased man
diseases common
to both sexes
(behaviour unaffected or equally affected - conforms with stereotypes within limitations of disease)

Diseased woman

Those at the top define normality for their whole community. It represents security and "rightness" for everyone. Anything different or abnormal engenders condescension, pity, suspicion, aversion or fear, depending upon the perceived nature and extent of deviance.

Under traditional patriarchal systems, the ideal man must conform to variations of one stereotype based on mythic heroes like Saint George, the dragon slayer, or Ulysses, the wandering adventurer. There is no equivalent for women. They seldom quest, and when they do - like Psyche - they search for their ideal man, not for themselves.\textsuperscript{155} Instead, women are the

\textsuperscript{155} Some women have tried to introduce new ways of looking at the hero myth which would open up alternatives for both men and women; for example, Carol S. Pearson, \textit{The Hero Within} (San Francisco: Harper & Row, 1989); Shirley Nicholson, ed., \textit{The Goddess Re-Awakening} (Wheaton, Ill.: Quest Books, 1989); Maureen Murdock, \textit{The Heroine's Journey} (Boston & Shaftsbury: Shambhala, 1990).
subject of competing myths and stereotypes. Young women are tempting seductresses, luring men
to evil or destruction; or they are innocent virgins in need of protection by the ideal man.
Women of reproductive age are still seductresses but may also be raging viragos; or they are
nurturing mothers whose place is to comfort the ideal man and to rear and protect his children.
Old women are evil crones or confused, depressed nonentities; or, in some cultures, they may
be wise rulers of extended families. The strongest stereotype, and one supported by a large
number of women, is that of the ideal or "normal" woman who is passive, obedient to men,
fertile and nurturing.

When behaviour fails to conform to set stereotypes, it is convenient to blame the body,
especially when sex differences seem to provide ready explanations for deviance. Epilepsy
provides an interesting illustration of the disease model, as explanations for its causes incorporate
myth, religion and medical science. Diseases thought to be related to sexuality provide further
overlays on this model. As I will show in the following chapters, scientific explanations for
disorders thought to be caused by abnormalities in human reproductive systems rest on
assumptions about men and women that have changed little over the centuries.
CHAPTER 3 - LANGUAGE, SCIENCE AND GENDER BIAS
THE PROCESS OF MEDICALIZATION OF DEVIANCE

In this chapter I will investigate the general concept of medicalization as it relates to people and behaviours that society has characterized, at one time or another, criminally deviant. In Part I, I will consider the lack of a female voice in medical science and how this has influenced concepts of normality and deviance. In Part II, I will examine the idea of medicalization as a tool for social control. Although there may be differing schools of thought about the definitions of medicalization, deviance and social control, I will largely confine this study to the model outlined by Conrad and Schneider since it provides a useful framework for analysis of specific topics such as PMS. I will discuss the nature of this framework, using for illustrative purposes the subject of suicide.

156 For a useful discussion of the concept of social control, see Cohen, supra note 1, With respect to women, he notes, at 354, that
[t]he question is not just how gender rules and roles may produce or inhibit deviance, but what are the structures and ideologies of control over women’s labour, identity and sexuality. Such controls - leading to invisibility, marginality or powerlessness - are not naturally located in the terrain of crime and deviance. Neither may they be naturally located in the terrain of medicine. However, when women commit criminal acts they cannot avoid interaction with the criminal justice system and, when they rely on biological defences, they can hardly turn their backs on the medical system.


158 I have chosen suicide because it is a behaviour that is considered by some societies to be deviant and by others to be normal. It is also a behaviour that is common to both men and women and does not depend upon sex-specific biology. Although the reasons for its occurrence might be influenced by gender issues, it is close to being gender-neutral. Hopefully, this will allow a general discussion of medicalization and deviance without the added complication of gender. However, I am aware that there could be possible links between female conditions such as PMS and suicide.
Deviance, by any standard, implies a detour around or away from the usual or normal. When this applies to human behaviour, a great deal of power accrues to those who are in a position to determine the dividing line between deviance and normality. Since medicalization plays an important part in the characterization of human behaviour, I will survey the rise of modern medicine and the gradual exclusion from or subordination of women within its ranks. This suppression of the voice of women in medicine has significantly deprived them of power to determine what behaviours are "sick" and appropriate for medical treatment. It has been left to men to formulate the language of scientific and medical "facts." Much of clinical practice is rooted in science, and since science is a social construct articulated by men,

[the] social agenda [of men] are incorporated by physicians in their ways of thinking about the problems of their patients.

I will show that, when it is dealing with sex differences, much of this language is based on the myths discussed in Chapter 2.

All of this information is essential to a rational evaluation of gender-based defences. As I will show later, the law is largely informed through the voice of medical experts. We are only just beginning an attempt to eliminate gender bias from our legal system. How can this be done

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160 Ibid. at 125. These statements may give the false impression that there is, or could be, one single voice for men and another single voice for women. I could be criticized for sidestepping issues of cultural, racial and class diversity within both genders. However, to keep this study within manageable bounds, I will assume for the moment that the "male" voice is composed of the accumulated articulations of the dominant male group within a Western culture; and that the "female" voice is an undefined body of opinion and belief that should be able, at least in part, to present common world views of a significant number of women.
and how can we accurately evaluate medical information if we fail to take into account prevailing
bias within the scientific and medical communities?

I. THE ABSENCE OF A "FEMALE" VOICE IN MEDICAL SCIENCE

A. THE HISTORICAL DEVELOPMENT AND ENTRENCHMENT OF MALE-
DOMINATED MEDICINE - THE ROLE OF WOMEN IN SCIENCE AND
MEDICINE

One of the stereotypical pictures of "woman" presents her as a nurturing care-giver, one
who soothes pain and comforts the distressed. Note that these are all attributes of a good
physician. In contrast, the stereotypical male is supposed to be tough and emotionless, likely
somewhat lacking in empathy. Note further that, until recently, almost all mainstream physicians
in Western society were men. How and why did this apparent role reversal occur? Are all male
physicians exceptions to the stereotypical rule? Do only empathic, nurturing (effeminate?) men
aspire to become doctors? Or does the answer lie in the aura of power that is part of the medical
profession? 161

Medicine was not always a powerful profession.162 Interestingly, or perhaps inevitably,
it was only when male physicians began to consolidate enough power to raise their own status
and to exercise significant control over society, that women were excluded. Not only were they

161 Barbara Ehrenreich and Deirdre English, in For Her Own Good: 150 Years of Experts' 
Advice to Women (New York: Doubleday, 1978) note, at 89, the requirement of lengthy training
that guaranteed that doctors would be largely from privileged backgrounds, but did not guarantee
that they would have any more practical experience and human empathy than the uneducated
healers they replaced.

162 Lander, supra note 154 at 11 notes that in the 18th century medicine was not even an
honoured profession.
excluded from general medicine, they were also squeezed out of disciplines concerned with
women's health - obstetrics and gynecology.

Once the medical profession gained power and respect as a monolithic organization, it
proceeded to define its own jurisdiction by classifying and stratifying the various specialties and
branches of medicine. In effect it created a perfect microcosm of present patriarchal society - a
hierarchy for everything and everything in its place within the hierarchy (a structure that should
be immediately recognizable to the legal profession). Subject matter that fell outside the
hierarchy was no longer "medicine" or else became "alternative medicine" - viewed with
suspicion by physicians and with hesitation by patients indoctrinated with mainstream ideology.

Researchers must be aware of modern definitions of medicine when determining the
historical roles of those in the healing professions. Until the medical profession drew its own
sharp boundaries, medicine could still incorporate a variety of healers from shamans and witch
doctors to midwives and herbalists. If we look at the past using definitions of today, we restrict
our vision of the roles of those who may now be considered outside the domain of medicine -
in particular, the role of women healers. For example, when Monica Green sought to determine
the number of women physicians in medieval England she found that official records were
"deafeningly silent." However, she found a dramatic increase in the number of women
practitioners when she expanded her definition to include anyone whose occupation was to care
for the sick.

With this caveat in mind, I will briefly trace the development and entrenchment of male-
dominated medicine and the gradual elimination of women from all but support or peripheral

163 Monica Green, "Women's Medical Practice and Health Care in Medieval Europe" (1989)
14 Signs: Journal of Women in Culture and Society 432.
roles. In doing so, I must be aware of cultural differences within what we tend to lump together as Western society. For instance, in North America there is little overlap between mainstream medicine and alternate forms. This division is not so rigid in Europe where physicians will often refer patients to chiropractors, for example, and where members of allied health professions enjoy greater personal responsibility for patient assessment and treatment. 164

We speak of the "profession" of medicine. What does this mean today? Eliot Freidson differentiates a "profession" from an "occupation" as follows:

It is useful to think of a profession as an occupation which has assumed a dominant position in a division of labor, so that it gains control over the substance of its own work. Unlike most occupations, it is autonomous or self-directing. In developing its own "professional" approach, the profession changes the definition and shape of problems as experienced and interpreted by the layman. The layman's problem is recreated as it is managed - a new social reality is created. 165

This definition applies with equal force to the specialized subdivisions within medicine; for example, urology, gynecology, neurosurgery. Each specialty defines its own area of jurisdiction and tends to concentrate on this area rather than on the human patient as an integrated being; or, as Louise Lander has put it, medicine tends to focus on a "small slice of

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164 For example, in my role as a hospital biochemist in Scotland in the 1960s, I was encouraged by physicians to interact with patients, to participate in assessment and therapy, and to attend educational seminars along with interested physicians. In Canada, few of these roles were open to me in a hospital setting - maybe because people tend to be more litigious in North America and, as a result, malpractice issues are of greater significance there. Doctors may be reluctant to delegate responsibilities for which they will be held ultimately responsible. (The same issues arise in the legal profession between lawyers and para-legals.)

human experience isolated from the whole." 166 This approach has been referred to as "atomism," identified as one of the "tenacious assumptions" of Western science and medicine. 167

The recent expansion of the holistic movement is a reaction against a profession that segregates one organ from another and treats it in isolation from the person it supports. Holistic medicine reflects ideas of interconnectedness now accepted in other scientific disciplines, including the "hardest" of them all, modern physics.

While medicine remained an "art" rather than the "science" that it has become today, physicians seemed to be more inclined to take a holistic approach. This may have been due, in part, to lack of knowledge of causation of disease and a lack of ability to cure specific disorders. As indicated in Chapter 2, prior to the modern era, physicians and laypersons alike believed that there was supernatural intervention or participation in disease. Healers, therefore, had to rely on an agency other than themselves to ensure the effectiveness of treatment. As well as providing an excuse in the event of failure, this subordination to a higher power ensured that physicians could not be the "gods" in society that they have since become.

Western medicine emerged as a separate discipline in Ancient Greece. Although Hippocrates believed that all diseases were visitations of the gods, he rejected superstitious beliefs held by the priests and shamans of that time. Women played a significant, but largely

166 Supra note 154 at 6.

167 Emily Martin, "The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles" (1991) 6 Signs: J. of Women in Culture and Society 485 at 497, citing Deborah Gordon who defines atomism as the notion that "the part is independent of and primordial to the whole."
forgotten, part in this new movement. Kate Hurd-Mead reports that there were many women doctors in Ancient Greece and Rome - surgeons as well as physicians. Seneca (approximately 4 B.C. to 65 A.D.) praised the "skilful fingers of his woman doctor" indicating that women were not confined to the treatment of their own sex. 168

However, appreciation of women's skill may not have included acceptance of their role in a man's world. For example, Pliny (23 - 49 A.D.) wrote "of the nobility of the profession of the obstetrix" but also remarked that women doctors should work in obscurity so that "after they were dead no one would know that they had lived." 169 If Pliny's attitude represents general opinion of his time, it means that those women physicians whose names have survived in history books must have been remarkable indeed. It seems that most writing by women doctors has been lost or absorbed as the work of male physicians. Hurd-Mead, herself a doctor, observed that

women lose their own identity in their professional life unless they publish some new and startling discovery; and invention and discovery are not common feminine qualities. 170

Although Hurd-Mead managed to overcome early 20th century reluctance to admit women to medicine, she, like Katherina Dalton of PMS fame, subscribed to stereotypical ideas of what constitutes "femininity." 171 I wonder how many earlier women physicians shared their view.

168 Kate Campbell Hurd-Mead, A History of Women in Medicine: From the Earliest Times to the Beginning of the Nineteenth Century (Haddam, Conn: The Haddam Press, 1938) at 41.

169 Ibid. at 41.

170 Ibid. at 70.

171 For example, Dalton's idea of a "normal" woman is represented in phrases such as "[her husband's] darling little love bird" [Once a Month (Pomona, California: Hunter House, 1979 and London: Fontana Paperbacks, 1978)] or (between attacks of PMS), "her usual sweet tempered and placid self." [The Menstrual Cycle (Harmonsndworth: Penguin, 1969) at 69.
Such self-effacement may partially explain the silencing of the majority of women in early medicine.

Although women were not confined to obstetrics and gynecology many of the few references to women in medicine deal with diseases of their own sex. Pliny recorded that Lais, Elephantis and Sotira wrote of abortion and treatment of menstrual difficulties. 172 There are also references by 2nd and 3rd century writers to the work of women physicians. A gynecological treatise by a woman doctor called Cleopatra was used until the 6th century, but no woman of that time gained the historical stature of famous male physicians like Galen.

With the rise of Christianity disease became equated with sin, and priests played a major role in medicine. History remembers two unusual women physicians of the Middle Ages. The first, Trotula, was a famous teacher in 11th century Salerno. 173 Healers used her work on gynecology and midwifery for centuries. The second, Saint Hildegard of Bingen (1098 - 1178), already mentioned in connection with epilepsy, wrote what have been described as the greatest scientific works of the Middle Ages: "Liber Subtilitatum," "De Simplicis Medicinae," and "Causae et Curae." She was also a philosopher, politician and prophet. 174

Despite their pioneering medical views, both women subscribed to prevailing stereotypes. Trotula believed that women were essentially weaker than men; Hildegard wrote that the weakness of woman’s will and her lack of bodily strength were due to the sins of Eve

172 Ibid.

173 Monica Green, supra note 163, notes at 340 that much of the work attributed to Trotula may have been written by other physicians. However, there is no doubt that she did make her own written contributions.

174 For further detail, see Hurd-Mead, supra note 174 at 183ff.
- this from a woman who survived migraines and seizures to live for eighty years in an era when average life expectancy was less than a third of that.

Although they have proliferated since the 19th century, there is evidence that numerous medical specialties existed during the Middle Ages and that women were scattered among them. Green states that in France between the 12th and 15th centuries, 1.5% of practitioners were women. She notes that during this period, licences were granted to women physicians and surgeons in Naples; and that records show that women practised medicine in Spain and Germany (most of the latter being Jewish). She also notes that, as in Ancient Greece, many records refer to women physicians but the women themselves remain nameless.

So far I have discussed "physicians" rather than healers in general. The former tended to be literate and well educated, often trained in universities. Between the 12th and 16th centuries secular and religious authorities instituted medical licensing throughout most of Europe. Practitioners with similar training and interests banded together to form guilds and protective societies. As Green points out, this led to fierce competition among university-trained physicians, surgeons and apothecaries who trained by apprenticeship, and empirics with no formal training at all.

Until the 14th century, these guilds appear to have been open to men and women. In 1322 a Frenchwoman called Jacoba (Jacqueline) Felicie was one of a number of people tried for practising medicine without a licence. Her accusers argued that, just as women were prohibited from practising law, they should also be prohibited from practising medicine.

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175 Green, supra note 163.
Similarly, in England in 1421 a petition was put before Parliament seeking to prohibit women from practising medicine on pain of punishment. 176

Like physicians, midwives came to be regulated by church or state authorities. Unlike physicians, midwives as a group do not seem to have organized themselves into guilds 177 maybe because midwifery crossed class lines. Generally midwives came from the class they were serving. 178 Thus medicine became not only gender but also class conscious. However, it was not until the 17th century, when men began to practice as midwives that the position of women started to deteriorate. Prior to this, women midwives held a respected position in society, only slightly below that of physicians.

The renaissance saw a renewed interest in Hippocratic medicine. Diagnosis rarely included a manual examination of the patient. 17th century physicians relied on visual observations and on what the patient reported about symptoms. Incomplete and inaccurate diagnoses, coupled with a lack of effective treatment even when the doctor could identify a disorder, made medicine a haphazard discipline at best and a lethal weapon at worst.

During this period, women continued to practice medicine one way or another, especially in the field of obstetrics. For example, many 17th century French noblewomen treated the sick during epidemics and in charity hospitals. 179 Obviously the Felicie trial of

176 Ibid. at 447 Green does not say why prohibition was sought or whether the petition was successful.

177 Ibid. at 448.

178 Brac, supra note 165 at 85.

179 Hurd-Mead, supra note 168, identifies Joanne Biscot (1601-1663) who was educated in medicine and Louise Marillac (1591-1671) whose assistants became the first Sisters of Charity. She also refers to two 18th century English physicians whose names have survived because of their special skill. Elizabeth Blackwell practised obstetrics and general medicine. Martha Mears
1322 did not fully accomplish what her accusers intended. However, in the case of epidemics it may be that the laws of supply and demand created a need for, and therefore a tolerance of, women physicians, just as wars have created a temporary need for and tolerance of women bus drivers and heavy machinery operators.

The rise of "scientific" medicine and the rise of a virtual male monopoly within medicine run in tandem. Four factors are important here: 1) medical competition and the formation of self-regulating medical associations; 2) the establishment of medicine as a "science"; 3) the creation of large public hospitals; and 4) the adoption of "scientific" explanations for women's supposed physical and mental inferiority.

1. Medical Competition and the Formation of Medical Associations

The competition between mainstream medicine and medical "sects," such as naturopathy and homeopathy, continued into the 19th century. In order to increase prestige and create practice standards within their profession, physicians in the United States, for example, joined together to form the American Medical Association. They also attempted to limit the number and type of practitioners by controlling access to medical education. This, of course, was the key to the exclusion of women from the practice of recognized medicine.

2. Establishment of medicine as a "Science"

It was not until the establishment of scientific medicine that physicians were able to create a monopoly for their chosen profession. Rival medical disciplines could not compete with the results of the discovery of bacteria and their partial control by antisepsis. Nor could they grant the relief from fear and pain offered by anesthesia. Science, not God, was now work in obstetrics was translated into German and used as a standard text throughout Europe.
responsible for curing the sick. Science proved to be more reliable in the eyes of the public, which began to grant physicians the status of gods.

Even though many diseases were beyond therapeutic control until the advent of antibiotics in the 20th century, improved standards of living led to improved standards of health. Conrad and Schneider observe that despite a lack of effective treatment, medicine was the beneficiary of much popular credit for improved health; and that medicine now had no difficulty in creating a self-regulating monopoly via state licensing which made other types of medical practice virtually illegal. 180

3. Creation of Public Hospitals

The 19th century saw this rise of centralization and institutionalization in many forms. For example, weavers and spinners no longer worked at home using hand equipment but were forced by economic necessity into large factories, to become virtual slaves of heavy machinery owned by a few employers. "Lunatics" were no longer hidden in attics or, if cast off by their families, allowed to wander the highways and byways. 19th century society treated madness as illness despite medicine's ignorance of cause or cure, and herded this new class of "patients" into large "asylums." 181

The expansion of large general hospitals and specialized "lying-in" hospitals was part of a process of medicalization via institutionalization. However, prior to Lister's discovery of antisepsis and Semmelweiss' work on the prevention of puerperal fever, hospitals were places

180 Conrad & Schneider, supra note 157 at 13-14.

181 For more information on the institutionalization of mental illness, see Conrad and Schneider, supra note 157 at Chapter 3.
to fear since the spread of infection often resulted in death after "successful" medical intervention.\footnote{For example, see Richard B. Fisher, \textit{Joseph Lister, 1827 - 1912} (London: MacDonald & Jane’s, 1977); Frank G. Slaughter, \textit{Immortal Magyar: Semmelweis, Conqueror of Childbed Fever} (New York: Schuman, 1950).}

4. \textit{Adoption of "Scientific" Explanations for Female Inferiority}

As society as a whole began to subscribe to a scientific model of medicine, it adopted "scientific" explanations for the inferior status of women. These explanations, although couched in biologically determined terms, served the economic and social interests of the day which mandated that woman be the breeder and man the provider. As the Industrial Revolution progressed, men and women no longer shared parenting and production. Each was relegated to his or her own separate and immutable sphere which varied according to class. New social directives "parcelled out personality traits along with tasks and geographical arenas."\footnote{Lander, supra note 154 at 31.} The belief arose that, for wealthier classes, motherhood is woman’s only proper function. Medicine became part of this process to the advantage of male physicians. It affirmed and expanded upon the perceived needs of economic and moral philosophy.

Medicine then, and even now, is not powerful enough to originate social values; the medical moralizers were simply echoing values triggered by larger social and economic interests and expressed equally in ways having nothing to do with medical theory. Medicine merely transmuted such values into the categories of health and disease, disguising ideology as etiology and concealing mundane interest behind the facade of medical expertise.\footnote{Ibid. at 24-25.}

\textquote{Lander, somewhat harshly, describes medical ideology as "a statement of ostensibly scientific, or at least objective, knowledge that furthers some social, economic, or political..."}
interest - bias camouflaged as expertise." 185 This may be true with respect to her topic - "Menstruation as Ideology" - and may also be true when medicine steps into the sphere of social control. But in those many instances where medicine has identified, cured and even eliminated disease (for example, smallpox), its very real expertise deserves recognition not dismissal. Rather than maintaining medicine on its pedestal, such recognition would, by sheer contrast, serve to highlight the inadequacy of the discipline when it attempts to tackle social problems within a medical framework and without input from other disciplines.

Although I have referred to the exclusion of women from the practice of medicine, it would be more accurate to say the attempted exclusion of women. Even in the United States, where medicine’s monopoly over health concerns was the most wide ranging, the wave of feminism toward the end of the 19th century contributed to the entry of a surprising number of women to the medical profession. For example, by 1890, there were 4,557 women doctors in the United States; and in the same year, 18% of Boston’s physicians were women - compared with 11.6% in 1976. 186

These statistics highlight the success of the early feminist movement which helped women enter medicine despite the fact that they were supposed to be "monthly cripples"

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185 Ibid. at 5.

whose heads were "almost too small for intellect but just big enough for love."  

However, as Walsh maintains, the decline in percentage between 1890 and 1970 serves as a warning to modern feminists that the recent upsurge in numbers of female physicians provides grounds for congratulation but not complacency. (The same sentiment could apply to other sciences and law.)

Physicians may have regarded the study and practice of medicine as beyond the physical and mental capacity of most women, but after Florence Nightingale’s efforts in Scutari during the Crimean war, they soon realised the usefulness of a band of trained women performing a helpmeet role within the new hospitals. As Walsh puts it: "somehow the nurse’s uniform was a successful antidote to the biological limitations that had been the curse of women doctors."  

Midwives, however, did not gain the same respect from the medical profession, perhaps because they were a greater financial threat than nurses. The role of the nurse was to provide physical and psychological support for the sick, not to diagnose and prescribe treatment. Midwives carried out many of the functions of nurses, but without the direction and control of physicians. They also intervened in difficult labour; for example, by using forceps. Once physicians had established jurisdiction over the birth process, it was in their financial interest to create a medical monopoly which would exclude or subordinate midwives. As already mentioned, midwifery took different paths in the U.S. and Europe. A short outline of its history provides a good example of both the medicalization of a natural

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187 Ibid. at 109 citing Horatio Storer, head of obstetrics at Harvard, and Charles Meigs, author of a standard text on obstetrics which included the second quoted phrase.

188 Walsh, ibid. at 120.
process, childbirth, and the absorption into, or the elimination from, medicine of midwifery as separate profession.

"In preliterate societies, experienced older women were holders of wisdom about childbearing."189 Midwives of that time - and of today where midwifery is recognized - did not merely tend to a woman's health; they also provided counselling and support to the mother and her family both before, during and after birth. 190 Men began to enter midwifery during the early 17th century when medicine had already established itself as a male preserve, and at a time when women healers still ran the risk of being accused of witchcraft. The first male midwives were university trained and generally confined themselves to the treatment of upper class women.191 Some men also entered midwifery through the guild system.192

The time was becoming ripe for a medical takeover. Brac identifies two hurdles that the medical profession had to overcome before gaining jurisdiction: 1) they had to be defined as socially acceptable persons to attend childbirth; and 2) normal childbirth had to be

189 Brac, supra note 165 at 85.

190 This leads me to wonder if postpartum mood disorders are less prevalent when women are assisted by midwives after delivery than when left to their own devices. Some studies (infra, Chapter 4) suggest that lack of social support is a factor contributing to depression.

191 For example, William Hunter assisted Queen Charlotte, wife of George III, at the births of 14 of her 15 children. He had university and apprenticeship training. His successful use of obstetrical forceps led to their acceptance by the general population. However, Hunter was a firm believer in letting nature take its course where ever possible - unlike some later male midwives. (See, James Willocks, "The Prize is Immortality" (1993) 14 Avenue 3 [Glasgow University Graduates" Magazine])

192 Brac, supra note 165.
redefined as a medical, rather than a natural, event requiring professional assistance by a doctor. 193

Medicine's grab for extra turf came up against Victorian notions of morality and sexuality. If physicians were to turn childbirth into a medical event, they would have to intervene by physical contact with the expectant mother; and not by some simple contact like tapping a knee reflex or looking down her throat, but by intimate contact with her sexual organs. Opponents of male midwives considered such contact to be immoral by exposing women to the "shame and pollution" of male touch. 194

On the other hand, midwives had relieved pain and saved lives with the use of obstetrical forceps. When given the choice between pollution and death, it is not surprising that pollution won, and having won, was redefined as necessary medical intervention. Green records the following 16th century advice to practitioners in Venice on how to ensure financial success: "get on well with pharmacists and make women fertile."195 She speculates that the latter road to success may have reflected male desire for progeny rather than concern for women. The same might be said for the removal of the taboo of physical contact with a male doctor, especially at a time when the medical profession was successfully eliminating or subordinating female midwives.

Now that physicians were acceptable care-givers, the last step in medicalization was the removal of the patient from her own domain to that of her doctor. In Europe that process has never become complete. Many women still deliver their babies at home under the care of

193 Ibid. at 83.
194 Ibid. at 89.
195 Green, supra note 163 at 455.
a midwife. However, licensing and regulating of midwives are now within the jurisdiction of
the medical profession; and the boundaries of midwifery are precisely set. The continuing
involvement of midwives has meant that, in Europe, childbirth has never been defined as a
medical "problem." It is still regarded as a natural process which should be left to take its
course unless abnormalities occur.

In the United States and Canada, the medical profession created a monopoly over
childbirth. Brac reports that Victorian beliefs about the frailty of women gained a stronger
hold in the U.S. than in Europe as evidenced by the following:

[W]omen are distinguished for their passive fortitude ... [T]hey have not the
power of action, or active power of the mind which is essential to the practice
of surgery ... [I]t is obvious that we cannot instruct women as we do men in
the science of medicine. 196

(It is interesting that men who witnessed the strength and endurance necessary to undergo
labour regarded it as "passive," and still believed women to be frail. This has to be an
example of preconception creating "imperception" - a topic discussed in the next section. It is
also amazing that these views gained hold in a country and at a time when women were
enduring the harsh physical hazards of pioneering.)

Until recently, midwifery was illegal in both Canada and the U.S. Qualified midwives
who immigrated from Europe could deliver babies only in an emergency when a qualified
doctor was unavailable. In the last few years, however, European concepts of midwifery
have been gaining popularity as part of a general holistic approach, especially among women
who are rebelling against a system set up for the efficiency and convenience of doctors rather

196 Brac, supra note 165 at 93, quoting from A Physician, Remarks on the Employment of
Females as Practitioners in Midwifery, (Boston, 1920).
than the comfort of women in labour. As a result, several states and some provinces have introduced licensing systems for midwives. This does not yet represent a process of demedicalization but may be an indication of a trend in that direction.\footnote{The demand for alternative methods of childbirth and the dangers inherent in an unregulated system, no matter how well intentioned, are highlighted in the case of \textit{R. v. Sullivan and Lemay}, [1991] 1 S.C.R. 489, 63 C.C.C. (3d) 97, 3 C.R. (4th) 277.}

Although public pressure has led to the development of "birthing rooms" and to the admission of family members to delivery rooms, it is likely that the medical profession has not changed its attitude significantly since 1979 when Brac noted that in the U.S. all deliveries were seen as potentially complicated and treated accordingly. Intervention by means of caesarian section, episiotomy, forceps and drug administration is still more common in North America than in Europe.\footnote{This intervention may well do more harm than good. Brac reports that there is a greater incidence of birth injury and infant death in the U.S. than in countries where intervention is not the rule. This, however, could be due in large part to the fact that the U.S. is the only developed nation that lacks some form of universal health scheme which makes medical care accessible to those who might otherwise be unable to afford adequate prenatal care. In the U.S., preventable complications may go untreated and may contribute to higher injury and mortality rates. That is, higher rates may be due to poverty and neglect rather than excessive medical intervention.}

Midwifery must still overcome the negative stereotype of the midwife as a "fat, dirty, drunken old woman" that has "passed from fiction into fact to encompass all midwives in all periods in many serious works."\footnote{Green, supra note 163 at 437, n. 6.} This stereotype seems to have arisen along with the rise of medicalization. It is not clear whether it originated with the medical profession or is an
expression of public opinion. I should imagine that, as with opinions about suicide, it arose from an interaction between both sources.

This brief discussion about midwifery demonstrates the process and results of medicalization. It shows how the layperson's language of childbirth has been transposed into the medical language of obstetrics, a language formulated and controlled by what is still a male-dominated profession. All disciplines develop their own "jargon," ostensibly as a means of precise intra-professional communication. To what extent is this jargon an aid to efficient communication; to what extent is it a tool to mystify the non-initiated and create an illusion of scientific objectivity; and, to what extent is it used to perpetuate the types of myths and stereotypes described in Chapter 2? In the next section I will elaborate on the idea, introduced in Chapter 1, of the power of language. I will also explore the effect of myth upon scientific observation and methodology.

B. LANGUAGE, SCIENCE AND GENDER BIAS

Although this section may appear at first sight to be an unnecessary digression from the central investigation, I believe that a fully informed evaluation of gender-based defences is impossible without some reference to basic assumptions inherent in biological research. These assumptions, and the language in which they are expressed, are the starting point from which flow medical "facts." In the courts these facts influence, and sometimes determine, the interpretation of legal "facts." If initial assumptions about basic human biology are invalid or biased, then defences such as PMS immediately become suspect. This illustrates the danger of polarized, either/or thinking. If we discredit the biological defence without investigating other possible extenuating reasons for women's "deviant" behaviour, such as
overwhelming social pressures and systemic discrimination, then many women may be unfairly deemed criminal. For example, this appears to be the case in the United States which does not recognize any distinction between infanticide and murder.

However, showing that medical facts rest on faulty assumptions need not lead to complete denial of the existence of possible biological conditions that might justify a legal defence. It merely invalidates the specific biological explanation that has been discredited. Some women, especially those who have experienced negative symptoms attributed to PMS, postpartum disorder and menopause, might naturally wish to cling to defences that appear to explain and excuse behaviour that society, and they themselves, perceive to be aberrant. Unfortunately, blind adherence to a faulty theory because of its supposed short term utility, closes the door to investigation of alternative explanations that might have less sexist biases. On the other hand, a blanket denial of the need for any defence based on biology may be equally unrealistic. 200 Just because one biological theory crumbles because of loose foundations does not mean that all biological theories must be suppressed as being politically incorrect for feminists, especially if research can be controlled for gender bias. The following discussion identifies sexist attitudes in biological research and reviews a number of suggestions for minimizing such bias.

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Conrad and Schneider have observed that "there is no greater right than the right to define the question." 201 In such an act of definition the questioner must draw on personal and collective experience, both conscious and unconscious, in order to reduce his question to words. (I use "his" advisedly, because in medicine and in science generally, the questioners have been overwhelmingly male.) In Chapter 2 I discussed the power of myth, especially gender-based myth, to affect our thinking in ways that are often beyond our awareness. Myths affect and sometimes create our world view. When we communicate them or connect them, through language, with scientific concepts, we perpetuate old ideas under the guise of new "discoveries." Nowhere is this clearer than in the area of sex difference research, which for centuries has rested upon the grand assumption of active male superiority and passive female inferiority. For years feminists have attacked this grand assumption. Many of them are now focusing upon the language used in scientific papers and are suggesting new ways in which to formulate questions and interpret results. 202

Language is the means by which we abstract an experience from its immediate physical context, and thereby attach to the experience a meaning independent of that context. 203

Courts have recognized the importance of language in the context of survival of minority groups. In a recent case, debating the legality of unilingual signs in Quebec, the Supreme Court of Canada wrote as follows:

201 Supra note 157 at 27.

202 For example, see Nancy Tuana, ed., Feminism and Science (Bloomington & Indianapolis:Indiana University Press, 1989).

203 Barbara Fried, "Boys Will Be Boys Will Be Boys: The Language of Sex and Gender," in Hubbard et al., supra note 186 at 37-38.
Language is so intimately related to the form and content of expression that there cannot be true freedom of expression by means of language if one is prohibited from using the language of one’s choice. Language is not merely a means or medium of expression; it colours the content and meaning of expression ... It is ... a means by which a people may express its cultural identity. It is also the means by which the individual expresses his or her personal identity and sense of individuality. 204

This reasoning could apply to gender, as well as linguistic groupings. But of what use is a right when most women are unaware or do not feel that they are speaking a foreign language - male; when they are unaware that they might have a choice; when they have no words of their own to express their identity?

Language is a crucial feature that distinguishes humans from other mammals. It is such an integral part of our existence that we tend to overlook its significance. This is particularly true in scientific research which seeks to extrapolate the results of animal experiments to human beings. Juliet Mitchell speaks of the significance of language as follows:

The human animal is born into language and it is within the terms of language that the human subject is constructed. Language does not arise from within the individual, it is always out there in the world outside, lying in wait for the neonate. Language always "belongs" to another person. The human subject is created from a general law that comes to it from outside itself and through the speech of other people, though this speech in its turn must relate to the general law. 205

"Consciousness requires language and language requires common communities." 206

Language and culture are inseparable and culture rests on myth. Therefore, from the moment


205 Juliet Mitchell, origin unknown.

206 J.C. Smith, supra note 36 at 18.
of birth (and some argue from the moment of hearing in utero) each individual absorbs myth. Adherence to a particular mythic system helps to define normal and abnormal behaviour within a community. Our present mythic system insists that men and women are innately different. Biologists and endocrinologists who search for "inherent" sex differences usually assume that they exist and can be explained by differences in hormone levels (or, more recently, differences in brain size). Thus they tend to study the effect of hormone levels on behaviour in an effort to equate the two. For example, they seek a connection between high levels of testosterone (traditionally called a "male" hormone) and aggression, and low levels of progesterone (traditionally a "female" hormone) and the non-passive behaviour attributed to PMS. They rarely document the effect of behaviour on hormone levels. Those who engage in the nature/nurture debate are only now beginning to realise the impossibility of attempting to separate the two when seeking causes for sex differences. 207

In this section I will illustrate the consequences of making mythic assumptions in scientific research, by summarizing some recent studies which will have relevance to later discussions on the medicalization of specific problems such as PMS.

A recent paper has described science as a "creative human endeavour whereby individuals and groups of individuals collect data about the natural world and try to make sense of them." 208 But whose sense is it? To many women, studying the field of sex difference research, the answer is "nonsense." Postmodern writers have exploded the myth


of scientific objectivity by pointing out that scientific questions and interpretations cannot be separated from the social context in which they arise. "An era's science is part of its politics, economics and sociology: it is generated by them and in turn helps to generate them." 209

Historian Nancy Tuana has traced the history of ideas about human reproduction from the time of Aristotle until the 18th century.210 She demonstrates how, throughout the ages, science and medicine have chosen their subjects and their approach from a viewpoint biased by contemporary fashion; and that fashion has been consistent in upholding the concept of female inferiority and "differentness."

Scientists, like everyone, work within and through the worldview of their time. The theories they develop and the facts they accept must be coherent within this system of beliefs ... From Aristotle to the reproductive theories of the 1700s we can trace a pattern of depreciation of the female principle in conception originating from the assumption of woman's biological inferiority." 211

I have already discussed some of Aristotle's beliefs about the process of conception in the previous chapter. In addition to his notions about male and female semen, he regarded the conception of a female child as a failure to produce a perfect specimen of humanity - a male; that is, "woman [was] a misbegotten man." 212

Later writers compared semen and uterus with seed and earth, the seed having an active, and the uterus a passive role. Mistaken observations about male and female sexual

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209 Ruth Hubbard, "Have Only Men Evolved?" in Hubbard et al., supra note 203 186 at 10.

210 Nancy Tuana, "The Weaker Seed: The Sexist Bias of Reproductive Theory" in Tuana supra note 208 at 147.

211 Ibid. at 147.

212 Ibid. at 152.
organs led to the belief that woman, in effect, was a "half-baked" man. Although there were minor amendments to these theories during the following centuries, their basic concepts remained unchallenged until the rise of the mechanistic theories of the 17th century, which held that each sperm contained a miniature, but fully formed, human being. Once again the female reproductive organs were reduced to a growth medium.

In the light of our supposedly sophisticated knowledge of today, some of these theories may appear to be ridiculous. However, they were political, as well as scientific, products of their times. Their sexist bias seems obvious to us now; but what about the bias of present day researchers? Without the impetus of feminist critiques, it is doubtful whether mainstream scientists would have considered changing the basic premise of female inferiority. Several writers have noted the continuance of terminology which assumes that male still equals "active" and female equals "passive."  

The Biology and Gender Study Group (the "Study Group") trace the evolution of 20th century ideas about reproduction and note that, even in the face of evidence that contradicts stereotypical sex roles, scientific writers continue to manipulate new data so that they seem to conform to old ideas. This is not to say that such manipulation is a conscious attempt to distort the facts. It is far more likely that sexist language is so engrained that it appears to the writers to be a convenient and appropriate vehicle for description of natural events.

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213 Ibid. at 154. Tuana notes that, when dissectors of the human body noted apparent similarities between the sexual organs of males and females, they concluded that those of the female were obviously inferior because they had been unable to emerge from inside the body.

214 For more detailed analyses, see The Biology and Gender Study Group, supra note 208; Luce Irigary, "Is the Subject of Science Sexed?" in Tuana, supra note 208 at 58; Evelyn Fox Keller, "The Gender/Science System: or, Is Sex to Gender as Nature is to Science?" in Hanen & Nielsen, supra note 9 at 33; Alison M. Jagger, "Sex Inequality and Bias in Sex Difference Research," in Hanen & Nielsen at 25; Emily Martin supra note 167.
Language used to describe the sperm’s journey to fertilise the human ovum borrows from such myths as the hunt, the hero’s quest, Sleeping Beauty and the rescuing prince. Writers talk about "armies" of spermatozoa, the ovum as "a passive victim, a whore and finally, a proper lady whose fulfilment is attained." Lombroso claimed that women’s passivity can be directly traced to the "immobility of the ovule compared with the zoosperm."

Emily Martin asks why positive images are denied to the bodies of women. She contrasts the negative words that describe female reproductive functions - ceasing, dying, losing, denuding, expelling in connection with menstruation - with the "breathless prose" that describes the male role. For example, the female "sheds" a single gamete each month, while the male "produces" hundreds of millions of sperm each day. It is remarkable how "femininely" the egg behaves and how "masculinely" the sperm. The egg is seen as large and passive. It does not move or journey, but passively "is transported," "is swept," or even "drifts" along the fallopian tubes. In utter contrast, sperm are small, "streamlined," and invariably active. They "deliver" their genes to the egg, and have a "velocity" that is often remarked upon ...
While the egg is a "dormant bride" the sperm burrows, penetrates, assaults. The Study Group claims that this designation of passive femininity and active masculinity to egg and sperm "means that sex, not just gender, can be socially constructed!" 219

New research has shown that neither the egg nor the female reproductive tract are passive; egg and sperm are, at the same time, both active agents and passive substrates. 220 Instead of speeding towards the egg, the forward thrust of the sperm is extremely weak; and, when it finally reaches the egg, its first tendency is to try to escape. To counteract this, the egg surface is designed to hold the sperm which then releases a digestive enzyme which softens the egg covering and allows entry. Despite this new evidence "researchers [continue] to write papers and abstracts as if the sperm were the only active party who attacks, binds, penetrates and enters the egg." 221

Sperm and egg produce molecules that are described as lock (female) and key (male). In biological papers dealing with topics unrelated to reproduction, the protein molecule is called the receptor since it has a pocket rather like a lock. Its partner molecule is thus called the key. In the reproductive process, sperm produce the protein molecule of the partnership. Despite this, the molecule from the ovum is called the receptor while the sperm is designated the key. In reproductive research "it is as if [the writer] were determined to make the egg the receiving partner." 222 Even though scientists now acknowledge a more active function for

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219 Supra note 208 at 178.

220 The Study Group describe writings by Gerald and Heide Schatten who have consciously tried to change metaphors by entitling an article "The Energetic Egg."

221 Martin, supra note 167 at 492.

222 Ibid. at 496.
the egg, it is "drawn in stereotypically feminine terms." The egg "selects," "prepares," "protects." 223

Some writers who have acknowledged an active role for the egg resort to another common stereotype. Instead of passively waiting to be awakened by the sperm, the egg is now pictured as a dangerous and aggressive threat, an entity that captures and tethers the hapless sperm, as a spider ensnares and devours its prey.

If these metaphors are so powerfully tenacious at the level of interaction between egg and sperm, how much more powerful they must become at the level of societal interaction between women and men. I will later show that these two pictures of woman - helpless victim or engulfing aggressor - influence decisions of judges and juries who have to decide the fate of women charged with criminal offenses.

In the legal field, women were justifiably pleased by recognition of the Battered Woman Syndrome because it helped explain why some abused women are ultimately forced to kill their spouses in self defence. But we must ask ourselves to what extent is this another version of the helpless female controlled to the point of annihilation by a strong overbearing male (the dragon monster) and who must be rescued by a scientific Saint George - the expert (usually male) witness. The language of this defence is such that, in order to be successful, it must adopt rather than refute sex-role stereotypes. 224

223 Ibid. at 495 and 496.

Both the Study Group and Martin note that new research "cannot seem to escape the hierarchical imagery of older accounts." 225 (Could the same not be said for defences that rely on sex and gender differences?) For example, in basic cell research "the modelling of the nucleus began with a template of domination: What controls what?" 226 DNA becomes the master or controlling molecule (male); cytoplasm is the passive substrate (female). Keller points out that the hierarchical depiction of DNA in most texts looks like "organizational charts of corporate structures." 227

The Study Group also observe that even organic chemistry uses fertilization metaphors. Small active molecules "attack" large passive, heavy molecules just as the sperm is mistakenly supposed to attack and transform the egg. "The imagery conforms to stereotypic attributions of maleness to energetic elements and femaleness to the passive ones." 228

Martin asks whether a less stereotypical view of human reproduction is possible. She points to a cybernetic model as one solution - with feedback loops, coordination of parts within a whole, and changing response to environment. However, she also warns that this model is itself non-neutral and has played an important role in the imposition of social control. She illustrates this by pointing out that, although it seems less narrow than other disciplines, social work's focus on the environment can be yet another way of exercising

225 Martin, supra note 167 at 497.

226 Study Group, supra note 208 at 181.

227 Ibid. at 181 quoting from Evelyn Fox Keller, supra note 30.

228 Ibid. at 183.
social control: "management of the "patient’s" psychology [is] a new entree to patient control." 229

If Martin’s warning is accurate, then researchers must beware of blindly espousing a multivariate approach as an unbiased solution to social and health problems. Sociology writers tend to focus on a multivariate approach, with environment playing an important part. Readers are led to assume that this approach will be free of the bias or one-sidedness inherent in other scientific disciplines. Martin reminds us that sociology, just like medicine, is an agent of social control and may be just as dangerous to women because it presents its findings under the guise of a balanced perspective. The answer is not to turn our backs on disciplines trapped in hierarchical metaphors. This would leave women in limbo, for in a patriarchal society no discipline (even feminism) can be entirely free of such metaphors. The answer is to be constantly aware of their nature and impact. "Waking up such metaphors, by becoming aware of their implications, will rob them of their power to naturalize our social conventions about gender." 230

However, such awareness is rare and slow in coming. Often it may be more politically expedient to rely on theories like biological determinism. Helen Lambert argues that people are more willing to make restitution for inequality if they perceive that it has social rather than biological causes. At the same time, scientists are constantly seeking for biological explanations for differences between men and women. This kind of explanation has sometimes appeared to work in favour of women - for example, in the creation of the crime of infanticide - but on the whole it serves as an excuse for unequal, unfair treatment.

229 Martin, supra note 167 at 498.

230 Ibid. at 500.
Feminist writers have also looked at the use of language in the field of hormone research; particularly with respect to investigations into "tomboyism." Longino and Doell have undertaken a detailed study of scientific methodology and bias from the formulation of hypotheses and the gathering of data to the interpretation of evidence and justification of conclusions. They concentrate on the operation of male bias as distinct from its existence, starting with the gathering of facts.

The choice of facts to be explained by scientific means is a function of the reality constructed by this process of selection [in which some facts are selected and others ignored]. What counts as fact - as reality - will thus vary according to culture, institutional perspective, and so on, making this process of selection one point of vulnerability to external influences.

Their discussion is pertinent to sections of the next chapter which will examine medicalization of specific problems of both men and women. They observe that questions about sex hormones can be grouped into three areas in which sexual differences are believed to be manifest; that is, the effect of hormones on 1) anatomy and physiology, 2) temperament and behaviour, and 3) cognition.

In "tomboyism" much research has focused on temperament and behaviour, often extrapolating results from animal experiments to humans, thus ignoring early environmental influences. As Diana Fishbein points out, results from animal studies are valuable but not

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231 Congenital adrenocortical hyperplasia (CAH) - supposedly caused by exposure to excess androgens in utero. (Androgens trigger male differentiation in the fetus with XY chromosomes).


conclusive with respect to human behaviour. Unlike animals, humans are not slaves to their
instincts or genetic patterns; humans have intellectual resources and social learning
environment that can modify biological drives.

One paper cited by Longino and Doell fails to take into account that data come from
patients and their families who know about the condition and therefore may treat the patient
differently because of preconceived expectations of boyish behaviour. 234 In an earlier
paper, Barbara Fried argues that "[i]n the act of naming the disease "tomboyism,"
[researchers] already impute to it a cause - namely, a woman imitating a man’s behavior"
235 and that

by choosing to assign different names to a characteristic when it occurs in men
or in women, the authors guarantee that they will discover that characteristic to
be differentiated by sex. [For example, Don Juan Syndrome versus
nymphomania] 236

Instead of using a neutral word to describe the same type of behaviour in men and women,
music assigns different value-loaded terminology to each sex. The same is true of
descriptions of the so-called sex-hormones themselves. Although both sexes produce
androgens and estrogens, the former have been designated as "male" and the latter as

234 Longino & Doell, supra note 232, describing experiments conducted by Anke Ehrhardt
and Heino Meyer-Bahlburg, "Effects of Prenatal Sex Hormones on Gender-Related Behavior"

235 Supra note 203 at 50.

236 Ibid. at 52.
"female" hormones; this despite the fact that in women as well as men it is testosterone that regulates libido. 237

It is also interesting that there has been a great deal of attention paid to the role of testosterone in the induction of testicular tissue in utero. It seems to be assumed that the Y-chromosome plays an active role in creating a male fetus while there is no corresponding role for the extra X-chromosome in the female fetus. Two women researchers have observed that the induction of ovarian tissue, like the induction of any other cellular differentiation, is an active genetically directed process; however, "[a]lmost nothing has been written about genes involved in the induction of ovarian tissue." 238 This is an interesting echo of the discussion in Chapter 2 where I noted that most societies believe that men are created by the active intervention of initiation rites but that women simply "become" because of their inherent nature.

The foregoing discussion has concentrated on sexism in research but has said little about means of counteracting or curing this defect. Some feminists might argue that myths about sex differences are so engrained that it is impossible to conduct studies on this topic without succumbing to sexist attitudes and terminology. Angela Jagger stresses that the motivation behind research into sex differences has always been the "pervasive existence of sex inequality," and that

237 See, for example, Elliot E. Philipp, Josephine Barnes & Michael Newton, Scientific Foundations of Obstetrics and Gynecology (London: Heinemann Medical Books, 1986), at 187, where they state that testosterone appears to have a stimulating effect on female sexual behaviour, and that oophorectomy and adrenalectomy (removal of organs that manufacture testosterone) decrease sex drive.

238 Eva Eicher & Linda Washburn, "Genetic Control of Primary Sex Determination in Mice," (1986) 20 Annual Review of Genetics 327 at 328, cited by the Study Group, above note 208 at 179.
the research context of sex inequality makes it more likely that research programmes that promise to confirm existing sex prejudice will be funded, that sex differences rather than sex similarities will be discovered, that those differences will be interpreted as female deficiencies rather than women's strengths, and that research results that reinforce existing sex hierarchies will receive a warmer welcome than results that challenge the sexual status quo.

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She reasons that the very existence of so much research into this topic makes credible the idea of inherent sex differences. However, she concludes that such research should not be abandoned but should be approached with suspicion; the same suspicion that would be accorded to similar studies on race difference.

The approach of the Study Group goes beyond suspicion, which could so easily degenerate into blind mistrust, to suggest that feminist critique should be one of the normative controls that any scientist must perform when analysing data - just as he or she might control for external temperature, time of day, etc. This would include controlling for the researchers' own norms which tend to impart their own social meaning instead of those of the subjects they study. 240 A number of writers note that researchers are typically less interested in the typical than the atypical and that little is reported on, for instance, happily married middle-class healthy women. 241

239 Alison M. Jagger, "Sex Inequality and Bias in Sex Differences Research," in Hanen and Nielsen, supra note 9 at 31.


241 For example, ibid. at 148. It is a moot point whether happily married middle-class healthy women are "typical" or "normal" but in Western society this still seems to be the standard of excellence in women for which we are supposed to strive.
Longino suggests that one response to male bias in research would be to adopt assumptions that are deliberately gynocentric, presumably in the expectation that this form of Hegelean dialectic would ultimately lead to a balanced central position of sex neutrality. This mirrors on a small scale the approach advocated by J.C. Smith who believes that the only way to end patriarchy is to consciously adopt a system based on matriarchal myth. This may well be a valid long term tactic but in the meantime I doubt that there is much hope of persuading mainstream male researchers to adopt a female worldview, especially when they are unlikely to admit, from their "objective" positions, that such a worldview is necessary or relevant.

The approach of the Study Group is more likely to achieve short term success as more women hopefully enter scientific fields. Gender bias is currently a "hot" topic in many areas including law and medicine and it is becoming "politically correct" to consider its existence both in theory and in practice. Ruth Hubbard suggests a number of tactics that would allow the continuance of sex difference research without the perpetuation of male bias. For example, she advocates paring away mythology to get closer to raw data - if such data are still available. This might lead to the formulation of hitherto unconsidered questions.

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242 Ruth Hubbard, supra note 203, also advocates the creation of female-centred theories to avoid the trap of unconsciously falling into existing myths.

243 J.C. Smith, supra note 36.

244 Hubbard notes the difficulty in obtaining such raw data in the scientific field. There are similar difficulties in the legal field where common law researchers rely so heavily on reported cases as primary sources. For example, reported cases on the PMS defence are conspicuous by their absence in mainstream law reports. Even cases that go to courts of appeal are ignored by editors. The Craddock case (see infra, chapter 6) that went to the English Court of Appeal is nowhere to be found in the All England Reports or the Appeal Cases. Researchers must rely on sparse information from computers or on personal surveys of court records.
Alternatively, she asks scientists to concentrate on the errors inherent in male myths - a kind of scientists' consciousness raising? Another strategy, often ridiculed in the popular media, is to remove sexist language; for example, "male" and "female" hormones.

Fear of continuation of the damage caused in the past by theories of biological determinism could too easily lead to denial of the existence of any differences based on sex. Some differences have been more imagined than real, but others can hardly be denied; the most obvious being the reality that men cannot gestate and give birth. The danger to women comes not from the existence of real differences but from the negative interpretation of those differences. Abandonment of biological determinism for environmental determinism is not the answer. This would merely switch the current of interpretation from one patriarchal pole to another. The very existence of such "-isms" is evidence of "either/or" exclusionary thinking.

One solution might be to combine these two extremes to create the "biosocial approach" outlined by Ann Hall in her study of women in sport. She believes that "insightful research in behavioral endocrinology and neuroendocrinology cannot be dismissed in the same way that it is possible to discredit the biological determinism of sociology." She distinguishes this approach from that of sociobiology which seeks biological explanations for social behaviour. Biological influences in both women and men interact with social influences. Denial of one gives too much weight to the other.

This is especially relevant to the question of gender-based defences which rely exclusively upon biological causes. Yet the inclusion of social factors in such defences could

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246 Ibid. at 74.
open a legal minefield. The law would have to deal with how to quantify social factors, if and when to draw the line, how to treat or punish, how to maintain sexual equality rights. However, as long as these defences are based on medical definitions, the law must wait until medicine and its allied disciplines make up their collective minds whether or not certain conditions are medical problems and, if they are, whether or not there are medical solutions.

II. MEDICALIZATION AND CRIMINAL DEVIANCE

Subject matter can be said to be "medicalized" when the medical profession and the community at large consider that it should come within the domain of medicine. Subject matter may also be "biologized," "psychologized" and "psychiatrized." When, as I will illustrate below, social workers use the "sickness" model in their dealings with their clients, it could be said that this branch of applied sociology comes within the ambit of medicalization. I will include these classifications within the umbrella definition of "medicalization." As Demie Kurz has put it:

Some now use the term "medicalization" to describe how the medical profession can label and gain jurisdiction over many areas of life which involve the workings of the body or mind such as drug addiction, alcohol, aging; birth control, pregnancy, and childbirth; and child abuse.

On its face, medicalization appears to be a fairly innocuous concept. Few would argue that the process starting with the discovery of bacteria and ending with antibiotic cures for disease is harmful to society. Such scientific advances have helped to separate medicine from

247 The only dictionary that recognizes the word "medicalize" is Random House (2nd ed., 1987) which states that it means "to handle or accept as deserving of or appropriate for medical treatment.

the superstitions of the dark ages. For example, people in earlier times may have believed
that the physical manifestations of tetanus were evidence of demonic possession. New
knowledge has classified it as an infection which is open to prevention and cure. In this type
of case the transition from myth to medicalization has been of benefit to all human beings,
regardless of age and gender. However, even in this simple example, the process of
medicalization tends to focus on individuals rather than society as a whole. Physicians tend to
look for cures that act on each separate patient. Unless they are involved in "public health,"
they are unlikely to investigate too closely those conditions - such as poverty and
overcrowding - that foster susceptibility to and spread of disease.

Feminist writers have for some time been aware of the danger of classifying or
creating categories that are confined within the narrow boundaries of "objective" science.
Once subject matter is slotted into the comfortable and often simplistic niche of biology,
endocrinology, gynecology or any other kind of "-ology." it tends to be taken out of the
realm of wider disciplines. Alternatively, each discipline follows parallel unrelated paths so
that available knowledge cannot be assessed on a global basis. This can result, as King points
out, in multiple diagnoses by multiple healers leading to multiple therapies. 249 If these
therapies were to complement each other there would be little cause for concern. However,
the gulf between some specialties within scientific medicine and the gulf between the Colleges
of Physicians and Surgeons and other healing disciplines such as naturopathy, make a
cooperative search for effective therapies a fairly remote idea at present.

15(4) Women and Health 1.
A. THE PROCESS OF MEDICALIZATION

How does subject matter come within the domain of medicine? Both Kendall and Bell refer to the following description of the process as outlined by Conrad & Schneider. Because of its adverse effect on many women, a number of feminist writers have imbued the word "medicalization" with negative connotations. In many cases it has become a pejorative term. In order to remain as neutral as possible at this stage, I will use the non-gendered phenomenon of suicide, discussed by MacDonald, to create a concrete example, and to show the initial stages of transition from "criminal" to "medical" behaviour.

1. Society classifies certain behaviour as deviant.

Inhabitants of sixteenth and seventeenth century England regarded suicide as "a kind of murder committed at the instigation of the devil." As well as profane burial and ritual mutilation of the body, penalties included the forfeiture of all the suicide’s movable property to the crown. Both secular and newly formed protestant authorities had an interest in promoting popular hostility towards self-murder. Some medical writers speculated that

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250 Kathy Kendall, supra note 62.

251 Susan Bell, supra note 67 at 151; and "Changing Ideas: The Medicalization of Menopause," in Formanek supra note 55 at 43.

252 Michael MacDonald, "The Medicalization of Suicide in England: Laymen, Physicians, and Cultural Change, 1500-1870" (1989) 67 The Milbank Quarterly, (suppl. 1) 69. However, some writers have tied suicide in women to their hormone cycles. A recent publication for "young women" refers to a "study of attempted suicide by hospitalized women in Los Angeles, London and Delhi (India) [that] shows that as many as 50 percent occurred in the first four days before or after menstruation." (Gilda Berger, PMS: A Guide for Young Women (Alameda, Ca.: Hunter House, 1991) at 31. [I would think that the occurrence after menstruation would rule out PMS by any of its many definitions. See discussion infra.]

253 Ibid. at 69.
suicides suffered from a disease of melancholy but society was not yet ready to allow this as an excuse. Instead medical arguments were "simply absorbed into the prevailing supernatural interpretation of the crime." Thus medicine was unable to influence prevailing cultural norms; instead medical opinion was absorbed or adapted to reinforce existing beliefs. (This theme will recur when I describe the medicalization of other problems.)

2. Discovery of medical etiology.

A prerequisite for the discovery of etiology was the secularization of disease. A "scientific" cause could not be entertained while everyone believed that

"[h]uman being’s susceptibility to disease was a consequence of the Fall, and any illness might be punishment for an individual’s sin – either sent directly from God as retribution or "judgment" or indirectly from the devil, acting as God’s malevolent instrument." 255

With respect to suicide, social, cultural and political factors caused a dramatic change in attitude between 1600 and 1800. Naturally, the ruling classes were unhappy about the loss of their goods and chattels. After the Restoration, the monarch had little power to enforce forfeiture and juries began to declare verdicts of non compos mentis. Blackstone declared that forfeiture was "odious." By the early eighteenth century public opinion had shifted to the point where all suicides were regarded to be out of their minds at the time of death. "Contemporary critics had no doubt that juries had embraced a secular, medical interpretation of self-destruction." 256 This progression mirrors that of infanticide two centuries later. As I

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254 Ibid. at 72.
255 Ibid at 74.
256 Ibid. at 78.
will discuss below, infanticide also changed characterization from crime to illness by means of medicalization - in large part due to effective pressure by jury members who ignored the letter of the law to achieve what they believed to be justice. 257

These changes in attitude were fostered by freethinking philosophers like Voltaire and Rousseau and a renewed interest in classical ideas. The subsequent rise of Romanticism, which included the notion of the "sentimental suicide," was strong enough to overcome protests from the clergy and evangelical parishioners.

It would seem only natural for medicalization to be instituted by the medical profession. However, in the cases of suicide and infanticide at least, the driving force came from laypersons. As MacDonald notes, "physicians made no notable contributions to the understanding of suicide in the late seventeenth and eighteenth centuries." 258 This may be, in part, because medicine at that time had little of the authority that it gained later. However, specific illustrations of the process of medicalization as it relates to the topics discussed in the previous chapter, tend to support the idea that politics and cultural change create a need for medical etiology; medical professionals, being members of that culture, transform this need into practice. 259

257 A similar phenomenon occurred during the early abortion trials of Dr. Henry Morgentaler. Despite overwhelming evidence that he had disobeyed the letter of the law, juries refused to convict him of a criminal offence.

258 Supra note 252 at 82.

259 See, for example, Riessman, supra note 159.
Formanek has observed that, despite new knowledge, old ideas continue to thrive and that science has little practical effect on superstition. This is especially true in relation to myths about the female body, as I will show in the next section.

3. Claimsmaking and counterclaimsmaking by professionals and non-professionals about proposed medical definitions of the behaviour.

As the medical profession began to gain great prestige during the nineteenth century, their voices began to outweigh those of laypersons, including philosophers. For example, eighteenth century philosophers of the Enlightenment viewed suicide as a rational choice not as evidence of a deranged mind -a view that is increasing in popularity today. In contrast, medicine regarded self destruction as an end result of irrational insanity. Similar competing ideas surfaced with the introduction of the concept of premenstrual syndrome. Many feminists see the symptoms as being a rational consequence of the powerlessness of women while many physicians see them as being the irrational consequence of hormonal fluctuations.

4. Contest for ownership of the "disease" among various medical specialties.

With the rise in popularity of the biochemical model of disease, psychiatrists and psychologists no longer have exclusive jurisdiction over suicide as a medical problem. Again this echoes the situation with respect to women’s problems. Therefore, I will discuss this aspect in more detail in the next chapter.

260 Ruth Formanek, (1990), "Continuity and Change and the "Change of Life"," in Formanek, supra note 55 at 3.

261 For full discussion, see Chapter 4.
5. Institutionalization - growth of clinics, recognition by professional organizations and self-help groups and, where appropriate, recognition by the legal profession.

The creation of suicide as a mental disorder occurred concurrently with the start of migration to the cities and the establishment of "madhouses" and "lunatic asylums." Families no longer had to watch over suicidal members. Those who felt helpless concern about the fate of their unhappy relatives could feel justified in sending them off for "treatment" by professionals. Those who considered these relatives to be embarrassing nuisances could have them certified and confined indefinitely.

Modern society still tends to regard suicide as a sickness that should be treated by psychiatrists but many professionals are now willing to look at external, societal causes. Several groups have sprung up to counsel potential suicides; recovering victims can join a number of self-help groups. The law no longer defines deliberate self-destruction as a form of criminal deviance. However, the law in North America continues to apply criminal sanctions for those who assist another to commit suicide so that anyone who, with the most humanitarian of intentions, participates in such an act runs the risk of a conviction for counselling, aiding or abetting suicide or even first degree murder.\(^\text{262}\)

The area of suicide offers a good illustration of the way in which medicine and law reflect rather than initiate changes in public opinion. This does not mean that law and lawyers play no part at all in the creation of intellectual and popular trends of opinion. To the

\(^{262}\) For example, see Jim Persels, "Forcing the Issue of Physician Assisted Suicide: Impact of the Kervorkian case on the Euthanasia Debate" (1993) 14 J. Legal Medicine 93. This issue has recently been in the news in Canada in relation to assisted suicide for AIDS victims; and, in particular, in Rodriguez v British Columbia (A.G.) [1993] 3 S.C.R. 519, 24 C.R. (4th) 281, in which a victim of A.L.S. (Lou Gerig's disease) unsuccessfully challenged S. 241 of the Canadian Criminal Code which forbids anyone to counsel, aid or abet suicide.
contrary, legal scholars, law reform commissions, adventurous judges, and imaginative lawyers all play an important part in movements for change. Although academic papers are often abstract and philosophical, most of them are also prescriptive, offering practical and theoretical solutions to legal and social problems. Public response is rarely instantaneous. However, if other factors are conducive to the adoption of these solutions, legal opinion will gradually filter through professional organizations to the mass media and will have an ultimate influence in the formation of popular interest groups. The chain is completed when these interest groups have enough political power to force legislative change.263

Conrad and Schneider, in *Deviance and Medicalization*, have conducted a wide ranging study of the relationship between medicalization and deviance. Just as Temkin's approach in *The Falling Sickness* provided a useful focus for my discussion of epilepsy, Conrad and Schneider's approach provides a logical framework for a general discussion of medicalization of subject matter that comes within the realm of law. In later sections I will show how these general ideas have been applied in the context of female and male reproductive functions and of epilepsy.264

263 Recent efforts in Canada to pass legislation authorizing assisted suicide have failed. However, the narrowness of the decision by the Supreme Court in *Rodriguez*, in which the slim majority (5:4) upheld the constitutionality of S. 241, indicates that this issue will once again be ripe for legislative change in the near future.

264 However, it must be remembered that Conrad and Schneider do not seem to include social science within the ambit of medicalization. Does this mean that they believe that social science is not a vehicle for social control; or that they believe that social science is so far removed from medical science that the former lacks the capacity to be "medicalized"?
B. THE MEANING OF DEVIANCE

Since this study focuses on criminal law, it deals with behaviour that fails to meet certain standards set by society. In other words it deals with a form of deviance that is so unacceptable that it subjects the actor to punishment under the law. Criminal deviance may be defined as a quality attributed to persons and behaviours that are objects of condemnation by those with decision making power in society. 265

Criminal law has no interest in medicalization except where it impinges upon definitions of criminal deviance or upon suitability for processing through the criminal system; for example, the application of police and prosecutorial discretion with respect to charges and fitness to plead. To understand properly the concepts and consequences of medicalization in relation to their relevance to law, it is necessary to deconstruct the concepts and consequences associated with the label "deviant."

Conrad and Schneider note that all societies have their own definitions of what types of behaviour constitute deviance. 266 They outline the following qualities of deviance which I will tie in to the example of suicide used above. Although separated for convenience into separate categories, there is a great deal of overlap among them.

265 This is the type of definition espoused by criminologists who subscribe to labelling theory. Although there are other beliefs about the meaning of deviance, I find this to be the most useful one in the context of the present study. As Condrad & Schneider have put it: "What is considered deviant in a society is a product of a political process of decision making. The behaviors or activities that are deviant in a given society are not self-evident; they are defined by groups with the ability to legitimate and enforce their definitions." - supra note 157 at 22.

266 Ibid. at 5ff.
1. **The concept of deviance is universal but there are no universal forms of deviance.**

   This means that deviance is also relative; the same act may be deviant in one society but praiseworthy in another, or rejected by most members of a society but accepted by a minority group. Suicide is a dramatic example. At various times, Western Judeo-Christian society has labelled suicide as sinful, immoral, criminal and cowardly. In sharp contrast, Japanese society has glorified suicide as natural, moral and brave. In fact, as in ancient Rome, *failure* to commit suicide in some circumstances - for example, when chosen to be a kamikazi pilot - is the selfish act of a cowardly deviant. Another example comes from Inuit tradition where the elderly who had become a burden on, or threat to the survival of, society were expected to leave the community and will themselves to death.\(^{267}\)

2. **Deviance is a social definition, an ascribed status, not an absolute.**

   "It is not the act but the definition that makes something deviant." \(^{268}\) For example, going to certain death in an attempt to save the life of another will result in public eulogies; whereas, going to certain death in order to escape personal pain will still likely result in the label "deviant" despite the efforts of people like Sue Rodriguez.

3. **Social groups make rules and enforce their definitions on members through judgment and social sanction.**

   Even if an act, like suicide, ceases to be criminal, society may still consider it to be intrinsically immoral. The consequences for the actor and her family will then depend on

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\(^{267}\) See, for example, E. Adamson Hoebel, *The Law of Primitive Man* (Athenaeum Press, 1983) in particular at 74-77.

\(^{268}\) Conrad and Schneider, supra note 157 at 65.
whether society identifies the cause as "badness" or "sickness"; that is, whether the subject has been medicalized. An unsuccessful suicide, in Western society, is an object of pity and concern, to be treated by medicine or psychology in order to ensure a return to the prevailing standard of normality. The suicide is therefore classified as "sick."

Suicide, the ultimate escape, is also an ultimate expression of criticism of society. The actor is saying: "This world created by those with political power is impossible for me to live in." Those with power are answering: "Very few people attempt suicide. Therefore, the problem lies not within society but within you." This means that, generally, society does not even recognize that the act may be a form of criticism. Instead, it classifies the act as deviant and mitigates its consequences by the application of the excuse of sickness.

This concept is important in relation to criminal defences, in particular those that offer an excuse for otherwise criminal acts. If society is at fault, or at least partly to blame for circumstances which lead to attempted suicide, then the person who tries to kill himself should not be subjected to criminal sanction. For example, a teenager with uncontrollable epilepsy may be the victim of stigma based on social myths and stereotypes. As a result, he is afraid to go out, lacks friends, and is a cause of embarrassment to his family who may also subscribe to adverse mythology. His disease is unpleasant and painful, but might be supportable were it not for the negative attitudes of society. In despair he tries to kill himself. The apparent unwillingness of society to remove prejudices about epilepsy denies hope for improvement. Because society is at fault, the teenager could argue that his action was excuseable. Society has driven him to it.

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269 Exceptions are teen suicide and suicides on native Indian reserves where society as a whole is gradually realising the effect of social and environmental factors.
However, if society refuses to recognize the existence of an external cause - prejudice, then it perceives that the fault lies entirely within the individual. The act of suicide is unconsciously interpreted as a reinforcement of the myth that "all epileptics are insane." Since medicalization already leads to the notion that "all suicides are insane," the cause of this person's suicide is obviously his disease - epilepsy - not the negative atmosphere created by society. Under this model, the act remains wrong but the actor has the unsatisfactory excuse of mental illness.

R.D. Laing has stated that "madness does not reside within the person, but rather is a response to the life situation in which a person finds himself." However, so far, his opinion has been unable to prevail against "the power of medical excuse." Application of the sickness label provides an "easy" way out except, of course, in those cases where the "cure" is worse than the disease. It absolves both the individual and society of responsibility for the deviant act and delegates action to the medical profession to "treat" rather than to society as a whole to change.

The label "sick" does not necessarily preclude the application of justification. The distinction between excuse and justification is dramatic in the context of homicide committed by victims of the "battered woman's syndrome." In this case, the label "sick" may result

270 Cited in Conrad and Schneider, supra note 157 at 65.

271 Ibid. at 244, citing Halleck (1971).

272 Many would argue that so-called cures like lobotomy, used in the 1950s to control violent behaviour, left their victims less than human. The side effects of many drugs, used to treat mental disorders such as schizophrenia and manic depression, are often more debilitating than the disease itself.

273 See Martinson et al., supra note 224.
in the application of the justification of self-defence. In contrast, there is no justification in
the eyes of society for a woman who commits infanticide. She is entitled only to an excuse
which reduces responsibility for a crime that would otherwise be classified as murder; and
even this partial excuse requires that she be designated mentally disturbed - that is, "sick."

4. **Deviance is contextual; what is labelled as deviant varies by social context.**

Just as suicide may be deemed moral or immoral from one society to another, it may
also change its classification from time to time within a single society. In the past, Western
societies have changed the definition of suicide from sinful to criminal to sick. There is a
possibility that in future certain types of suicide may be viewed as the best solution to
individual problems. The Hemlock Society, for instance, advocates the assistance of those
who wish to die because of unbearable physical or mental pain caused by terminal illness.
The idea of "passive euthanasia" is now an acceptable topic for legislatures and for the
courts. 274 Those who answer pleas for help from a friend dying of AIDS, but incapable of
committing suicide without assistance, now receive sympathy and understanding for, if not
acceptance of, their participation in suicide. 275 It may be that the label deviance will be

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274 For example, see Nancy c. v. Hotel-Dieu de Quebec, (1992) 69 C.C.C. (3d) 450, 86
D.L.R. (4th) 385 (Que. S.C.), in which a young woman won the right to have herself removed
from artificial life support systems.

275 Critics of active euthanasia and assisted suicide point to the dangers of misuse; for
example, the possibility that death will be accelerated in order to reduce health care costs to the
patient's family and to society or in order to relieve the pressures of population explosion. These
critics assume that life itself is sacred no matter how miserable or painful. This seems to be a
philosophy that is largely confined to modern caucasian societies. As already mentioned, Inuit
societies accepted the idea that those who were no longer productive had a duty to die. Those
who would advocate patients' choice, on the other hand, must be conscious of, and provide
strong measures against, the possibility of abuse. Unlike early feminists, for instance, they must
removed from this type of suicide. In such a case natural death is inevitable, probably imminent and unpreventable; the cause is clearly seen to lie within the individual, not within society. 276 The harm, if it can be called harm, accrues to the perpetrator, not an innocent bystander. I doubt that this latter type of reasoning can be applied to those who commit antisocial acts supposedly under the influence of malfunctioning hormones. They end up in court because they have harmed persons other than themselves. Unless society abandons the normative standard of the average man, it is unlikely that these offenders will give up their antisocial acts or will be identified as anything other than deviant.

5. **Defining and sanctioning deviance involves the exercise of power.**

This is the most important factor in relation to deviance. However, Conrad and Schneider observe that only a few studies focus on the labelling process. Most concentrate on deviance-processing organizations, deviant careers, and stigmatized identities. 277 This indicates an unawareness of the importance of the power to define aspects and attributes of individuals and society at large.

What is considered deviant in a society is a product of a political process of decision making. The behaviors or activities that are deviant in a given society are not self-evident; they are defined by groups with the ability to legitimate and enforce their definitions. 278

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276 Unless society has created the conditions that have cause the terminal disease; for example, proliferation of toxic carcinogens in industry.

277 Conrad and Schneider, supra note 157 at 18.

278 Ibid. at 22.
The use of the power to define and sanction leads to the power to control or eliminate elements in society that fall within the definition of deviance. The definers may do this by way of legal sanction or medical treatment. Conrad and Schneider seem to presuppose that medicine and law have, in all cases, snatched this power for themselves. An analysis of the development of, for example, the concepts of suicide and infanticide indicates that society has delegated to, and sometimes has forced on to, medicine and law the jurisdiction to fine tune definitions and apply sanctions and remedies. The broad definition of sickness, in those examples, has originated within public opinion. However, the end result remains the same; medicine and law become major agents of social control.

C. MEDICALIZATION AS A TOOL FOR SOCIAL CONTROL

Medical social control may be described as

... the ways in which medicine functions (wittingly or unwittingly) to secure adherence to social norms - specifically, by using medical means to minimize, eliminate, or normalize deviant behavior. 279

Adherence to norms may be attempted through formal controls such as parliamentary legislation and regulation, or by standards of conformity promulgated by powerful institutions such as medical associations. Conrad and Schneider identify the following agents of social control: the criminal justice system, education, welfare agencies, mass media, and medicine (and previously the church). They note that the greatest control comes from authority to define behaviour. Although many professions have a role to play in defining behaviours that, in their opinion, should be controlled, law and medicine head the list when it comes to the exercise of political power since

279 Ibid. at 242.
...in modern industrial society, only law and medicine have the legitimacy to construct and promote deviance categories with wide-ranging application. With medicine this application even transcends social and national boundaries. 280

But law and medicine do not always work in tandem. Sometimes there can be conflicts between the two groups about definition and jurisdiction. A good example of this can be found with respect to current Canadian mental disorder defences where legal and medical definitions of "disease of the mind" address different policy concerns.

The goals of medicine are to treat and cure; the goals of criminal law are, simply put, to deter, punish and rehabilitate. The ultimate objective of both is supposed to be the return to mainstream society of a healthy and conforming member. In a system that has ostensibly discarded the concept of vengeance by operation of law, punishment and rehabilitation could be viewed as a social form of treatment and cure. The difference lies in the fact that most people perceive medicine to be caring and benign but criminal law to be retributive and coercive. How much is the legal perspective a reflection of legal principle and how much is a reflection of public opinion? It may well be that, in cases involving violence, the legal, in contrast to the medical, approach is a more accurate mirror of public opinion, indicating a collective will to punish, regardless of the likelihood of cure, rather than to treat.

Law and medicine may not always be in unison, but they create a complex interplay in which power can be deployed from one to another. 281

When law and medicine act in concert they are doubly powerful. One discipline reinforces the other. The use of the "battered woman's syndrome" to extend the concept of self-defence

280 Ibid at 23. I should note, however, that not all scholars agree with Conrad & Schneider on the issue of social control. For instance, Stanley Cohen, supra note 1, questions the supposed control functions of law, medicine, etc.

is a good illustration of their combined power to effect a substantive change in an established legal principle - the right to use reasonable force to protect oneself.

Along with authority to define deviance comes a responsibility to correct it. For example, medicine has defined suicide as a symptom of mental illness. Therefore, psychiatry and other "psy" professions 282 now have responsibility for preventing its occurrence and treating those who have tried, but failed, to kill themselves.

The description of the process of medicalization shows that it can be a powerful tool for social control. John O’Neill puts it as follows:

... as Foucault has argued, modern social control has shifted from a largely external threat of execution wielded by cruel but administratively weak state authorities to the self-administered discipline of minds and bodies in the therapeutic state. 283

O’Neill also argues that "philosophers, physicians, economists, penologists, psychiatrists and sociologists [form] shifting alliances in the production of a docile citizenry." 284 Transformation of what might be a political issue into a medical one serves to make acceptable a degree of control that might otherwise be unpalatable to the electorate. It is obviously easier for those who govern if those affected believe that the fault lies within the individual rather than within society at large. Commitment to the status quo becomes normal while withdrawal from or anger towards it become abnormal. 285 Physicians and society

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282 Term coined by Carol Smart, ibid.


284 Ibid.

285 See O’Neill’s discussion of Parsons’ conception of the sick role and the role of the therapeutic agent in the framework of social control, ibid. at 359.
identify certain conduct as "disease" because of cultural expectations about acceptable
behaviour. 286

Medicine is used to reconcile the individual with the collective. O’Neill sees the
physician’s role as follows:

1. as the promoter of universalistic standards by means of
generalization of propositions about diagnosis and probable therapeutic
consequences of medical measures.

2. as being functionally specific with the focus on the patient’s
health rather than on other sorts of personal problems.

3. as performance oriented, requiring the active intervention of the physician.

4. as affectively neutral, requiring detached concern.

The end result of this process, in O’Neill’s view, is that

[s]uch discursive strategies, by favouring the medical model of discourse in the
treatment of social and political problems, strengthen the place of social
science professions in the therapeutic state and increasingly reduce citizens to
the role of docile clients or patients. 287

If this is true, it means that an interdisciplinary approach to "medical" problems will not be
effective in bringing about social change while members of alternate disciplines such as
sociology insist, for theoretical or pragmatic reasons, on adopting the medical model of
sickness and cure. For example, it may be that government assistance will be forthcoming
only if the problem is defined as "medical" rather than "social."

In British Columbia, for instance, a sexual abuse victim in need of counselling will be
covered by the provincial medical plan if she goes to a psychiatrist. If she goes to a

286 King, supra note 249.

287 Ibid. at 361.
psychologist or qualified counsellor who specializes in helping sex abuse victims, she must pay for treatment out of her own pocket. Very often such victims are unable to cope with their problems and are unable to hold down a long term, adequately paid job. Very often clinical psychology is a more helpful tool than psychiatry as it concentrates on self-help rather than medication. In this case medicalization is narrowly defined and does not include any discipline that does not come under the jurisdiction of the provincial medical association.\(^{288}\)

Another example comes from the field of geriatrics. Jacqueline Azzarto notes that many health professionals are being forced to define the social needs of their elderly clients in medical terms in order for these needs to be addressed.\(^{289}\) She believes that this phenomenon is related to "inadequate policies, deep-seated attitudes and patterns of thought, and fiscal constraints."\(^{290}\) In this case, the medical profession recognizes that there is a connection between social problems, negative roles and ill health. However, medical awareness has not been strong enough to overcome negative stereotyping of the elderly. As will be seen below, there is little express awareness among mainstream physicians of possible social causes of women's problems. Unless women speak out about their own reality, it is unlikely that medicine will overcome the stronger stereotypes based on sexual mythology.

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\(^{288}\) This information comes from personal observations and data gathered while working as a volunteer counsellor at the Women's Resources Centre in Vancouver. For example, one of the few women psychiatrists who specialize in treating victims of sexual abuse has a waiting list of three years and has had to refuse to accept any further patients. Many of these patients could be helped immediately by well qualified professional counsellors were it not for their lack of money.


\(^{290}\) Ibid. at 190.
These examples reinforce the argument that disciplines that dominate society and have high status also have the political power to enforce medicalization - even when they recognize alternative solutions to a social problem. Social work has a relatively low status in relation to medicine. Unless the public and members of alternate disciplines undergo a radical change in attitude, medicalization will be the only way in which to gain access to those who need help.

It is just such a change in attitude that feminist writers such as Louise Lander, Sophie Laws et al., and Ruth Formanek are seeking. Like King, Landers sees medical events as cultural questions and medicine as a social institution rather than a scientific discipline. As the illustration about suicide suggests, medical ideology is about more than just healing the sick; it also furthers "a particular view of reality [which helps] shape the self-conceptions of those who fall under its influence." Thus women who present with symptoms that fit within one of the PMS models come to believe that they are diseased rather than merely disadvantaged and possibly repressed.

Bell and Formanek both comment on the intertwining of illness and factors relating to class. This was especially true in the nineteenth century when the majority of patients diagnosed with disorders such as neurasthenia and hysteria came from the upper classes. Today, as Bell points out, specialists' focus is narrow and class specific. They acknowledge social and environmental factors such as poverty but continue to prescribe the same treatment for rich and poor.

Whether or not medicalization is initiated by society, once a problem becomes the property of medicine it tends to grow in proportion to the number of available and relevant

291 Lander, supra note 154 ; Laws et al., supra note 64; Formanek, supra note 55.

292 Lander, ibid. at 6.
specialties. If no specialty is available, medicine will create a new one; for example, the creation of gynecology in the nineteenth century and of andrology (the study of the male reproductive system) in the twentieth. Specialties, like diseases, are constructed rather than discovered. Patients themselves contribute to this expansion of medical jurisdiction by their sheer vulnerability. It is natural that anyone in acute or chronic physical or mental distress should shop around to find relief from suffering.

Where previously a sufferer might have consulted a priest or lay healer, she now consults a physician who, because of the creation of medical monopolies, has become a powerful agent of social control. How did this power arise? Have women had any say in its creation? Like Conrad and Schneider, I agree that it is essential to trace the historical development of ideas in order to understand their present application. I also believe that knowledge of history is a prerequisite for any attempt to deconstruct and to reconstruct prevailing norms because

[the medicalization of social problems … is not the culmination of a movement to find a solution to the problems but only another period in which one imputed reality is substituted for another.]

If medicalization continues to expand there is a danger that society will be faced with the "medicalization of life" in the name of "health." Just as "the best interests of the child" has led to increased interference, often justified, with the rights and freedoms of adults, so "the best interests of the patient" has led to increased interference with the lives of those suffering from "illness."

293 Laws, supra note 64.

294 Joseph R. Gusfield at p. vi of the Foreword to Conrad and Schneider, supra note 157.

295 Ibid., Conrad and Schneider, citing Ivan Illich (1976) at 29.
III. SUMMARY

So far I have discussed the elimination or exclusion of the majority of women from decision-making roles within healing and scientific professions. Therefore, in these areas as well as most others, it is men who decide what is deviant and what is normal.

To recap briefly, deviance implies a detour from the normal. Behaviour that is deviant may range from mild eccentricity to criminal violence. What one society tolerates as harmless intransigence, another may consider to be unacceptable defiance of established norms; what one society allows, another may find criminal. Behaviour may be outward manifestations of underlying mental or physical states; they may also be reactions to social or environmental states. In the former case, medicine and allied disciplines may claim jurisdiction over these states by labelling them "sick but susceptible to treatment and cure." In the latter case, where behaviours are perceived by those in power to cause serious harm, the legal system may claim jurisdiction; not over the social and environmental states, however, but over the behaviours which may have resulted from them. As I will discuss in Chapters 5 and 6, medical and legal jurisdictions will overlap when violent crimes are committed by a person with a "disease of the mind."

When the etiology of a disease is well identified, medicine will focus on its causal agent in order to treat and cure. However, when etiology is uncertain or in dispute (for example, with PMS or AIDS), medicine is forced to concentrate upon alleviation of symptoms. The patient often becomes a guinea pig, by assisting medicine's trial and error search for cause and cure. Sometimes this method results in long term success. For example,

296 For example, polygamy is legal in many moslem countries but not in countries with a judeo-christian tradition. Conversely, consumption of alcohol is illegal in the former but accepted with restrictions in the latter.
acetyl salicylic acid (aspirin) has been used for decades, without too many unacceptable side effects, to reduce pain and fever symptoms. Science has only recently begun to understand the reasons for its efficacy. In other cases, even when the source of body failure is known, as in diabetes, the only present treatment is symptom control. In yet others, the result of ignorant treatment is long term harm; for example, the use of diethylstilbestrol (DES) to prevent miscarriage and the resulting vaginal cancer in daughters.

Symptom alleviation is a legitimate goal as long as it does not ultimately worsen the human condition; as long as physicians admit their ignorance about biological cause; and as long as medical scientists do not label behaviour as symptoms of disease when it is really a symptom of a greater social malaise. When the choice boils down to criminal deviance or sickness, the "sickness" label may seem more benign. Someone who supposedly commits a crime because of bodily or mental infirmity may be "more to be pitied than scorned." But who is to say that this type of pity is less harmful than scorn, if it manifests itself in the form of spurious and damaging "treatment"? 297 It may be less of a strain on the giver if he or she is in a "curing" rather than a "punishing" profession. It may be more comforting for those in mainstream society to feel that their community is benevolent rather than vengeful. But a sickness of society that is erroneously accepted as sickness of an individual will never be cured until its root cause is recognized.

When behaviour, rather than mere feeling (such as pain), is held to be a symptom of disease, we must ask ourselves how it becomes a symptom. What differentiates it from

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297 Susan S.M. Edwards in Women on Trial (Manchester, England: Manchester University Press, 1984) at 97 states that the process of calling the criminal mentality "sick" "is to avoid granting the criminal the "legitimacy" of a rational interest contradictory to the requirements of morality and social order."
normal behaviour? Who and what constitutes a normal control? If the cause remains unknown, how can this symptom/behaviour be elevated to the status of disease? The central questions are who defines what is normal and how do they define it? How do gender issues affect the answers to these questions? I will attempt to answer these questions, within the context of this study, in Chapter 4.
CHAPTER 4 - THE MEDICALIZATION OF GENDER DIFFERENCES

In this chapter I will concentrate on the history and present status of a number of "male" and "female" problems and will once again use epilepsy as a "normal control." I will show that the myths and stereotypes and the silencing of women, described in previous chapters, played a large part in the formulation of medical answers to human problems that the dominant members of society believed, and still believe, are related to sex differences. I will also show how behaviour that failed to fit into what society considers normal for men and women was designated as "sick."

In Part I, I will trace the development of medical ideas about various signs experienced by women during their menstrual cycle, after childbirth and after their reproductive years. I will note that, even after 150 years of research, medical researchers have made little real progress in finding causes of women's "diseases" that they have identified and even created. I speculate whether this lack of progress is partly due to stereotypical assumptions about women that may well mask true etiology. In Part II, I will show that similar problems exist with respect

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298 In many medical tests and experiments, researchers will use a "control" group of "normal" individuals. The results of any tests carried out on the control group will establish a normal range. The severity of an illness may be evaluated by the extent to which the results from a patient deviate from this range. The use of the phrase "control group" is semantically appropriate in the context of female disorders, for identification of what is normal is very much an issue of control and power.

299 I deliberately use the word "sign" as a neutral term for physical and mental fluctuations experienced by women (and men). Unlike the word "symptom," it does not have a connotation of disease. Many writers indiscriminately use the latter word and by doing so automatically import an element of medicalization even when they are arguing against the process. The word "syndrome" - meaning a cluster of symptoms that usually occur together - has even stronger medical connotations.
to medicalization of male problems. In this case, stereotypical assumptions tend to conform to ideas about "real" men presented in Chapter 2.

Finally, in Part III, I will briefly examine the increased involvement of medicine in classifying and subdividing epilepsy and, where relevant, will compare and contrast the medical concepts of epilepsy with those of sex specific disorders.

This chapter will provide necessary groundwork for the analysis of gender based defences and of feminist criticisms of them. Those who formulate and apply the law must recognize that when they call upon medical experts to interpret human conditions, they are also calling upon centuries of unconscious prejudicial assumptions based on patriarchal values. Just as purveyors of medicine must look deeper and further than it has done to date to pinpoint accurate disease causation, law must look beyond gender bias studies that identify real but only superficial discrimination within its own field.

I. MEDICALIZATION OF WOMEN BY DEFINING PHYSICAL AND MENTAL SIGNS AS DISEASE

The previous sections have discussed medicalization of certain human conditions, attributes and circumstances, and have shown how deviant (criminal) behaviour may be transformed into the symptoms of disease. The end effect may be the decriminalization of the behaviour itself, as in suicide and homosexuality, or the expansion of a legal defence, as in the recognition of the mental effects of the Battered Woman's Syndrome. Where male problems are concerned, the focus is generally on the behaviour and its causes, not on the male gender as a whole. Thus, the behaviour, not the gender, is considered abnormal.300

300 There are some exceptions to this rule. For instance, I will discuss below the efforts of some researchers to find a causal link between testosterone and aggressive behaviour in men. Since testosterone is present in all men (and in all women for that matter - but in lesser...
The picture is reversed in the case of women. Because society considers the "man" in mankind to represent the standard for normality, the implication is that women are abnormal.\textsuperscript{301} Thus the gender as well as the behaviour becomes abnormal. However, an overlay on this basic notion of abnormality is a patriarchal perception that has led to special formulations which define the type of behaviour that is deemed "normal" or "healthy" - meaning acceptable to men - for the female gender (already discussed in Chapter 2). Whereas the healthy man is equated with the healthy adult, the healthy woman is not. "The implications … for women who seek treatment are profound, given the common clinical assumption that the normal behaviour of women and adults do not coincide."\textsuperscript{302} Any behaviour that fails to conform to the definition of normal or healthy woman (something less than adult) is labelled "deviant."

This deviance may, in turned be defined as criminal, antisocial or sick. The consequences of describing half the population as criminal or antisocial would lead to incarceration or costly surveillance of a large number of women to prevent them from harming or contaminating conforming members of society. This, of course, is already done, perhaps for different reasons, in societies that segregate women or refuse to allow them freedom of movement.\textsuperscript{303} In Western amounts), the implication could be that all men are potentially violent because of their inherent hormone distribution.

\textsuperscript{301} See, for example, Ehrenreich & English, supra note 161. I will describe below how the medical profession has reacted to this perceived abnormality.

\textsuperscript{302} Helen Levine, "The Personal is Political: Feminism and the Helping Professions," in Angela Miles & Geraldine Finn, eds., \textit{From Pressure to Politics} (Montreal & New York: Black Rose Books, 1986).

\textsuperscript{303} For example, in moslem countries like Saudi Arabia where women are not allowed to drive. Even in more westernized states like the Emirates, well-off women must be ferried around by chauffeurs who also double as watch dogs - personal observation and communication with a woman resident of Dubai.
countries, where women's labour is now essential for economic efficiency and where freedom of movement is accepted (within the parameters set by fear of male violence), control is achieved by a form of medicalization based upon the female reproductive system, the biological feature that most obviously differentiates women from men.

Stevi Jackson observes that the associative link between reproduction, sexuality and deviance is still a means of defining and categorizing women. 304 "The menstrual cycle has been transformed by the medical profession into something only experts can tell us about." 305 Sophie Laws argues that premenstrual tension (PMT) (and, therefore, PMS) is part of this medical model and is not an idea that has come from women. I do not think that this is completely true. Laypersons pressured the medical profession for explanations for suicide; similarly, a number of physically and mentally distressed women, who did not recognize societal causes or who were terrified of the idea that it was "all in their heads," have sought the socially acceptable relief of the disease model. Medicalization requires cooperation between physicians and persons who identify themselves as patients. There may well be valid biological reasons for many of the symptoms described by women. The danger lies in making gender-biased assumptions about these reasons.

Because woman, as gender, is perceived as abnormal, every facet of her existence is open to medicalization. The most obvious areas are puberty, menstruation, pregnancy and menopause. All of these are associated with disease: puberty (and beyond) with dysmenorrhea; menstruation with PMS; pregnancy with conditions requiring invasive treatments such as caesarian section;

304 Stevi Jackson, (1985) in Laws et al., supra note 64 at 14.

305 Sophie Laws, ibid. at 20.
post-pregnancy with postpartum disorders; and menopause with hormonal deficiency disease, depression and even kleptomania.

In the following sections I will discuss the processes of medicalization of women’s problems, beginning with an historical background and continuing with the difficulties encountered when attempting to reconcile what are, in whole or in part, artificial constructs, with currently acceptable scientific doctrine. These different problems - now identified as disorders or diseases - have much in common. To avoid repetition, I will concentrate mainly on PMS while pointing out those aspects of postpartum and menopausal problems that differ from PMS.

A. NINETEENTH CENTURY MEDICALIZATION OF WOMEN - BEFORE THE AGE OF HORMONES

When it serves the smooth functioning of the economy for women to be active, their unique function is an attribute of health; when an active woman is more a nuisance than a help, that function becomes a sickness. 306

During the nineteenth century, active middle and upper class women became nuisances if they ventured too far from their duties as homemakers - especially if they had the temerity to belong to the women’s rights movement. Society countered this nuisance by convincing large numbers of these women that, merely because they menstruated (or sometimes failed to menstruate), they were inherently sick.

Several feminist writers have already charted the course of women’s relationship with medicine during this time. 307 Therefore, I will present only a brief overview in order to show that present medicine and medical practice are part of a continuum that mirrors changes in

306 Lander, supra note 154 at 52.

patriarchy. I have already pointed out in Chapter 3 that, although new scientific discoveries occur every day, their interpretation and language used to describe them are influenced by patriarchal stereotyping. This is especially true of research into women's concerns. As I will show below, there is an interesting parallel between the nineteenth century concepts of neurasthenia and hysteria and the supposedly new 20th century concept of PMS.

In patriarchal cultures, women have always been subordinate to men. However, until the rise of the machine age, women of all classes had active roles to play in society at large. During the eighteenth and early nineteenth centuries, physicians encouraged both men and women of all classes to live healthy and active lives. As long as manual labour was essential for an efficient market, there were pressing economic reasons to promote industriousness in both sexes. Women played a large part in the productivity of cottage industries and in agriculture. Therefore, society could not afford to look upon normal menstrual functions as disease.

In Europe, all of this changed during the Industrial revolution - at least for middle and upper class women. Suddenly husbands began to conduct business outside the home and women were left behind to deal with domestic and child rearing chores. Men were the sole

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308 Landers, supra note 154 at 13.

309 The same applied in the more established parts of North America with the development of railroads, steel mills, and other factories. In the rural parts of Canada and the United States and in the unexplored regions of the West, pioneer and farm women continued to work alongside men and play an essential and valued role. Perhaps this is why the farm women of Western Canada were so politically influential during the first decades of the 20th century. However, the model chosen by the medical establishment as being representative of women who mattered were those non-working wives and daughters who could afford their medical fees. Thus the dominant culture created a dominant (but weak) form of womanhood.
money earners and women became "dependants" 310 - a category that persists today despite a mass of evidence that shows the economic worth of "housework." This was the dawn of what modern right wing moralizers call "traditional family values" - a "tradition" of geographical and mental separation that is only 150 years old, compared with thousands of prior years of cooperative, often interchangeable, family and work roles.

These traditional family values stress the importance of the woman’s role but give her little authority over it. Woman was expected to be the guardian of the race, but wholly subject to male authority; preserver of civilization, religion and culture, yet considered the intellectual inferior of men; the primary socializer of her children, but given no real responsibility and dignity than a child herself. Inevitably countless women were troubled by the ambiguities of their position. 311

No wonder many women gave up trying to reconcile the contradictions of their position and retreated into sickness; that is, if their husbands earned enough to allow them to do so. As Formanek notes, illness and social class factors intertwined. It became a sign of sensitivity, exploited by victims and physicians alike "as an advertisement of genteel sensibility and an escape from the too pressing demands of bedroom and kitchen."312

310 This discussion focuses on medical and social attitudes towards the middle and upper classes because these have formed the basis for medical ideas about today’s women. However, I briefly refer to nineteenth century class distinctions below.


312 Formanek (1990), supra note 55 at 12. I digress at this point to observe that there is a danger that feminists, themselves, may be creating their own stereotype of nineteenth and twentieth century medicalization; that is, all women as victims, being turned into fragile invalids by male-dominated medicine. It is tempting for women to accept this stereotype as it offers an understandable explanation for women’s suffering. But all women did not suffer. Most likely went about their daily lives, dealing with pain and pleasure - or too busy to think about causes of dissatisfaction and social wrongs. Others, mostly rich single women or widows, became eccentric Victorian voyageurs, privileged enough to escape the constraints of social conformity.
A form of synchronicity occurred around this time. All the convenient disciplines appeared at the convenient times to reinforce the idea that middle and upper class women were fragile, diseased and economically useless. The laws of supply and demand governed their economic utility. These women were removed from income generating roles. Meanwhile race and class bias were also prevalent. Working class women toiled for longer hours and in harsher conditions than ever before. How could society immobilize one set of women while simultaneously expecting another to be active to the point of exhaustion? Evolutionary theory explained this apparent paradox. The more "civilized" the woman, the more delicate she was. Working class women and women from "primitive" cultures were thought to be closer to the animals in their development and therefore more physically robust - a view maintained despite evidence of massive death from disease brought about from overcrowding, childbirth and malnutrition. Obviously these theories were exclusive to women since men, who were supposed to be highest on the evolutionary scale, were encouraged to remain active.

Other disciplines came up with reasons for these apparent contradictions, most of which rested upon biological differences between men and women. Physics was experimenting with the idea of the closed energy system which may have been appropriate for machines made from biologically inert material. When medicine adapted this idea to the human organism, it had constricting effects on both men and women - but especially women.

Hindsight tends to create generalizations but these generalizations are helpful as long as we are conscious of their limitations.

Formanek notes that factory work by women was legitimated by stating that women were able to work in atmospheres that would have been poisonous to men, Ibid. at 20.

In fact, on the evolutionary scale, one natural historian of the day rated women on a par with the grown-up Negro, the child and the senile White. ( Ehrenreich & English, supra, note 161 at 117, quoting Professor Carl Vogt.)
In summary, national economics declared middle and upper class women redundant with respect to paid employment. Darwinism separated them from their poorer sisters by labelling them more evolved. The economics of the medical profession required a steady pool of patients, conveniently available in the form of stay-at-home wives and daughters. This led to the creation of a new medical specialty - gynecology. Physics and medicine created the idea of the body as a finite energy source. Since man had to "provide," he was encouraged to direct his energy toward the development of brain power; since woman had to procreate, she was taught to save her energy for her reproductive functions. 

Biologists (and, later, criminologists like Lombroso) accentuated physical differences between women and men. All of these disciplines drew upon existing myth and stereotypes, granting credibility in the name of the new religion "objective science."

Women, being excluded from this science, were not allowed to interpret their own experiences. Apart from the first wave of feminists at the turn of the century, few women questioned the pronouncements of science. They knew that they felt ill, irritable or depressed. They believed that the fault was in themselves, not their external circumstances. They lacked the means to recognize that their "illness [had] become a cultural metaphor for a vast array of [women’s] problems." If they were bored, irritable, angry or depressed, it was the fault of their ovaries or their uterus, not the circumscribed role set by society. If we substitute

315 Edward H. Clarke (1873) in Sex in Education, or, a Fair Chance for the Girls, believed that undue brain activity would produce a sterilizing effect - cited in Lander, supra, note 154 at 33ff.


317 Catherine Riessman, supra, note 159 at 123.
"hormones" for "ovaries" it is tempting to argue that PMS is merely a similar rose with another name.

Just as twentieth century women, for valid reasons, have assisted in the perpetuation of their own medicalization, nineteenth century women assisted in its inception. As in the case of suicide, there was a feedback loop mechanism at work between problem bearers and available problem solvers. Society created conditions in which women felt useless and ill; medicine responded by offering explanations and cures that increased women's problems. Women, in turn, grasped these explanations as scientific justification for their pain and discontent. This is not to say that white, privileged males deliberately set out to immobilize and demoralize white privileged women. Many of these same males had saddled themselves with gender-specific problems of their own. Although physicians had a heavy financial stake in the success of their profession, "many believed that they had a mission to bring scientific objectivity to the "Woman Question." They were probably the more dangerous for this. It is much more difficult to fight a misguided benefactor than an open enemy.

(i) MENSTRUAL PROBLEMS

Exactly what was nineteenth century medicine telling women about themselves and how does it compare with what twentieth century medicine is saying? Ehrenreich & English describe the central theory that governed medical practice from the late nineteenth to the early twentieth century; namely,

318 See discussion infra, section II, Medicalization of Men.

319 Ehrenreich & English, supra note 161 at 116.
that women's *normal* state was to be sick. This was not advanced as an empirical observation, but as physiological fact. Medicine had "discovered" that female functions were inherently pathological. 320

Women were seen as "fragile and vulnerable, totally dominated by their reproductive system and its inexorable cyclicity, doomed to periodic bouts of disability." 321

Some physicians believed that the uterus controlled the female body; others that a "woman's entire personality was directed by the ovaries" 322 - and if that personality was anything but passive, then the woman was ripe for medical or surgical intervention. Nineteenth century passivity was supposed to extend to woman's sexuality. "The more refined the woman, the more she was to avoid orgasm during intercourse lest it prevent conception." 323

No wonder well-off women took to their beds in droves. They were not allowed to work outside the home lest this reflect negatively on their husbands' business ability; they were not allowed to think lest they drain energy from their reproductive organs; they were not allowed to enjoy sex lest they interfere with the perpetuation of the white middle-class race. Women, in other words, were like confined but cossetted battery hens.324

320 Ibid. at 110.

321 Lander, supra note 154 at 29.

322 Ehrenreich & English, supra note 161 at 121.

323 Ibid., at 121. This indicates a dramatic shift from the older idea, going back to Galen, that conception could not occur without orgasm. (See Edward Shorter, *A History of Women’s Bodies* (New York: Basic Books, Inc., 1982) at 12)

324 I do not wish to imply that *all* women succumbed to this model. To the disgust of doctors, many women continued with normal activities. (Lander, after discussing the views of Michelet, a French historian, concluded that such women "could simply be dismissed as uncouth men in disguise," supra note 154 at 53.) Other women still followed non-traditional medicine or consulted the new women physicians like Mary Putnam Jacobi who refused to subscribe to mainstream notions about female fragility.
What were the symptoms of these all-pervasive female disorders? As with PMS, they ran the gamut from fatigue and irritability to clinical depression and rage. Ehrenreich and English list a number of nineteenth century women, many of them feminists, who succumbed to incapacitating "nervous prostration." One in particular, Charlotte Perkins Gilman, changed after the birth of her daughter in 1885 from an energetic, intelligent woman to a depressed, mentally numb invalid. Unlike most others, she recognized that the source of her problem might be the imprisonment of marriage rather than her wayward biology. She never recovered completely, but after divorcing her husband and leaving home with her baby, she was able to take up an active career as a feminist writer and lecturer. Perhaps, because she did not suffer the invasion of major surgery, she retained a belief that "science [was] a liberating force against justice and domination." 325 Other women were not so lucky.326

Besides nervous prostration, doctors diagnosed, among other things, "neurasthenia," "hyperthasia," "cardiac inadequacy," "dyspepsia" and, eventually, "hysteria." Had the term "syndrome" been popular at the time, it is probable that, like PMS, these "diseases" would have been consolidated under one heading. Common symptoms included backache, irritability, indigestion, "troublesomeness, eating like a ploughman, masturbation, attempted suicide, erotic

325 Ibid. at 17.

326 Ehrenreich & English, supra note 161 describe other well known women who, in the middle of what seemed to be active and satisfying lives, suffered from sudden and prolonged depression, including: Margaret Sanger, the birth control crusader, at the age of twenty; Ellen Swallow (later Richards), the founder of the early twentieth century domestic science movement, at twenty-four; Jane Addams, the famous social reformer, at twenty-one. These particular women probably did not collapse because of boredom but because they experienced a sense of futility and exhaustion at constantly swimming against the tide of popular conception about what a "proper" woman should be. They questioned the role that society decreed but, as misfits, were constantly asking what was their purpose in life.
tendencies, persecution mania, simple "cussedness" and dysmenorrhea." 327 Many of these disorders centred upon what were considered abnormal sexual drives; for example, nymphomania and masturbation - an apparent source of disgusted fascination for Victorians. 328

Some symptoms resulted from steps women took to achieve the ideal fashionable body shape. To conform to the prevailing ideal of female beauty, women had to lace themselves into tight corsets and burden themselves with enormously heavy skirts. This resulted in disorders such as prolapsed uteri, breathing problems and deformed pelvisses. The modern image of female beauty, the fit, tanned, slim but shapely, young woman has taken a serious but different toll from women. It has been blamed for the increase of problems like anorexia nervosa, bulimia, melanoma and "cures" such as liposuction, fad diets and breast enlargement. 329

Nineteenth and early twentieth century treatments for women’s problems ranged from the sensory deprivation of the "Rest Cure" to the pain and mutilation of cervical cauterization, clitoridectomy and oophorectomy. These, in turn can be compared with the various modern treatments for PMS which range from exercise programs and vitamin supplements to hormone injections and hysterectomy. Depending upon severity, we tend to laugh at or recoil in disgust from the ignorance that led to the older treatments. But are are modern treatments really so different? Both rely on a supposedly "scientific" base; both make stereotypical assumptions about

327 Ibid. at 124, quoting historian G.J. Barker-Benfield.

328 Note that masturbation was also thought to cause epilepsy, insanity and impotence.

329 Although it is beyond the scope of this study, it would be interesting to compare the origin and treatments of nineteenth and twentieth disorders that have resulted from feelings of inadequacy and ugliness induced by an inability to live up to society’s changing definitions of beauty.
the "normal" woman and her allotted role in society; and both tend to support and extend these stereotypes in one form or another.

Since this study is primarily concerned with offenses thought to be committed under the influence of bodily functions peculiar to women, I will concentrate more on behavioural than on physical symptoms. The woman herself may be disturbed by impulses to act out in ways that she has been educated to believe are not "feminine." However, the impetus to seek medical help often comes from those around her, especially a husband who is upset or embarrassed by his wife's aberrant conduct. Dalton talks about the way that PMS turns many sweet little women into raging viragos who make their family's life a misery.330 Apparently the same problem occurred a hundred years ago. A passage from Ehrenreich & English is worth reproducing in full:

Patients were often brought in by their husbands, who complained of their unruly behavior. Doctors also claimed that women - troublesome but still sane enough to recognize their problem - "often came to us pleading to have their ovaries removed." The operation was considered successful if the woman was restored to a placid contentment with her domestic functions.331 (emphasis added)

I wonder how often this operation was "successful" since what it did was to plunge women into instant menopause, a state both potentially harmful or at least unpleasant. Since menopause was also considered to be a pathological state, it is strange that this pathology was thought to be a cure for another pathology. Presumably, because hormones were yet to discovered, the connection between oophorectomy and menopause was not clear to physicians of that time.

This focus on abnormal behaviour made women ripe subjects for the new discipline of psychiatry. Medical diagnosis of diseases related to the menstrual cycle was so successful that

330 For example, see Katharina Dalton, supra note 171.

331 Supra, note 161 at 124.
it seemed that there would be few "civilized" women left with the physical and mental fortitude to endure the rigours of childbirth. Instead of increasing the birth rate among middle and upper class women, this fixation on her reproductive organs had the opposite effect. Privileged male society foresaw a racial crisis in which the civilized elite would be overrun by racially and socially inferior populations. This was particularly the case in the United States where the Daughters of the Revolution were much less prolific than the immigrant (often catholic) masses.332

Gradually medical focus shifted from nervous prostration to hysteria - a disease characterized by violent, irrational outbursts. As the name suggests, the origin of this disorder remained in the uterus but concentration shifted to the brain. Like PMS, once identified, it spread like wildfire. It presented a way in which a woman could blow her behavioural fuses yet avoid public obloquy. Eventually physicians "were diagnosing every independent act by a woman, especially a woman’s rights action, as "hysterical"."333 I believe that a similar situation exists today; that both men and women are blaming PMS for what might otherwise, on proper reflection, be construed as feminist protest behaviour. If the biological excuse were not available, then they might be forced to recognize that women’s anger and frustration with their allotted position in society has a logical rather than biological basis.

332 Ibid.at 134 ff. Presumably the same attitude prevailed among descendants of the Canadian Empire Loyalists. It is interesting to compare these fears of racial dilution with fears of cultural dilution in Quebec when the birth rate dropped after the catholic church lost its moral and political stranglehold over the general population. Financial incentives to have more children, rather than accusations that women were failing to carry out their ordained duty, seem to be regarded as the more acceptable solution.

333 Ibid. at 139.
"Hysteria" was a convenient category for linking woman's mental incapacity with her reproductive functions. It was anything but a new concept being "among the oldest recorded diagnostic categories of neurosis." 334 Followers of Hippocrates believed that it occurred in women when they were unduly sexually continent, when the uterus became "a restless animal, raging through the female body." 335 Nineteenth century physicians and alienists adapted this core belief with enthusiasm. "Not unexpectedly, hysteria [emerged] as the quintessentially female malady" despite the fact that men could experience the same symptoms. 336 It was not until the focus of medical attention moved from the uterus to the brain that the possibility of male hysteria could be entertained. 337

By the end of the first decade of the twentieth century, gynecology texts were deploring constant pelvic examinations and invasive surgery which had "fixed firmly in the minds of women the idea that the most frequent source of ill health of girls is to be found in the pelvis." 338

One relates that

334 Mark S. Micale, "Charcot and the Idea of Hysteria in the Male: Gender Mental Science and Medical Diagnosis in Late Nineteenth Century France" (1990) 34 Medical History 363 at 363.

335 Ibid. Treatment included pelvic massage and "immediate marriage."


337 I will discuss Charcot's ideas of male hysteria below.

338 Howard A. Kelly, Medical Gynecology (New York & London: D. Appleton and Company, 1909) at 73. Dr. Kelly. a professor of gynecological surgery and gynecologist at Johns Hopkins University and Hospital, respectively, states in the preface that the chapter from which this quotation comes, entitled "Hygiene of Infancy and Girlhood," was written by Dr. Lilian Welsh, Professor of Physiology in the Women's College of Baltimore and Dr. May Sherwood, Director of the Gymnasium at Bryn Mawr School. They believed in vigorous exercise for girls and daily showers, preferably cold. The fact that their views were expressed in a standard text shows how far medical, if not lay, attitudes had changed from the 1880s.
It has hardly been possible in the present generation for a neurotic or hysterical
girl, or one suffering from malnutrition, to reach the age of seventeen without
having passed through some more or less prolonged gynecological treatment by
the general practitioner, or, if she has avoided the physician, without having used
largely the various nostrums or local applications of the patent medicine vendors.

The site of women’s problems had now moved to the nervous system. Treatment was shared
between the gynecologist and the psychiatrist who dealt with "Functional Nervous Disorders Met
With By the Gynecologist." 340 It is worth noting that the authors of this chapter of Kelly’s text
observed that "a persistent sense of boredom [was] not an infrequent complaint in the
gynecological consulting room," 341 a reflection of the emptiness of women’s lives at that time.
They also stressed that "[i]t is consideration of the woman as a whole which is all important in
these cases." 342 This 1909 text deals at some length with environmental concerns as they
affected women and especially growing girls. Kelly’s 1928 text deals with "mental hygiene" but

339 Ibid.
340 Ibid. at 541, title of chapter 23.
341 Ibid. at 547.
342 Ibid. at 549.
not with the environmental issues presented in his earlier work. This marks the beginning of the trend towards compartmentalization of the body to the exclusion of outside factors.

How did public and professional attitudes about women's bodies and minds affect attitudes toward their criminal acts? If all women were inherently sick were any capable of formulating the requisite mens rea to commit an offence? Could anything they did be said to be "planned and deliberate"? Women could and did carry out the actus reus of a whole range of criminal offenses but society tended to offer them partial excuses where their actions fitted into the appropriate medical categories. In essence, women were robbed of the dignity of having wills of their own. Either their actions were thought to be directed by a male offender, for example, by obsessive attachment to a worthless lover or by conventional obedience to a dominating husband; or their actions were the product of abnormal reproductive organs.


[m]enstruation has always been considered a legitimate scapegoat for all sorts of behavior anomalies, nervous instabilities, and give-up reactions. (at 1004)

They also note, however, that in some women there is "a marked tendency to moodiness and instability prior to the onset of the period, which disappears as soon as the function is well started." These women are those who "have a childhood history of being touchy, hypersensitive, petulant, and labile in their reaction to strains of any kind" which makes them more liable to "bend emotionally" under external stress. This small paragraph (at 1004-1005) in the 1928 text is now the subject of volumes on PMS.

343 For more discussion on this topic, see Susan Edwards, supra note 297 at 80.

345 An early twentieth century criminologist, Hargrave L. Adam, in *Women and Crime* (London, England: T. Werner Laurie, 1912) writes about one of the most "puzzling attributes of the female character .... her sometimes invincible, unreasoning, and self-sacrificing devotion to the most brutal ruffian of a man." He describes it in uncomplimentary terms as follows:

Just as she, as a wife, will conceive a slavish and dog-like devotion to a brutal ruffian of a husband, so, as a mistress she will pursue with equal canine servitude the criminal career followed by her lawless paramour. (at 5)
In the latter case, medicine robbed them of the right to be treated as a rational independent actor. Women were banned from the ranks of that legal fiction, the "reasonable man."

"[M]edicalization" of criminal acts involves directly a reinterpretation of will. 346

As the nineteenth century progressed, women's natural functions became not only an excuse for but a cause of female crime (rather than the other way round). As Ann-Louise Shapiro puts it, the medical-legal discourse of that period drew tight conceptual links between female criminality and reproductive biology...

Doctors asserted a scientific link between biology and madness that, in effect, rendered women not legally responsible for their behavior. 347

The age of the expert was ushered in when only medical professionals could tell whether a woman had crossed "the boundary between reason and unreason in the throes of "menstrual psychosis," "puerperal insanity," or "menopausal mania." 348

Shapiro interestingly compares the witch of the sixteenth century with the hysteric of the nineteenth. She could well have extended this, in the criminal context, to the PMS sufferer. She states that both witch and hysteric, through biology and sexuality, "evoked medical, juridical and philosophical discourses that addressed not only the nature of woman but, even more, definitions of normalcy, sexuality, relations between mind, body and behavior." 349 Old mythical fears of


347 Ann-Louise Shapiro, "Disorderly Bodies/Disorderly Acts: Medical discourse and the Female Criminal in Nineteenth Century Paris" (1989) 4 Genders 68 at 68. Although she illustrates her paper with case studies from France, her discussion applies equally to other Western countries of the period.

348 Ibid. at 72.

the menstruating woman became part of medicine and filtered indirectly into law. Not only menstrual bleeding, but its abnormal suppression, were supposed to make a woman more susceptible to mental illness. Homicidal monomania was the most extreme form. Shapiro illustrates her paper with case reports of the time; for example:

On 16 April, 1874, Heloise Desiree, widow, age 31 years, left in the evening accompanied by her two children. Having arrived at a pond, she took the little girl, age 5, under her arm, and gripping her little boy, age 8, tightly by the hand, she jumped violently into the pond dragging her children with her. She was pulled out, but her two children drowned .... [t]he widow was in the second day of her period at the time of her crisis and ... evidenced cephalagie and temporary aberrations of reason with each menstrual period.

Heloise ended up in an asylum rather than prison. There is no indication whether her life circumstances were such that they might have been responsible for or have contributed to her actions. The medical report implies that the sole cause is menstruation.

Another example illustrates the dangers of suppression of menstruation (amenorrhea):

A twenty-nine year old woman, predisposed by heredity, experienced violent attacks of jealousy after her marriage; her periods stopped and she became insane. One day her periods reappeared ... From that day, all her ideas were reasonable, her accusations dissipated, her hallucinations ended, and after a month, the sick woman was in a state to return to her family.

Again there is no mention of any social or environmental factors in this description. Did the woman have reason to be jealous? Did her periods stop because of over-stress, or perhaps

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350 A similar case occurred recently in California, where a Japanese/American woman walked into the sea with her two children. Cultural factors leading to her action were disregarded and she was accused of murder. This case is discussed in a series of articles in (1990) 8 Pacific Basin Law J.
because she was not eating properly, etc.? These case studies fail to disclose any investigation of possible causes other than menstrual. 351

In contrast, investigation of menstruation itself was meticulous and led to a list of seventy varieties of disease, twenty-nine of them being forms of madness. 352 Symptoms of menstrual psychic disorders - ranging from extreme lethargy to hyperactivity - were "so variable that it seems impossible to enclose them in a single formula." 353 (The similarity to PMS is striking, the latter also having multiple manifestations, many of them psychological.) If menstruation is inherently pathological and this pathology is an excuse for criminal actions, why are all women not criminals? The answer probably lies in this multiplicity of symptoms; that is, there is a symptom for all seasons. If a woman is lethargic and depressed, she may be suffering from a menstrual disorder that does not lead to criminal behaviour. If she is angry and belligerent or steals for no apparent reason, then she is suffering from an alternate form of the same disease. Only the second woman is likely to come before the criminal courts. The same applies to PMS.

The above discussion has shown how the medical profession began to classify the menstruating woman as abnormal or sick. However, what about the non-menstruating woman; that is, the pregnant woman, the woman who has recently delivered a child, and the menopausal woman. I will briefly look at the recent history of social and medical attitudes towards the last two.

351 It would be interesting to determine how many women were committed to insane asylums based on a diagnosis of menstrual madness. What was the ratio of women thus deprived of the small freedoms they had, to women saved from criminal punishment by the excuse of menstrual problems? The dangers of this excuse being used as a sword against women in the nineteenth century should serve as a warning to present day women.

352 Shapiro, supra note 347 at 73, citing the nineteenth century French physician, Berthier.

353 Ibid. at 74.
(ii) POSTPARTUM DISORDERS

I have already illustrated how childbirth was medicalized. It naturally followed that complications following childbirth would be similarly medicalized and that the law would seize upon medical explanations for unmaternal conduct. This resulted in the only legislation to date in common law countries that, in effect if not in form, creates a gender specific defence. The Infanticide Act of England and the Criminal Code of Canada have created the crime of infanticide, a less serious offence than murder or manslaughter. These provisions apply when a woman kills her baby while mentally disturbed due to giving birth or to the effects of lactation.\textsuperscript{354} As I will discuss below, there are many doubts about the scientific base for this form of mitigation.

Unlike the menstrual disorders described above, postpartum disorders were thought to be suffered by lower as well as upper class women. This was a way for society to reconcile its notions of inherent maternal instincts with the fact that so many poor women were killing their newborn bastards. Much more recognition was given in this area to environmental and social factors, but it would have opened legal floodgates to recognize that terror of starvation and social ostracism might be excuses for murder. Too many people would have qualified for such a defence. The medical model was much more convenient. It narrowed the number of possible beneficiaries of leniency to manageable proportions and fitted neatly into prevailing medical stereotypes.

How did this medical model arise? Not surprisingly, medicine reaches back once more to Hippocrates who noted that psychiatric symptoms often began with the onset of lactation. The first systematic studies of puerperal psychosis began with Esquirol in 1845 when he distinguished

\textsuperscript{354} Criminal Code of Canada, sections 233, 237, 662.
four distinct forms: dementia, mania, lypemania (melancholia) and monomania.\textsuperscript{355} Nineteenth century clinical reports were remarkable for their detailed descriptions of signs and symptoms of disease.\textsuperscript{356} This means that we now have access to volumes of data describing abnormal postpartum behaviour. Symptoms included confusion, delirium, hallucinations and insomnia. Even accounting for possible gender bias of the observers, these case reports disclose the existence of severe mental disturbance. Modern argument does not deny the existence of these symptoms, but centres around whether they are manifestations of a particular disorder or should be subsumed under existing definitions of psychosis. \textsuperscript{357}

Louis V. Marce who studied this topic during the mid nineteenth century made observations that have also been noted by twentieth century researchers: for example, that women who had postpartum manic symptoms and recovered were vulnerable to premenstrual recurrences.\textsuperscript{358} Marce recognised that postpartum illnesses could display many and varied symptoms and that these symptoms were similar to non-puerperal diseases. However, he also noted that there was a "simultaneous march of psychiatric symptoms and the physical changes


\textsuperscript{356} J.A. Hamilton, "The Identity of Postpartum Psychosis" in Brockington & Kumar, ibid. at 1.

\textsuperscript{357} I will discuss below the inconsistent trends in psychiatry; (1) the gradual removal of postpartum disorders as distinct categories, and (2) the gradual introduction of PMS as a distinct category.

\textsuperscript{358} J.A. Hamilton, supra note 356 at 4.
which follow childbearing." 359 This correlation was a matter of debate a century ago and is still a matter of debate today. Both Marce and Gundry, a researcher who gathered a large number of cases at the Ohio Lunatic Asylum in 1886, noted that the only way to distinguish puerperal from other psychoses was to search for evidence of recent delivery. 360 On the other hand, Esquirol, James McDonald of the Bloomingdale Asylum (1847), Robert Jones, Medical Superintendent of the Clayburn Asylum (1902), Karnish and Hope (1937), and James Hamilton (1962) have noted that there are symptoms, such as fever and delirium, that are absent from other forms of psychosis. 361

In reading the literature about postpartum disorders and the history of infanticide, I could not help noticing that the clinical descriptions of puerperal mania had little in common with the conduct that led to most charges of infanticide. In the former case, the patient was usually a married woman, who often had other children before the particular delivery associated with mental disturbance. Case reports do not make it clear whether each woman was a charity patient in an asylum or a private patient but it would probably be safe to say that a significant proportion were paying patients. Mania did not appear until, at the earliest several days after delivery. Symptoms of violent psychosis were usually obvious to any spectator.

In contrast, in cases of neonaticide (killing of a baby within twenty-four hours of birth), 362 the mother was usually single, young and poor. I will discuss further the laws of

359 Ibid. at 16.

360 Brockington et al., supra note 355 at 42.

361 Ibid. at 44-45.

362 The term "neonaticide," meaning the killing of a child less than 24 hours old, was coined by P. Resnick in "Child Murder by Parents: A Psychiatric Review of Filicide" (1969) 126 American Journal of Psychiatry 325, cited in Neil S. Kaye, Neal M. Borenstein & Susan M.
infanticide in Chapter 6. However, at this stage, I would like to point out that critics of the scientific base for these laws, do not seem to distinguish between neonaticide and other forms of infanticide. Because there is little evidence for psychosis within twenty-four hours of birth, they tend to discount medical evidence of postpartum psychosis and attribute environmental, cultural and social causes to all infant killing.

There seem to be two completely different phenomena at work here, both of which may have multiple causes. The mother who committed, and occasionally still commits, neonaticide may have done so in large part because of social and cultural pressures. However, this does not mean that she was not suffering from some form of mental illness. Otherwise, why did all mothers in that position not dispose of their babies? Recent studies postulate that the stress of unwanted pregnancy in young women who face stigma and ostracism may lead to denial of the pregnancy itself by the expectant mother and her family. When the mother is forced to cope with the sudden reality of childbirth, she may react by further denial in the form of neglect or by actively killing the baby. So little action is needed to kill a newborn child that it may be easy for a distressed mother, who has not bonded with her baby, to treat the death as a kind of late abortion. To a large extent, the legal and philosophical dilemmas about maintaining the infanticide defence spring from the use of medical data appropriate to postpartum psychosis infanticide for the defence of neonaticide caused by social pressures and unbearable stress. The credibility of both the conditions themselves and the legal defence come into question because

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Donelly, "Families, Murder, and Insanity: A Psychiatric Review of Paternal Neonaticide" (1990) 35(1) Journal of Forensic Sciences 133. (Discussed further infra, Chapters 5 & 6)

363 Until recently, an unmarried mother was justifiably terrified of what the neighbours would say and afraid that she would end up in the workhouse along with her bastard.

364 Infra, under Modern Medicalization - Postpartum Disorders.
of this failure of classification. Just what was medicine looking at when it talked about puerperal psychosis?

Since the law in this context is mainly concerned, rightly or wrongly, with defences for crimes of violence committed by new mothers I will quote in full the description of what Marce considered to be the usual progression of postpartum mania, the type of disorder that has been connected with the irrational killing of infants.

The majority of the manic episodes developed progressively with talkativeness, labile mood, almost complete insomnia, violent agitation dangerous to patient and the whole family, exaltation of all intellectual and nervous functions, delusions and hallucinations, erotic excitement, excessive sensitivity to sound and light, headache, incoherence and albuminuria.365

Apart from some of the terminology, Marce’s case descriptions are similar to some of those reported today. For example, one of Marce’s cases reads as follows:

A 30 year old woman delivered 6 days ago of her 4th infant was suddenly seized by a "delire furieux". The first sign was that she wanted to put her baby (whom she was suckling) in a stove to cook him. The family managed to stop her, but only against her vociferous and violent resistance. When the doctor arrived it required 4 men to restrain her... She was treated with ether and immediately fell asleep for 2 hours. When she awoke she was in a rational frame of mind, though tired, and remembered nothing of the incident. She resumed her normal life 2 days later. Some years later (unrelated to childbirth) she had a similar attack. 366

Recent cases reported in the literature describe similar symptoms, some of which have led to the death of newborn children. I will discuss the legal aspects of these cases in chapter 6.

365 Brockington, Winokar & Dean, supra note 355 at 40, analysing Marce’s descriptions of post partum mania. Out of a total of 44 cases of postpartum disorder, 33 began to show symptoms within 10 days of delivery and the other 11 towards the end of the sixth week. Most disorders lasted for several weeks but a few were intense but transitory.

366 Ibid. at 40-41. (The last sentence of this description suggests that childbirth may have been an event that activated an underlying disorder. It is a pity that Marce did not document the circumstances surrounding the second attack.)
In summary, medical practitioners noted a number of symptoms that occurred in a few women some days or weeks following the birth of her baby. They interpreted these symptoms, in keeping with the overall attitude toward women and their bodies, as evidence of severe mental illness caused by childbirth and lactation. Society grasped upon these medical ideas to justify the acquittal of or sentence mitigation for numerous desperate young women who killed their babies immediately after birth.\footnote{This misuse of medicine has brought the whole idea of an infanticide defence into disrepute. It has also allowed the law to avoid the difficult task of deciding what other principles, if any, might be more appropriate to justify society’s obvious wish to spare these women from draconian punishments.}

Having given an outline of the medicalization of postpartum problems, I will now show that menopause was another stage of a woman’s life that was ripe for nineteenth century medical intervention.

\subsection*{(iii) MENOPAUSE}

Now that the wave of feminists who started publishing in the 1960s are reaching the age of menopause, there has been a recent flood of literature on the topic ranging from Gail Sheehy’s endorsement of hormone replacement therapy to ward off aging\footnote{Gail Sheehy, The Silent Passage: Menopause (Random House: 1992).} to Ruth Formanek’s more balanced approach.\footnote{Just as impotence has been regarded as the last taboo for men, menopause has likewise been seen as the last taboo for women. This has resulted in dread and ignorance in many women approaching what could be their most productive years in terms of intellectual and social roles.} Just as impotence has been regarded as the last taboo for men, menopause has likewise been seen as the last taboo for women. This has resulted in dread and ignorance in many women approaching what could be their most productive years in terms of intellectual and social roles.

\footnote{For examples, see Constance Backhouse, supra note 54.}

\footnote{See also Germaine Greer, supra note 58.}
personal development. As indicated in chapter 2, menopause, like menstruation and childbirth, has been shrouded in myth and stereotype. Inevitably this filtered through to nineteenth century medicine.

Since white Western society placed so much value on the procreative value of the female, it is not surprising that medical texts devoted only a small part of their wisdom to the state of menopause. Since they were ignorant of the mechanism of the menstrual cycle itself, they were able to uncover little about the mechanisms of menopause.\textsuperscript{370} Also, as today, issues of menopause and aging were inextricably mixed.

I have already noted some of the derogatory terms used by nineteenth century physicians to describe the menopausal woman\textsuperscript{371} and need not repeat them here. Susan Bell notes that twentieth century creation of a "deficiency disease" grew out of the nineteenth century idea that menopause was a "physiological crisis."\textsuperscript{372} Because even temporary amenorrhea was considered bad for the brain, permanent cessation of menses could lead to insanity. This link between mental disorder and menopause persists today in the form of "menopausal depression."

Formanek observes that, apart from books by Edward John Tilt, menopause is hardly mentioned in nineteenth century texts and that what information there is, comes almost exclusively from male sources.\textsuperscript{373} The term "menopause" was first used in the 1870s to denote cessation of menses. However, it is now popularly, and erroneously, used to describe the totality

\textsuperscript{370} For example, in Kelly's 1909 text, supra note 338, the authors were still speculating about whether ovulation and menstruation were connected in some way and whether conception was most likely to occur at the onset of menstruation.

\textsuperscript{371} Supra, chapter 2.

\textsuperscript{372} Susan Bell, supra note 251 at 43.

\textsuperscript{373} Formanek, supra note 55.
of the female climacteric. Tilt made up for the deficiency of other gynecologists by writing, in 1882, *The Change of Life in Health and Disease*, in which he described case histories from 500 "upper class" menopausal women. Like Berthier in connection with menstrual disorders, Tilt listed over 100 diseases connected with menopause.

Menopausal insanity was of several types: delirium, mania, melancholy, suicidal tendencies, uncontrollable impulses and perversion of moral instincts, uncontrollable peevishness, dipsomania, apoplexy, hemiplegia, and so forth.

Popular manuals passed on the negative attitudes of gynecology, stressing the dangers of "abuse" ("sexual passion, immodest dress, the use of stimulating foods, prurient reading, contraception, or masturbation". The antimedical establishment touted remedies, such as Lydia Pinkham's Vegetable Compound, that would cure "all female weaknesses" and might even prevent murder! If these attitudes were firmly imbedded it is surprising that the modern menopausal stereotype is of the confused shoplifter and not the castrated killer. The latter's place seems to have been filled by the premenstrual murderer.

Early twentieth century texts looked at environmental issues but devoted little space to menopause. Kelly's 1909 text has only three pages on the subject of natural menopause and describes it as "the term given to the cessation of menstruation at the close of sexual activity."
(emphasis added). Under "symptoms" he notes the physical disturbances described today such as flushing and sweating. He also lists "confusion of ideas" and a tendency to become neurasthenic, which may end up as full blown insanity if there is a family history of neurotic temperament. His treatment consisted of gland extracts (for example, thyroid and ovary), fresh air and exercise, and in extreme cases, rest at a sanatorium "where she can receive constant attention and be free from the atmosphere of anxiety and petty cares which is frequently to her disadvantage at home." 379

Despite the earlier discovery of hormones and increased knowledge of the mechanisms of menstruation and menopause, Kelly's 1928 text deals with the gynecological aspects of the latter in only four out of one thousand and twelve pages. He devotes one page to psychiatric aspects, referring to the unfortunate medical practice of "fall[ing] back upon menopause as the causal factor in the maladjustment of women in middle age." 380 However, the blame for her condition remains within the woman in the form of "inferior heredity and inferior somatic organization." 381 Kelly encouraged menopausal women to "remain in the traffic stream of life" 382 in order to maintain mental stability. This indicates at least some recognition of social and environmental factors.

Before going on to discuss present day medicalization of women's problems, I will create a bridge between the two eras by briefly mentioning two twentieth century publications for laypersons, one from 1935 and the other from 1956. The first is Marie Stope's Change of Life

379 Ibid. at 90.
380 Kelly, supra note 343 at 1011.
381 Ibid. at 1012.
382 Ibid.
in *Men and Women*. She cites with condemnation current texts of the day that perpetuated the idea that women’s sexual activity must cease at menopause. Obviously Victorian ideas were still prevalent in the thirties. Stopes deals with the effect of negative expectations as follows:

> Fear has made unnecessary difficulties materialize, which should never have come into existence; nor would they were that fear not generated in the minds of those who seek knowledge by the very people who ought to know enough to counteract the fear instead of to generate it.

She notes one study that found that 900 out of 1000 women continued their work without interruption and that 158 experienced no symptoms at all. Obviously this information had not filtered down to the rest of the medical profession or the general public because judging from their exhortations most writers for climacteric women have very little knowledge of health and sanity and their exhortations are often extremely dangerous to women.

Stopes believed that middle-age depression in both women and men was mainly caused by a thyroid deficiency and instead of discussing it under "menopause," referred to it in her chapter on physiological factors in both sexes. Stopes, of course, did not represent the mainstream medical community of the thirties but her book offers interesting insights into the tenacity of menopausal myths.

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384 Ibid. at 129.

385 Ibid. at 134.

386 Ibid. at 135.
The second book is *Women of Forty: The Menopausal Syndrome* by Muriel Elsie Landau, published in 1956. Like Stopes, she believes that menopause is a normal change which should be welcomed by women. However, she cites a study by the Medical Women’s Federation that found that 31 out of 100 menopausal women suffered "nervous instability." After reassuring women in chapter 1, Dr. Landau goes on to list a cornucopia of negative symptoms. Although she advises women that "insanity is hardly ever a concomitant of the menopause," she states in the next paragraph that

about half the number of menopausal women suffer some emotional strain, which may be manifested as a feeling of general inadequacy, depression, irritability or aggressiveness, or, conversely, it may cause lethargy and lack of enterprise. Such women apparently may become "peevish" with their husbands and "difficult and obstructive" with their fellow workers. Another manifestation "in many women" was masochism in which a woman, imagining herself to be a martyr, "can be a holy terror to her husband and family." For the traditional housewife, Landau recommends: "knitting and crocheting, cooking, gardening, decorating, and their exotic cousins, brewing, weaving,

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388 Ibid. at 9.

389 Ibid. at 24

390 Ibid. at 25.

391 Ibid.

392 Ibid.
dressmaking, etc. ...  

For the working woman whose disturbance is severe she recommends a leave of absence combined with hormones and sedatives.

I have referred to these two publications to show that, although the language may have changed over time and physicians may have become less outwardly negative than before, there was still an undercurrent that led women to expect depression or confirmed that existing depression was a symptom of a medical disorder. Women doctors were not immune. Muriel Landau and Katharina Dalton after her have, with the best of intentions, reinforced negative stereotyping of women.

(iv) SUMMARY

Nineteenth and early twentieth century medicalization of women’s bodies resulted in ever increasing reliance by women on medical solutions to what, in many cases, were primarily lifestyle problems ranging from the wearing of tight corsets to enforced inactivity once a month. From menarche to menopause, women were categorized as medical time bombs waiting to be defused by professionals. Otherwise they were likely to erupt in violence. This violence, as often as not, would be defined as sickness, and the supposed cures imprisoned women in their homes as effectively as any modern electronic device. For those beyond simple remedies, the spectre of the lunatic asylum was always present. I realise that the comments in this paragraph could be attacked as over-generalization, a stereotyping of its own. There were women with the strength to reject these damaging notions that developed from a silent conspiracy between the medical profession and other women who saw sickness as a refuge from an intolerable existence. Medical case studies also disclose the presence of real illness, whether physical or mental. Thus, not all

393 Ibid. at 27.
of these problems of women could or should have been disregarded as figments of bored imaginations. The real problem for women as a whole was the lack of distinction between normal healthy female functions and the extremes of behaviour that could, perhaps, legitimately be regarded as symptoms of criminality or sickness.

One hundred years later, the situation is little changed. Only the labels for the various "diseases" have changed, not always in the interests of greater accuracy. In the next section I will look at the outcome of this intensive medicalization of women, especially in the context of those facets of female disorders that have been linked to criminal behaviour.

B. MODERN MEDICALIZATION - DEFINING AND TREATING WOMEN'S PROBLEMS

Because the philosophy behind the way society deals with women's problems today resembles quite closely the thinking of yesterday, I will create a bridge into this section by recapping in part some comments already scattered throughout the text. Then I will examine the modern concepts of PMS, postpartum disorders and menopause. I will concentrate most heavily on PMS, as attitudes towards menstruation can have a greater impact on women than the other two categories. They have the potential to affect every woman every month for over forty years of her life. When linked to criminality, PMS, because of public and professional perceptions of its constantly recurring symptoms, has the ability to create ever-increasing interactions among law, medicine and women patients/criminals.

Since the law is a hierarchical system of rules and categories, criminal defences must be clearly classified and defined. This means that any medical condition that contributes to such defences must also be clearly classified and defined. Herein lies the crucial dilemma of using
women's problems, in the guise of illness, as excuses under the law. Because of the stereotypical notion that women are per se abnormal, there has been little effort to discover what, in connection with female rhythms, is normal. For example, researchers have identified up to 150 symptoms for PMS and some report that up to 97% of all women suffer from PMS. No "disease," unless it occurs in a catastrophic short-term epidemic, strikes virtually all of the population; no one syndrome can possibly exhibit so many symptoms. Even AIDS with its numerous manifestations and varied symptomatology is not so wide ranging. Almost all writers acknowledge this but there is no agreement about how to narrow the definition. To feminist critics, this vagueness is but one more weapon in the masculine arsenal of female subordination as it reinforces the misconception that today's woman, like the Victorian woman, is actually or potentially sick.

It is interesting to note the periods in which these disorders have become fashionable. It would appear that scientific advances have marched in tandem with advances in women's rights to the eventual detriment of the latter. No sooner did women gain the vote than science discovered the female sex hormones. No sooner did women show (in World War II) that they were the equals of men in the workplace than PMS rose to the fore. Medicine, supported by society at large, responded to the increasing numbers who survived long enough to experience menopause by "treating" their "disease." "Good works," rest and tranquil pursuits were prescribed as therapy in Western cultures; a perversion of the functions for which women are honoured in many third world cultures. The discovery of hormones gave the law an additional handle upon which to hang the crime of infanticide despite doubt in some medical circles of its

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394 For example, see William R. Keye Jr. & Eric Trunnell, "Premenstrual Syndrome: A Medical Perspective" (1986) 9 Hamline Law Review 165, citing a number of studies.
validity. This particular method of mitigating possible murder charges was seen to be necessary while the stigma and consequent economic catastrophe of illegitimate birth remained.\textsuperscript{395} However, although medicine began to slap new labels on these disorders in the 1920s, little progress has since been made in diagnosis or treatment. (This lack of progress, in itself, would merit investigation.)

A great deal has been written in recent medical and legal publications about PMS; less is available in connection with post partum conditions and very little about the menopause. Rather than repeat the technical details set out in those papers, I will outline some factors that they have in common and which are relevant to their use as criminal defences.

The diagnosis of each of these complaints depends to some extent on time of onset. However, time of onset varies from woman to woman and from disorder to disorder; and its range may vary from expert to expert. Some post partum disorders manifest themselves within a few days of delivery; others may appear up to three months afterwards (or later if the woman is breastfeeding). The statutory limitation period in Canada and the U.K. for the application of the crime of infanticide is one year after delivery. This time limit appears to be arbitrary rather than based on scientific criteria. Experts are agreed that for symptoms to come within the definition (such as it is) of PMS they must appear within a certain number of days prior to onset of menstruation and disappear, or significantly subside, a few days after. However, there is no precise agreement about duration. Some practitioners report that it may be up to three weeks;

\textsuperscript{395} Illegitimate birth did not lose its stigma in mainstream Western society until very recently. In some segments of that society and in many other cultures, to bear a bastard is still to bring disgrace upon a family. Thus fear, rather than hormone imbalance, could still be considered a major reason for killing the newborn. (However, there still remains the question: does extreme fear cause hormone imbalance that may, in turn, cause abnormal behaviour?)
others limit it to five to seven days. Another problem that has become evident during studies is the fact that the duration of symptoms for one particular woman may vary from month to month — perhaps due to social or environmental factors, perhaps to uneven hormone swings.396

Onset and duration of menopause is even more difficult to pinpoint. It varies in terms of years rather than days or months. Although the average age of cessation of menstruation is fifty, the normal range is from around forty-five to fifty-five. To complicate matters, menopause may

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396 Endicott, Halbrecht and Schaft define PMS as follows:

the cyclic occurrence of symptoms that are of sufficient severity to interfere with some aspects of life and which appear with consistent and predictable relationship to menses. (quoted at p. xv of the Introduction to L.H. Gise et al., eds., The Premenstrual Syndromes (Churchill Livingstone, 1988)).

Dalton’s definition is much narrower:

The recurrence of symptoms in the premenstruum with complete absence of symptoms in the postmenstruum.

She lists a number of criteria required to satisfy her definition:

1. Recurrence of symptoms in every cycle, which, for practical purposes, may be taken as recurrence in at least the last three consecutive menstrual cycles.

2. Limitation of symptoms to the premenstrual or luteal phase; that is, from ovulation until menstruation. The luteal phase cannot be longer than 14 days, even in those women with cycles as long as 35 days. The symptoms may continue during early menstruation ...

3. Complete absence of symptoms after true menstruation begins, for a minimum of seven consecutive days.


Other writers disagree with the requirement of complete absence of symptoms during the postmenstruum as PMS may exacerbate underlying psychiatric conditions to the point where mens rea is affected on a monthly basis.
be well under way prior to cessation of menses, and duration of symptoms may vary from a few months to a number of years. Obviously, a criminal defence based on menopausal symptoms has a great potential for abuse, and a great potential for further entrenching stereotypes such as the confused depressed middle-aged kleptomaniac.

Another problem common to each disorder is identification of etiology. Because so many symptoms are lumped together under one name, it is impossible for researchers to come up with a definitive cause. Shaughn O'Brien, a frequent writer on the subject of PMS, points out that "which of these [symptoms] are pathological, and which constitute the normal, physiological, physical and psychological changes of the menstrual cycle is probably one of the most important issues." 397 For most endocrine diseases there is no fixed dividing line between normal and abnormal; instead there is a sliding scale containing grey areas in which some patients with the same tests results will be clinically normal and others will be clinically ill. This applies to the hormonal disorders described in this study. But not only is there a grey area between normal and abnormal, there is also a grey area between symptoms and behaviour that are severe enough to lead to a criminal defence and those which may be debilitating but do not affect mens rea.

I have briefly outlined a number of problems common to all of these "disorders." However, each area presents issues specific to itself which I will discuss under separate headings.

PREMENSTRUAL SYNDROME(S)

Since the early sixties and especially in the last decade the entity now called "PMS" has proved a fruitful source for research in a multitude of professional and philosophical disciplines. It has been dissected by the medical profession, puzzled over by the legal profession, examined by social workers and psychologists, analyzed by anthropologists, condemned by feminists and grasped as a lifeline by suffering women. It has been grist for the mill of interdisciplinary conferences and radio talk shows. However, after more than sixty years of scientific attention, we seem to be no nearer to diagnosis and effective treatment than before. In 1960, twenty nine years after Doctor Robert Frank first attempted to define what he called "premenstrual tension," another physician wrote about PMS as follows:

The incidence of premenstrual tension varies a great deal between different series... Differences in criteria for making the diagnosis undoubtedly play a part in these variations, but the type of patient being studied also contributes to the variation....

Many theories have been advanced to explain this syndrome... It is difficult to understand how one disturbance of [this] type could allow for the varied symptoms... It is clear that a number of factors play a part, but the important point is that in most cases no definite cause can be established...

Recommendations for treatment have been similarly varied ...

The results of this study suggest that psychological factors are responsible for the symptoms in a large number of cases. Hormonal imbalance and water retention are probably of major importance in others. It is however, impossible to differentiate one group from another on present evidence...

For particular references, see under each relevant section of this study.


B.P. Appleby "A Study of Premenstrual Tension in General Practice" (1960) 5170 British Medical Journal 391, at 391 and 393.
I have quoted from this paper at length because it could well have been written today (or a hundred years ago). For every assertion about PMS there seems to be a counter-assertion both within and among separate disciplines. I will deal briefly with some of these assertions from some of these disciplines, starting with gynecology.

One gynecological text selected at random devotes only half a page out of 625 to PMS - under the title "Psychosocial Aspects of Menstruation." It confirms the tone of the quotation above:

Mood, psychic and physical changes during the period immediately preceding menstruation are observed in a majority of women. The occurrence, intensity and subjective response of women to premenstrual changes vary considerably between subjects and between cycles in the same subject.... It is frequently stated that the incidence of violent crimes committed by women during the premenstrual phase is significantly higher that during any other part of the cycle.

Considerable confusion persists in the literature regarding the etiology of the premenstrual syndrome....(emphasis added)

The text goes on to mention various biochemical theories about the relationship between sexual and emotional behaviour in women and cyclical chemical changes. The authors refer to an unnamed study that has found that overt and latent negative attitudes towards menstruation appear in only a small percentage of college women. Although they do not say so, they appear to use this information to downplay psychosocial causes for PMS in favour of biochemical etiology. This is common among biochemical authors who usually make only passing reference, if any, to psychology or environment. As two clinical gynecologists have put it:

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401 Philipp, Barnes & Newton, supra note 237.
402 Ibid. at 196.
403 For example, Maureen Dalton in Chapter 17 - "The Premenstrual Syndrome" - in Gynecological Endocrinology: A Guide to Understanding and Management (Houndsmills, Basingstoke, England: Macmillan, 1989) at 87, that the causes of PMS are unknown. Under
Biological hypotheses all attempt to reduce PMS to a single abnormality in the body's physiological function... The biochemical model assumes that all abnormalities of human function (diseases) are derived ultimately from a single primary derangement of an underlying physiochemical function.\textsuperscript{404}

Medical clinicians and general practitioners, although they are oriented towards the biochemical model, generally take a wider view and at least speculate upon the nature of possible environmental and psychological causes.\textsuperscript{405}

One name stands out among all the rest in the area of PMS research and therapy, that of Katherina Dalton who has been writing on this subject since the 1950s. She is important to this study as she has testified in a number of criminal trials in support of a PMS defence. She firmly believes that severe PMS is a progesterone deficiency disease. My research to date indicates that all but a few writers are almost completely polarized in their reaction to her work. Those whose lives have been transformed for the better by progesterone therapy regard her as a saviour;\textsuperscript{406} those who do not believe in the biological model, or who object to her methodology, or have suggested causes, she lists five biochemical theories but does not mention hypotheses from any other disciplines. This is only one of several possible sources. Unless I specify to the contrary, when I cite only one example to support a statement, it will be one choice of many. There is not space in this study to survey the enormous selection of available sources. Most papers chosen as examples provide excellent bibliographies.

\textsuperscript{404} Keye & Trunell, supra note 394 at 173.

\textsuperscript{405} For example, American gynecologists Keye & Trunell examine sociobiologic, social and psychological causes as well as biological theories in ibid.

\textsuperscript{406} For example, see Virginia Cassara, "A Consumer Organization's Perspective" in Gise, supra note 396 at 145. She is founder and Executive Director of PMS Action, "a non-profit organization whose mission is to educate laypersons and professionals about PMS." (at 145) The basic premise of this organization is that PMS is a biochemical disorder. Lay publications make multiple references to Dr. Dalton; for example: Gilda Berger, supra note 252 and Ronald V. Norris with Colleen Sullivan, \textit{PMS: Premenstrual Syndrome (A Doctor's Proven Program on How to Recognize and Treat PMS} (New York: Berkley Books, 1984).
been unable to replicate her results, reject her ideas outright or, at the least, view them with a
great deal of suspicion. 407

Although she had already been working in the field for over thirty years, Dalton burst
upon the public scene in the early 1980s when she testified on behalf of two women who had
killed during the premenstruum. Subsequent treatment with progesterone reduced or eliminated
negative premenstrual behaviour patterns in these women. Dalton employs a restrictive definition
of PMS which insists upon a complete absence of symptoms after true menstruation begins. This
eliminates all women who may have an ongoing underlying behavioural or psychiatric disorder.
Dalton herself emphasizes that the "symptoms themselves are not unique; they all can occur in
men, postmenopausal women, and children." 408 The crucial distinguishing feature is the timing
of symptoms within the menstrual cycle. Dalton’s model excludes many women who would be

407 For example, Gwyneth Sampson, "An Appraisal of the Role of Progesterone in the
Therapy of Premenstrual Syndrome" in P.A. Van Keep & W.H. Utian, eds., The Premenstrual

408 Katharina Dalton, supra note 396 at 148. As well as timing, Dalton considers several
other risk factors as an aid to diagnosis, the most important being:

1. Initial onset at the time of a major hormonal event; e.g. puberty, completion of a
   pregnancy, termination of the use of oral contraceptives, amenorrhea, or sterilization.
2. Increased severity, similarly, occurring at the time of a major hormonal event.
3. Side effects of oral contraceptives, including such symptoms as headaches, depression,
   weight gain, and nausea. [Since all oral contraceptives today contain artificial progestagens, it
   should be noted that these lower the blood progesterone level. This is in contrast to natural
   progesterone, which raises the blood progesterone level, except when taken orally, in which case
   it is inactivated by the liver.]
4. Weight gain in adult life exceeding 12 Kg.
5. Pregnancy complicated by threatened abortion, pre eclampsia (seizure disorder), or post
   natal depression.
6. Increased libido in the premenstruum.
7. Altered hunger during the premenstruum.
8. Altered tolerance to alcohol in the premenstruum.

(Quoted from Ginsberg above note 48 at 290.)
classified by other therapists as PMS sufferers. It is therefore possible that progesterone is a valuable therapeutic tool for some women but is no more effective than a placebo for others.\footnote{409}

"The relationship of menstrual cycle to symptoms has been shown to be correlative but not causal." \footnote{410} The same could be said about the role of progesterone. It relates in some way to PMS symptoms because many patients with extreme symptoms respond positively to it. Dalton notes that progesterone receptors are plentiful in the midbrain - identified as the area associated with rage and violence in animals - and postulates that PMS is caused by unknown faults in progesterone metabolism.\footnote{411} For legal purposes - for example, court ordered treatment - it does not matter whether progesterone level is a cause or an effect as long as its administration is an effective therapy for those who exhibit uncontrollable social or criminal behaviour.\footnote{412}

\footnote{409} Several writers have conducted studies which appear to show that progesterone is no more effective than a placebo; eg. Gwyneth Sampson in "Premenstrual Syndrome: Characterization, Therapies, and the Law" in Ginsberg, supra note 48 at 301. However, Ronald Norris in "Historical Development of Progesterone Therapy" in the same publication at 273, criticizes the methodology of these studies. He points out that popular lay remedies have contained progesterones; for instance, "Lydia E. Pinkham's Vegetable Compound" whose sales exceeded $3 million in 1925, contained plant estrogens and glycosides, plus sapogenins from which progesterone was subsequently derived in 1947 by Russell Marker.

Dalton has published so many articles on PMS that it is impossible to list them here. Volume 3 of Oryx Science Bibliographies, "PMS: The Premenstrual Syndrome" lists publications up until 1985.

\footnote{410} Gise, supra note 396 at xvi.


\footnote{412} The same arguments could be made about a new therapy outlined in J.F. Mortola, L. Girton & U. Fischer, "Successful Treatment of Severe Premenstrual Syndrome by Combined Use of Gonadotropin-Releasing Hormone Agonist and Estrogen/Progestin" (1991) 72(2) Journal of Clinical Endocrinology and Metabolism 252A. This study is less open to the criticisms aimed at Dalton, in that it contained a double blind aspect. The authors (endocrinologists) also employed independent psychiatrists and psychologists to screen out women with underlying psychiatric
Until recently, individuals acquitted by reason of insanity have run the risk of indefinite incarceration at the pleasure of the Lieutenant Governor whether or not effective treatment is available for their condition. Because of this, only those accused of the most serious crimes have resorted to the insanity defence. However, now that the Supreme Court of Canada has held that indefinite incarceration is contrary to the Canadian Charter of Rights and Freedoms, people so acquitted will be released more readily if they can show that treatment will prevent repetition of their offence. Therefore, the insanity defence may be used more often in the future for less serious offenses. The availability of treatment can also affect the type of sentence handed down. Someone who can show that a treatable condition affected his or her judgment is more likely to be granted a discharge or suspended sentence conditional upon submission to therapy. This is what happened in England when Dalton was able to convince the courts there that progesterone therapy can prevent recurrence of criminal behaviour in sufferers of severe PMS.

Dalton has conducted extensive studies of "PMS offenders" - women who exhibit the most severe antisocial symptoms. She emphasizes that

only a small percentage of women suffer so severely that their premenstrual mood variations are so violent that they are no longer responsible for their actions or aware of what they are doing for a short time each month.414

Linda Chait notes that if 40% of women experience PMS, and if all women who commit violent crimes were PMS sufferers (which is far from the truth), then only 1/10 of 1% of women with illness or histories of drug abuse. However, the sample studied was small - only eight women with severe symptoms. The study lasted nine months.


414 Dalton (Hamline study), supra note 396 at 145.
PMS commit violent crime.\textsuperscript{415} Since not all women who commit violent crime are PMS sufferers, the final figure would be even lower than this. If PMS were to be subdivided as Kumar and others have done for post partum illness,\textsuperscript{416} then it might be possible to relate certain of these subdivisions to legal defences without stigmatizing all women.

Dalton has been emphatic about distinguishing PMS from "menstrual distress" which she defines as alteration in mood or symptoms in the menstrual cycle with deterioration during the premenstruum or menstruation.\textsuperscript{417} She also differentiates between PMS and Premenstrual tension, the latter including only psychological symptoms. Judith Abplanalp (psychiatrist), on the other hand, seems to include menstrual distress in the definition of PMS when she says that "PMS really refers to a significant increase [of severity of symptom] during the premenstrual phase." (emphasis in original)\textsuperscript{418} If Dalton’s definition of severe PMS is accepted by the legal system, what would be the outcome for a woman who suffers from a combination of milder PMS and an underlying psychiatric disorder, neither of which is sufficient by itself for a defence? What if her criminal behaviour and mental state at the time of the crime are the same as a Dalton

\begin{footnotesize}
\textsuperscript{415} Chait, supra note 44 at 283. See also McArthur, supra note 71 at 850 where she cites Norris & Sullivan, supra note 406 - "These women who experience psychotic episodes or commit violence are a minority. They don’t even represent one percent of PMS sufferers."

\textsuperscript{416} See discussion infra.

\textsuperscript{417} Katharina Dalton, supra note 396 at 217.

\textsuperscript{418} Judith Abplanalp, "Premenstrual Syndrome: A Selective Review," in Lifting the Curse of Menstruation: A Feminist Appraisal of the Influence of Menstruation on Women’s Lives (1983) 2/3 Women and Health 107. Michael H. Stone, in "Premenstrual Tension in Borderline and Related Disorders" in Friedman, supra note 396 at 317, observes that many of the symptoms of PMT are also symptoms of borderline personality disorder, and asks whether factors that dispose a woman to PMT interact with genetic factors predisposing to manic-depression, to bring the latter to the surface since severe PMT and severe affective disorders are so often found together as to appear unitary in essence and origin.
\end{footnotesize}
PMS sufferer? Is she to be imprisoned while her sister in crime is released on probation? There is no logical justification for such disparity - but of course the law is not always logical.

The probable key to legal thinking in such cases is effectiveness of proposed treatments to eliminate or significantly reduce the likelihood of repetition of criminal behaviour. Knowledge of cause, in the eyes of the law, might be merely a vehicle for increasing credibility of treatment. For example, the cause of diabetic symptoms (but not the cause of diabetes itself) is well known. Although these symptoms, resulting from hypo- or hyperglycemia, may severely affect cognition, they may also be fairly easily controlled. Courts are reluctant to commit diabetic patients to psychiatric institutions even though they might exhibit the same conduct as someone with epilepsy.419 Although epilepsy research has advanced considerably, treatments to control behaviour are not always reliable. This may contribute to the continuing definition of epilepsy as a disease of the mind.

Although the causes of PMS may still be shrouded in mystery, in a few cases Dalton has demonstrated that her treatment prevents recurrence of violent symptoms. English courts have responded by mitigating sentences and freeing women on probation coupled with treatment, after that treatment has been proven effective. Should the law, then, ignore problems of etiology and choose as its main criterion, effectiveness of behaviour control? Should it matter to the justice system whether a disorder is called biological or psychiatric if the symptoms are similar and can be effectively treated? Theoretically the answer should be "no." However, pure theory makes no allowance for input from the realms of myth. Insanity still has the power to terrify, whereas biochemical illness is explainable in more comforting terms. I believe that most women would

419 I have personal experience with dealing with severe insulin reactions and can testify that, in many cases, a bystander could easily confuse them with epileptic seizures.
prefer their doctors to locate PMS in gynecological texts rather than the DSM.\textsuperscript{420} This may, in part, reflect their expectations of different reactions from friends and family, depending on the supposed source of their illness. It may well be that judges and juries will also have different attitudes to different classifications of PMS.

If the biochemical model is more desirable because it is subject to less stigma, why has there been such an outcry among knowledgeable feminists about its use?\textsuperscript{421} I have already discussed in the previous chapter some general criticisms of scientific investigations into the menstrual cycle. So many writers have attacked the validity of results from PMS research that I will do no more than list those areas that come in for most criticism.\textsuperscript{422}

1. Failure to understand or examine the biological mechanisms of the "normal" woman. Does this verify the proposition that the medical profession generally assumes that all women are abnormal? \textsuperscript{423}

\textsuperscript{420} Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

\textsuperscript{421} I will discuss some of this feminist criticism in the next chapter.


\textsuperscript{423} Although they are few and far between, there have been some attempts to establish baselines in non-complaining women. See, for example, Vivienne J. Yuk et al., "Towards a Definition of PMS: A Factor Analytic Evaluation of Premenstrual Change in Non-Complaining Women" (1990) 34(4) Journal of Psychosomatic Research 439. This study examined 133 women who answered an advertisement for control women without menstrual or premenstrual problems. The authors considered factors such as age, parity, civil status, occupation and socio-economic status. They identified two distinct psychological subtypes, "uppers" and "downers" who exhibited distinctly separate physical as well as mental symptoms.
2. Failure among researchers to reach a consistent definition of PMS. For example, is there
one syndrome or several? What degree of severity of what symptoms is necessary to call
a woman’s experience a "disease"? Exactly what time period is meant by the
"premenstruum"? 424

3. Useless expansion of already published work as if constant repetition of mistakes could
somehow lend credibility to a faulty study.

4. Biased selection of research subjects. Many studies confine themselves to women who are
seeking help for their symptoms - they already see themselves as "sick."

5. Lack of, or deficiencies in, control groups and lack of double-blind studies.

6. Use of retrospective data which usually relies on faulty or negative memories.

7. Inconsistent use of a multitude of questionnaires to accumulate prospective data. Many
symptoms are subjective and difficult to assess. There is also a problem of negative
selectivity in women who have expectations of illness, and failure to discuss or grant any
weight to positive symptoms. "The role of societal and personal expectations as potential
confounding variables is present in nearly all descriptive studies." 425

424 Koeske, supra note 422 at 11 notes that

since the same measurement may be differently labelled or the same concept differently
operationalized by any two researchers, many of the findings represented in the literature
are non-cumulative. A variety of different interpretive schools exist side by side, each
subscribing to a particular set of beliefs and dismissing competing beliefs on
methodological grounds - not necessarily because theirs are better researched but because
their share a common framework of untested assumptions.

425 Michael S. Gitlin & Robert O. Pasnau, "Psychiatric Syndromes Linked to Reproductive
Psychiatry 1413 at 1416. See also Laws, supra note 64 at 33:

"[B]eing ill" ... is a social process, which we may or may not decide to enter into when
we experience some feeling which could be called a symptom ... So one must examine
not why people who have symptoms do not take any action but rather why some people
8. Sample sizes are often too small. Results from these small samples may be extrapolated erroneously to women as a whole.

9. Time periods of studies are often too short and therefore fail to detect other possible cyclical variations in individual women. For example, some people, men and women, experience seasonal mood changes. Hormone levels in both men and women follow a daily rhythm so that consistent timing is essential when comparing biological samples from different days.

10. Lack of controlled treatment trials. Inconsistent dosages and methods of administration in treatment studies. For example, Dalton prescribes large amounts of progesterone intramuscularly or via suppository. Her results are then compared with studies using smaller doses given orally or with progestins, which have a different metabolism. Added to this problem with one particular therapy are the numerous problems resulting from a proliferation of different treatments, all based on different theories of causation. So far, over three hundred and twenty seven treatments have been suggested.\(^{426}\)

11. No research on long term effects of some drugs, although progesterone has been in use for years.

These illustrations are enough to show that critics of the biological model should be taken seriously. But is the psychiatric model any better?

Dalton, being a gynecologist, is not a member of the psychiatric specialty that lawyers usually refer to when relying upon a defence based upon impaired cognition. What, then, do

d, and why they do so at the time they do."\(^{426}\)

other disciplines say about PMS? Writers who are not firmly wedded to the biochemical model, are more likely to acknowledge that the etiology of premenstrual changes is multitedetermined. For instance, Leslie Gise, a psychiatrist, enumerates three types of causes for PMS: (1) predisposing - for example, a family history of menstrual problems, mental illness, or sexual abuse; (2) precipitating - for example, discontinuance of birth control pills, bilateral tubal ligation, hysterectomy, post partum depression; (3) sustaining - life-style issues such as diet, smoking, exercise, or stress. 427 Note that all of these causes, except possibly stress, rely on defects within the woman.

Psychiatrists and psychologists, perhaps naturally in a world broken down into separate classifications and segments, say little about physical symptoms such as water retention. Instead, recent papers have concentrated on the similarities between the behavioural symptoms of severe affective disorders and severe PMS. This should be of interest to the legal profession as any positive relationship between the two would tend to draw PMS toward the insanity defence. Rubinow, who consistently uses the term syndromes rather than syndrome, believes that, although there may be a overlap between PMS and psychiatric illness, they present two distinct identities. 428 He notes that, despite the existence of numerous cyclical disorders in psychiatry, there are few studies of the role of menstruation as a possible biological synchronizer of other rhythms. He speculates that constant sensitization by menstruation may create a gradual increase in severity of affective illness. In a later paper, he discusses one of the typical chicken-and-egg

427 Gise, supra note 396, in Introduction, p. xvii. Gise is one of the few scientific authors I have encountered who suggests that PMS must be viewed within the broader context of cyclic changes in mood in both men and women, since testosterone (male hormone) converts to estradiol (female hormone) in the brains of both sexes.

questions about PMS - is menstrual disturbance a cause or a symptom of psychiatric disturbance? - and concludes that

[menstrually related mood syndromes are complicated biobehavioral disorders that cannot currently be adequately understood with monolithic medical and psychological models.\footnote{David R. Rubinow & Peter J. Schmidt, "Menstrual and Formal Mood Disorders" in Demers, supra note 56 at 45.}]

However, he, like most other writers, identifies an important question but fails to answer it.

If PMS presents an endless list of questions without a corresponding list of answers, how did it make its way into the American psychiatric bible - the DSM-III-R - under the guise of Late Luteal Phase Dysphoric Disorder (LLPDD); and why has the American Psychiatric Association decided to include it in the appendix of the DSM-IV, due to come into effect in 1994, as Premenstrual Dysphoric Disorder (PMDD)? Was it turf-grabbing from gynecology and endocrinology or did it come from patient demand for recognition? Or did it represent real progress in psychiatric diagnosis? As I pointed out above, mental patients are still stigmatized in our society. Therefore, any profession should be cautious about pinning a psychiatric label on a patient. This is doubly so when the patients are female and the labels are being applied by males.\footnote{Paula J. Caplan, Joan McCurdy-Myers & Maureen Gans, in "Should "Premenstrual Syndrome" Be Called a Psychiatric Abnormality?" (1992) 2(1) Feminism & Psychology 27, point out, at 29, that, in 1986, 86% of U.S. psychiatric practitioners were men and that most creators of the DSM have been white middle-class males.} Gitlin and Pasnau have astutely stated the following about the adoption of this new psychiatric disorder:

Observations and implied etiological links may more accurately reflect the psychology of the observer (usually a man) than the psychology of the observed... The controversy during the adoption of the DSM-III-R definitions demonstrates...
the need to distinguish between symptoms and the labeling of these symptoms as a syndrome, with its many adverse stigmatizing connotations. 431

For lawyers who wish to use PMS as a criminal defence, the recognition in the DSM of its severe manifestations could be a powerful tool, even though its inclusion in the appendix means that PMDD is not yet an officially recognized disorder but one that requires further study. Instead of relying solely on one expert witness, who could easily be contradicted by the other side, he or she may now point to a respected text as a source of reinforcement. 432 PMS (as PMDD), whether it deserves it or not, becomes established within the medical profession - a step forward towards its acceptance by the legal profession. As I will discuss later, a diagnosis of PMS may be used as a club in the hands of violent husbands who argue provocation and ex-husbands who want to prove their spouses unfit for child custody.

Caplan et al. have undertaken a detailed analysis of the dangers of accepting this new disorder. It is worth summarizing at some length as it confirms some of the fears expressed during the discussions on adoption of the PMDD category. The authors start by pointing out that there is no evidence that women's mood changes are any more severe than men's hormonally based mood or behaviour changes. Yet there is no DSM equivalent for men, and no apparent interest in finding one.

431 Gitlin & Pasnau, supra note 425 at 1420.

432 The lack of inclusion of postpartum psychosis as a specific entity in the DSM has proved a detriment to women in the U.S. who have wished to rely on a psychiatric defence to infanticide (see below). This illustrates the power that this publication has within the legal community, whether or not psychiatrists approve the use of the DSM for legal purposes.
Caplan et al. argue that the PMDD designation "concretely legitimizes [the] pathologizing
[of women];" 433 that it is a vivid illustration of social control by medicalization,
supported by the illusion that psychiatric categories are included in the DSM as
the result of a scientific, objective, rational process of such complexity that it can
only be accurately carried out by the anointed few. 434

Most papers on PMS pay some lip-service to social factors. However, after reading the
description of PMDD 435, I note that the DSM authors do not even go that far. They do not
seem to realise that social context "is crucial in a culture that tends to use any sign of difference
in a low-status group as proof that it deserves its low status." 436 Thus, an aura of scientific
objectivity coupled with blindness to social and political concerns sites yet another syndrome
squarely within the individual so that the only possible cure must come from change in or to her,
rather than change in communal attitudes.

Caplan et al. found only five articles that examined new empirical data in connection with
PMDD. They listed criticisms of these studies that closely resemble those I have listed above
with respect to PMS and conclude that this new category "has little to do with science and a
great deal to do with ideology." 437 If the observations of Caplan et al. are correct, it appears
that researchers are relying on what men have traditionally considered to be a "female" attribute-

433 Caplan et al., supra note 430 at 29. This paper discusses the form of PMS designated in
the DSM-III-R as "LLPDD." Instead of creating confusion with an overabundance of initials,
I am using the newer nomenclature "PMDD" which has now replaced LLPDD.

434 Ibid at 30.

435 The diagnostic criteria from DSM-III-R are summarized in an appendix to the article by
Caplan et al., supra note 430 at 42.

436 Ibid. at 31.

437 Ibid. at 40.
intuition - when conducting experiments. A defect that is crucial for the application of legal
defences is the continuation of the failure to create criteria for the assessment of severity of
mental disturbance. When all is said and done, the addition of PMDD to the existing multitude
of female disorders seems to have added no new scientific knowledge and has created no real
incentive to get to the root of the problem - however the problem may be caused or defined. But,
like the emperor's new clothes, I believe that PMDD will maintain its credibility until its
deficiencies are brought home irrefutably to those who wield medical and political power.

In summary, it is evident that both gynecology and psychiatry have failed to come to
grips with the reality of PMS as experienced by different women in different situations. So far
there has been no division of PMS into meaningful subgroups. The same label is used for
countless different combinations of symptoms. It is possible that those writers who state that
PMS is a hormone deficiency disorder and those who argue that it has only psychological or
social causes are both correct with respect to the particular group of patients whom they study.
Comparison of results of different researchers is difficult because population samples,
methodologies, reporting techniques and duration of observation vary from study to study. It is
impossible not to question the lack of progress in subdividing and defining this disorder when
its symptoms have been recognized and described for millennia and have been identified as a
medical condition for over sixty years. Does the answer lie in the fact that irrational myths about
the female body outweigh any rational desire to discover the true etiologies of women's illnesses;
etiologies that might free women from damaging stereotyping?

There have been some attempts in other professions to examine PMS in a wider context;
for example, nurses, sociologists and anthropologists. Thomas Johnson, an anthropologist,
postulates that PMS is one of a number of Western culture-specific disorders and also wonders
why the "syndrome" has only appeared in Western literature in the last few decades when the symptoms have been reported in diverse cultures for centuries. He argues that by "[striving] to discover the biological "reality" of PMS ... without examining the cultural forces which are attendant on the process of creating that reality" we fail to recognize that PMS may be an "expression ... of the key elements (statuses, relationships, institutions) of the society’s social structure, as well as the central cultural meanings and norms that legitimate them." Unlike medical writers, he has recognized that the appearance of PMS in Western cultures closely followed a major shift in the status and roles of women in those cultures. I believe that this is a manifestation in a modern form of the same phenomenon (the appearance of menstrual mania, neurasthenia and hysteria) that occurred in the nineteenth century after the separation of home and workplace.

Johnson sees PMS as a "symbolic cultural "safety-valve" " which allows women to escape from the conflicting demands of career and family. Women are now expected to have both children and a career - "a cultural double-bind in which expectations for doing either or both are equally conflict ridden." Johnson substantiates my previous observation (and implicitly disagrees with the contention of a number of feminist writers), that many "disorders" are not manufactured by the medical profession. Rather they arise within the medical profession in answer to demands for recognition by certain segments of the public. He explains the impetus for recognition of PMS by lay women as a form of "negotiated reality" which allows a change

438 Thomas M. Johnson, "Premenstrual Syndrome as a Western Cultural-Specific Disorder" (1987) 11 Culture, Medicine & Psychiatry 337.
439 Ibid. at 347-348.
440 Ibid. at 348-349.
in the status of women "without directly threatening or destroying the structural status quo." 441
If what he says is true, it is no wonder that a number of feminists, who challenge the very existence of our present status quo, become incensed at the idea of acceptance of PMS as a legitimate medical entity.

The foregoing discussion highlights the confusion, disagreement and probable false assumptions surrounding what is likely a Western cultural-specific, or culturally created disorder. I stress culturally created, rather than medically created. I agree with Johnson that, despite what some feminist writers would argue, women have been willing accomplices in the transition from a set of medically recognized symptoms to a medically created syndrome. After ploughing through what seems to be an endless, and often repetitive stream of articles what, if any, new insights can I, a generalist rather than a specialist, bring to the topic? Must I merely repeat the litany of woes already presented in the literature? What, in fact, is the sum total of our knowledge about PMS?

First of all, too many women over too many millennia have reported cyclical changes for these to be dismissed as mere products of environment or as reactions to male dominance. These changes are real. However, the subjective experience or interpretation of these changes may differ according to social or cultural background. Many changes are viewed as positive but these are seldom discussed. I cannot believe that one hundred and fifty symptoms that attract over three hundred "cures" can possibly constitute one syndrome. The sole criterion cannot be timing, although this can be indicative of a cyclical component within a number of symptom groupings. Also, how can we possibly tell what is abnormal when we are still ignorant of what is cyclically normal? No research into disease should proceed without identifying a normal baseline.

441 Ibid. at 350.
Before continuing to medicalize premenstrual symptoms and after identifying a normal range, these symptoms should be subdivided into separate groupings that seem to appear consistently together. These may well be defined as separate syndromes, one or more of which might be such as to affect cognitive capacity to such an extent as to justify a legal defence. PMDD may have been one of these syndromes, but at present this classification perpetuates too many of the problems created by the concept of PMS. By suggesting subdivision into a number of symptom groupings, I am conscious of the danger of falling into the trap of atomism described at the beginning of this chapter. That is, the danger of looking at each grouping as an independent entity. The literature on PMS has served to confirm my original opinion that each part of the body and mind reacts with and depends on every other part, and that researchers must allow for a large number of variables - physical, psychological and social. This is what makes endocrine/psychological research so complicated and so hard to pin down for legal purposes.

However, I do not believe that it is too complicated for doctors, lawyers and others to sit down and agree what cyclical conditions, either singly or in combination with other conditions, are severe enough to call for a legal defence. If PMS were to be subdivided as Kumar and others have done for postpartum illnesses, then it might be possible to relate certain of these subdivisions to legal defences without stigmatizing all women.

Many studies have been carried out in an effort to correlate testosterone levels with competitiveness, aggression and physical violence. Although some men have expressed fears that this type of research will brand men in general as violent, so far competitiveness and physical violence have not been subsumed under one heading; for example, testosterone

442 See infra under Postpartum Disorders.

443 See Chapter 5.
aggression syndrome. Women must take conscious steps to ensure that premenstrual irritability, however caused, is not equated with the form of psychosis that led to the Dalton defence. They must also ensure that those whose state of mind justifies such a defence are not denied it in the cause of some concept of feminist political correctness.

This might be done via interdisciplinary research design. To date there have been a number of multidisciplinary conferences and symposia on PMS. However, these consist of parallel discussions; one specialty talking to the other specialties about discoveries made in isolation from each other. At best, gynecologists may work with psychologists or health workers with psychiatrists. I have not found any research projects in which, for instance, feminists, anthropologists, sociologists, gynecologists and psych professionals have cooperated with each other to design a research model and to allow for multiple variables. I also believe that control for gender bias is essential in any research that proposes to identify sex specific phenomena. Just as the Cell Biology Group deliberately set out to control for gender bias in biological research, workers in the field of PMS - and any other sex specific areas, female and male - should create a similar protocol. This might not eradicate negative stereotyping overnight but it would certainly be one place to start. The law could only benefit from any new reality identified in this way.

These suggestions may be helpful with respect to PMS. But are they relevant to postpartum and menopausal problems? I believe they are, since the similarities among all three

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Mary Ellen Robertson, "A Survey of Multidimensional and Interdisciplinary Approaches to Premenstrual Syndrome" in Taylor & Woods, supra note 48 at 129, has studied current practices at 40 PMS centres in the U.S. She found that eleven categories of personnel worked at these centres and that they referred patients to nine other categories. Unfortunately, she did not ask whether this interdisciplinary practice included research or whether these centres were adding to existing knowledge.
sets of conditions appear to outweigh the differences. However, the differences are important too. I will point out some of these below.

(ii) POSTPARTUM DISORDERS

Since this study relates to legal defences based on states of mind, I could not help but be struck by the discovery that the American psychiatric community has such contrary attitudes towards PMS and postpartum mental disorders. It seems that, just as PMS is gradually working its way into the DSM, postpartum disorders have been working their way out. 445 This is a curious state of affairs when both, as presently defined, occur only in women and at times of hormonal change; both are related to mental states ranging from the "blues" to full-blown psychosis; both are the topic of similar differences of opinion as to definition and causation; both are subjected to multiple treatments; and both have been identified as justification for legal defences.

The omission of postpartum disorders as specific entities from the DSM is even more striking in face of the progress made in subdividing these into separate categories in accordance with severity and type of symptom. One researcher who has been consistently instrumental in creating these subdivisions is R. Kumar, a senior lecturer in psychiatry in London, England. 446

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445 The DSM index refers the searcher for postpartum psychosis to "Schizophrenic disorder, Brief reactive psychosis, Major affective disorders, Organic brain syndrome." DSM-III mentions it under 298.9 "atypical psychosis." The eighth Revision of the International Classification of Diseases (ICD-8) retained under heading 294.4, "Psychosis associated with childbirth" if it occurs within six weeks of delivery and cannot be classified under headings dealing with schizophrenia, affective psychosis, paranoid and other psychoses. The ninth revision removes postpartum psychosis to the section on obstetrics. (See Brockinton, supra note 355 at 43-44.)

446 Perhaps, because he is English, the authors of the DSM give his conclusions less weight than contrary opinions of American psychiatrists. I have located only one article published in the U.S. (although my research is not exhaustive). For example, see R. Kumar,
He identifies them as: (1) maternity "blues - transient emotional reactions which occur towards the end of the first week postpartum; (2) Postnatal Depression - non-psychotic, or depressive neurosis which arises in about ten percent of new mothers, usually in the first three months after delivery, and which is not clinically distinguishable from other depressive illnesses; (3) Postpartum Psychosis - a very rare disorder - which includes hallucinations, delusions (often in the form of commands to harm the baby), agitation, mania, and deviation in moods - but one which Kumar estimates is accountable for between three and ten percent of all female psychiatric admissions. Another author states that the occurrence of postpartum psychosis ranges from one in one thousand to one in three thousand births 447 and "perhaps one percent [of psychotic mothers] kill their babies." 448 (1 in 100,000 to 1 in 300,000 births) A recent Canadian study adds a fourth category which the authors claim is distinguishable from neurotic depression; namely, depression suffered by women with borderline personalities. 449 Women with this disorder may suffer from some psychotic episodes but rarely lose touch with reality. 450

James Hamilton, an American psychiatrist, believes that postpartum psychosis was removed from official classifications because it did not fit the categories that were established


448 Kumar in Demers, supra note 56 at 166.


450 Ibid. at 9.
in the early twentieth century. Consequently, "[t]he distinguishing characteristics of postpartum psychosis were first minimized, then forgotten, [doing] a disservice to patients and to the advance of knowledge." This exclusion from psychiatric classification did not deter efforts to establish an organic, hormonal cause of postpartum disorders but so far no clear physiological etiology has emerged. Thus most psychiatrists have confined themselves to treatment with psychotropic drugs that are used for non-puerperal illness.

Hamilton, who has spent several years observing and treating postpartum patients, notes that, instead of the gradual onset associated with other psychiatric disorders, postpartum illness often appears suddenly and is marked by swift remissions and regressions. It comes with a large component of fear and anxiety which may set up feed-back mechanisms that may perpetuate or worsen the original illness. Hamilton, over a period of eighteen years has administered a combination of estrogen and testosterone to forty high risk patients at delivery to prevent a recurrence of postpartum psychosis, and reports no recurrence in any of them. However, he acknowledges that no controlled study has been carried out to substantiate his result.

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451 Supra note 356.

452 Ibid. at 1.

453 Ibid. at 5.

454 Brockinton et al., supra note 355 list a variety of evidence which supports the hypothesis that postpartum psychosis can be distinguished from other types of psychosis. These authors deplore the fact that there has been little advancement in knowledge since Marce's work 120 years ago. "All we know now is that primiparous patients are more at risk and that there is a link with manic depressive psychosis." (at 65).

455 Ibid. at 7.
Researchers who focus on biological causes have suggested a number of theories. Hamilton, although a psychiatrist, believes that organic factors play an important part. Dalton extends the reasoning in her hormonal theories about PMS to postpartum disorders. 456 Iffy et al. have noted psychotic reactions after administration of bromocriptine, a drug used to suppress lactation. 457 Vinogradov and Csernansky report two cases in which patients with a history of psychiatric disorders went into complete remission during pregnancy, but experienced acute onset one to three weeks after delivery. 458 They hypothesize that high estrogen levels during pregnancy may decrease brain dopamine activity while triggering the development of dopamine receptor supersensitivity. The twentyfold drop of estrogen levels following delivery may then unmask an increased number of dopamine receptors which results in the rapid emergence of severe psychosis. It is interesting that many of these organic theories come from psychiatrists whereas, in PMS research, psychiatry and biology remain largely separate.

Social factors seem to play a major part in the quality of experience of women with PMS. A number of writers have suggested that the major causes of postpartum illness are social in

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456 For example, see Katharina Dalton, Depression After Childbirth: How to Recognize and Treat Postnatal Depression (London: Oxford University Press, 1980).

457 Lesley Iffy et al. (gynecologists and psychiatrists), "Puerperal Psychosis Following Ablaction (sic) with Bromocriptine" (1989) 8 Medicine & Law 171. This chemical is an ergot derivative. The authors list 29 symptoms that are common to both puerperal psychosis and ergot poisoning and speculate that a number of instances of the former may be caused by the latter, since symptoms may continue for some time following withdrawal of the drug. It is interesting to note that treatment with estrogen, a previous method of suppressing lactation, was found to suppress psychotic symptoms.

origin. However, most of these authors are concerned with depressions, rather than psychoses. Recent studies tend to support the view that negative life events increase the likelihood of depression but have little effect on the incidence of psychosis; the latter apparently being related to a previous history of psychosis, number of pregnancies and genetic susceptibility. This evaluation would sit psychoses firmly within the woman, leaving no room for a "rotten social background" defence to child killing. It would also fit within the current legal definition of insanity.

My reading suggests that medical writers have identified the following major factors as grounds for creating separate categories for postpartum illness:

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459 For example, Jonathan P. Richards (a lecturer in general practice, University of Wales), "Postnatal Depression: A Review of Recent Literature" (1990) 40 British Journal of General Practice 472 - vulnerability factors for postpartum depression include: a poor relationship between the mother and her partner, poor quality social support and lack of a confidant, prior mental illness, and low family income; Dwenda K. Gjerdingen & Debra G. Froberg (professors of family practice and public health, University of Minnesota) "The Measure of Health in New Mothers: A Factor Analysis of Physical and Mental Health Variables" (1991) 17(2) Women & Health 119 - a study of married biological and adoptive first-time mothers plus a control group which found, among other things, that lack of work readiness is linked to reduced activity in adoptive mothers and to acute health problems in biological mothers; Landy, Montgomery & Walsh (Canadian nurses), supra note 449 - early depriving or abusive experiences are necessary but not sufficient conditions to explain the development of severe postpartum depression; Dawn S. Gruen (social worker), "Postpartum Depression: A Debilitating Yet Often Unassessed Problem" (1990) 15(4) Health & Social Work 261 - new parenthood is a "biological, social, psychological, emotional, and sometimes spiritual crisis" (at 262).

I am aware that new fathers may also be susceptible to depression following the birth of a child. This might have to be considered if depression, as well as psychosis, were grounds for a criminal defence. However, postpartum depression in fathers is beyond the scope of this study.

460 M.N. Marks et al., supra note 446. These authors (including Kumar) note that the relative risk of admission to a psychiatric hospital with psychotic illness is 22 times greater in the first month following delivery than in the 24 months preceding birth. This is increased to 35 times after a first baby. Their prospective study tracked women with previous psychiatric disorders against normal controls and found that life events seem to be significant precursors of non-psychotic postpartum illness, but are less important in the etiology of postpartum psychosis.
1. Research into these disorders is hindered because their incidence is not recorded. Separation into serious and less serious categories could assist general practitioners and paramedics in identifying, treating and, where necessary, referring patients to specialists. Women are often ashamed of their feelings and may not reveal their concerns to medical personnel until the symptoms are out of control. Therefore, these people should, without alarming asymptomatic or unconcerned mothers, actively investigate the status of the mother. The six week check-up should not be confined to the baby's welfare but should include the mother's mental health as well.

2. It is premature to assume that biologic events surrounding parturition play no part as causal or predisposing factors of postpartum psychologic illness. This forecloses the possible emergence of specific hormonal or other treatment strategies for such illness.

3. Maintaining categories of postpartum illness may help refine the understanding of affective disorders and reduce their heterogeneity.

These reasons could equally well apply to PMS and menopause. Kumar notes that there are humanitarian reasons for maintaining a separate diagnostic category for postpartum illness; that is, to protect mentally ill women from serving draconian sentences for the murder of their newborn children. He contrasts the position in the U.K. (and, by implication, Canada) under the Infanticide Act where these women are treated as patients, with the "vagaries of state laws" in the U.S. where they are treated as criminals and may serve sentences of ten to twenty years. 461

Our present legal system has an interest in separate diagnostic categories which might assist in the apportionment of criminal responsibility. 462 For instance, psychoses which impair

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461 Kumar in Demers, supra note 56 at 166. Also see Hamilton, supra note 356 at 11, where he compares the outcome of two similar cases: (1) a verdict, three months after the killing, of not guilty by reason of insanity for Martha Prior who, in 1847 England, escaped supervision after diagnosis of postpartum psychosis and killed her two week old baby; and (2) a verdict, three years after the killing, of guilty of second degree murder for Helen Winter who, in 1976 California, killed her baby after expressing bizarre fears to several people about hurting her baby. In the interim, Mrs. Winter had another baby and was immediately treated with estrogen injections. There was no recurrence of her psychosis.

462 I am not arguing here that the present legal system is good or bad, but that to use it to obtain an approximation of justice for women certain actions must be taken by law and medicine. However, in the long run we should not look at whether these disorders fit the legal system, but rather whether the legal system fits women's reality.
the brain's ability to receive, interpret and react to incoming stimuli would probably qualify as legal insanity. Severe clinical depression, although not legal insanity, might lead to a defence of diminished capacity (in jurisdictions that recognize such a defence). Alternatively it could contribute towards a finding of lack of specific intent or mitigation of sentence. Mild depression, such as "baby blues" would not constitute a criminal defence. Such demarcation is impossible if all symptoms are lumped together under one heading - as with PMS.

Even though the cause (or causes) of postpartum illness are still unknown, separation by severity and type of symptoms that affect cognition and volition, would assist in the formulation of defences for the very few women who are entitled to them, without implying that all women who have babies are likely to exhibit criminal tendencies. ⁴⁶³

In contrast with PMS which I suspect is a further manifestation of menstrual theories that were born in the nineteenth century, postpartum psychoses, recognized a hundred years ago as specific entities peculiar to women after childbirth, have now been denied validity in their own right. This has affected their acceptance as criminal defences in jurisdictions that do not have infanticide statutes. ⁴⁶⁴ It would certainly be desirable to identify reasons, historical or otherwise, for the different reactions in the psychiatric community towards classification of PMS and postpartum disorders, before taking any steps to abandon the protection offered by infanticide provisions.

⁴⁶³ The fact that there has been no popular trend towards labelling all women as possible murdering mothers (compare with menstrual madness) may indicate that the myth of the nurturing mother is stronger than the myth of deranged menstruator. However, when the maternal myth is overcome, there is evidence to suggest that courts exact a heavy toll on mothers who kill their children. See, for instance, Ania Wilczynski, "Images of Women Who Kill Their Children: The Mad and the Bad" (1991) 2(2) Women & Criminal Justice 71.

⁴⁶⁴ I will discuss the legal ramifications of this failure to recognize postpartum psychosis below in chapter 6.
Before leaving the topic of postpartum disorders, I must point out that little medical literature that deals with this subject appears to consider the phenomenon of neonaticide - the killing of a baby before it is twenty-four hours old. Either it is perceived as a separate entity or it is not readily recognized as the outcome of a medical disorder. Since those who apply infanticide statutes seem to assume that neonaticide can be explained by the presence of mental disorder, I think it appropriate to say more on the topic here. I will discuss its legal ramifications in greater detail in the chapter on defences.

I have already referred to the distinction between neonaticide and infanticide in the historical section above and will say more when I deal with medicine and crime below. However, since this chapter is an exploration of medicalization of human bodies and aspects of human lives, this surely is the place to ask what, if any, medical context surrounds the mental state of mothers who have just given birth and fathers who might also be influenced by this situation.

Most writers point to social factors such as the shame of bearing an illegitimate child or a child not fathered by her husband as a proximate cause of neonaticide. However, some have considered the possibility of mental illness. Kaye et al., psychiatrists, estimate that fewer than thirty percent of mothers who kill their newborn children are psychotic or depressed. However, thirty percent is a significant figure. Reports of court cases suggest that many women (or

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465 Kaye et al., supra note 362. The main focus of this paper is on four cases of paternal neonaticide - the only cases the authors could find between 1751 and 1990. They characterized these killings as (1) altruistic - father poisoned newborn because he thought his own poor health might prevent him from adequately supporting his wife and child; (2) unwanted pregnancy - father, forced into marriage by wife’s pregnancy, strangled baby as he was delivering it. He became schizophrenic three years later; (3) psychosis - father stabbed 5-hour-old son to death in hospital; (4) psychosis - father smashed head of newborn, obviously abnormal son. (Were it not for the violence of this act, it might have been classified as altruistic.)
girls) have been in a state of denial during pregnancy and may be genuinely shocked by the advent of birth. This may seem far fetched to the rational observer who cannot imagine how a pregnant woman could possibly be unaware of, let alone conceal, her physical condition. Maybe that is one of the reasons why judges and juries have been so ready to assume irrationality. Should such denial be labelled "mental illness?" Even though this state of mind may differ from the postpartum psychosis described above, is it equally deserving of recognition as a defence?

These women use denial as the predominant defense mechanism, a fact which can no longer be avoided when birth occurs. This sudden dissolution of the major defense causes overwhelming fear, particularly fear of abandonment by the mother, from whom the pregnancy was hidden all along. This acute breakdown of defenses serves to produce disorganized thinking, impaired judgment, and possibly even psychosis.  

If this observation is true, then some kind of criminal defence or mitigation mechanism would be necessary for neonaticide. Obvious problems arise if the law seeks to rely on a scientific basis for a defence. I have already listed numerous drawbacks to acceptance of research data in the fields of PMS and postpartum disorders - lack of control studies, small samples, etc. Control studies and prospective studies would be impossible and unethical for the gathering of empirical data about mothers who conceal pregnancy. Psychiatrists have to rely on subjective reports and retrospective data which could be self-serving especially after the laying of criminal charges.

Bourget and Bradford, Canadian psychiatrists, identify neonaticide mothers as having abnormal personalities with immature, impulsive, antisocial characteristics.  

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466 Ibid. at 138. Kaye et al. advocate the subdivision of infanticide into three subtypes: A - at birth, B - birth to six months, C - six months to one year, since each has its own special characteristics despite some overlap.

whose thinking processes are seriously disturbed from deprived youths who act out their frustration via criminal acts.

Although I have an instinctive feeling that some of these young mothers are entitled to a defence based on mental illness, I do not know how much of this instinct is based upon my own stereotypical notions of motherhood and how much is based on what small scientific knowledge I possess. Neither do I know how the law or medicine could separate those who are seriously disturbed from those who merely have low coping skills. Negative social factors are so obvious in this area that the importance of medical factors may have been downplayed by those who criticise infanticide provisions.

Fortunately for society, but unfortunately for science, neonaticide is a very rare offence now that birth control and abortion are more readily available. Only a very careful, consistent study of neonaticide mothers could help solve this dilemma. Another possible complicating factor is underreporting of this crime. Methods of proving deliberate killing of newborns are still quite unreliable, which means that police may not lay charges despite suspicion. 468 Maybe it is only those mothers that are seriously deranged that are detected. It would be interesting to know how many neonaticides are characterized as non-infanticide killing and how many are listed as infanticide. 469

468 For a detailed study of problems encountered by forensic pathologists, see R.J. Kellett, "Infanticide and Child Destruction - The Historical, Legal, and Pathological Aspects" (1992) 53 Forensic Science International 1.

469 It is interesting that suicide (complete or attempted) - an action that we usually assume to come from a deranged mind - is statistically associated with non-infanticide killings, rather than infanticide. (See Robert A. Silverman & Leslie W. Kennedy, "Women Who Kill Their Children" (1988) 3(2) Violence & Victims 113). This contradicts medical sources that note a fairly high suicide rate in cases of "altruistic" filicide; that is, those mothers who kill their child to relieve its suffering - real or, in the case of psychosis, imagined. (See Resnick, supra note 362) Is it possible that some suicidal women who kill their children in a psychotic state are being
It is notable that the only crime that attracts a specific postpartum medical defence is a very narrow type of child killing. If the new mother is so deranged, why are there no reports of other types of crime? There is plenty of variety when it comes to premenstrual crime. In fact, PMS has been used as an excuse for offenses from murder to impaired driving. 470 If the law is genuinely focusing on state of mind and such defences are justified, they should not be confined to homicide. 471

Cases of crimes characterized as "menopausal" are even more rare than infanticide. I have yet to run across a case of murder by a "raging granny" caught in the violent sway of her hormone changes - this despite allusions to the possibility by nineteenth century writers. 472 Instead, the stereotypical idea of menopausal crime is shoplifting by confused, middle-aged, middle-class housewives. To what extent is this stereotype supported by modern medicalization?

(iii) MENOPAUSE

I think that menopause is a sex-linked, female dominant estrogen deficiency disease, and I think that these little old ladies should be given a better deal.

Dr. Barry Wren, Australian menopause "expert," 1984. 473

470 See Chapter 6.

471 Although this is precisely what the U.K. has done with the defence of diminished responsibility.

472 Supra, section I(A)(iii) of this chapter.

My research tends to support the idea that society has continued to medicalize women's biological functions, especially during the period in which women have the potential to have babies. It is not so clear whether this medicalization is still so powerful after women have reached menopause and their value as procreators has ceased. I have criticized stereotypical assumptions made about women by science, medicine and, by implication, law. However, I must constantly be on the alert to uncover my own assumptions about current society's interpretation of women's bodies and social roles. It is tempting to assume that, if childbirth and menstruation have been medicalized, then menopause must merely be an extension of the same phenomenon. This fails to probe deeply enough into the perceptions that lead to medical action. It also fails to recognize that the myths underlying medical opinion about the phases of a woman's life are not all cut from the same piece of cloth. Motherhood myths that might affect attitudes to childbirth are very different from the old crone myths that underlie menopause.

I have stressed the importance of myth and its consistency over time but this does not mean that myths remain completely static. If they did not adapt and reassemble themselves to conform to changing worldviews, they would be much less powerful. It is their protean ability to adjust themselves to current social, political and economic needs that makes them so elusive. Just as we think we have grasped the nature of a particular myth, it mutates to another form that requires further consciousness raising. I believe that menopause may be one of these areas that is undergoing present change and that feminist assumptions about conditions ten years ago may not be entirely valid today.

Some feminists, who hypothesize that the agenda of men, medicine and the pharmaceutical industry include control over and profit from women's alleged disabilities, argue that menopause is yet one more normal aspect of women's lives that has been moulded to the
medical model. Others say that the data used by these feminists are skewed because they originate from women who are asking for medical treatment, not from women at large.

Up until recently, menopause has differed from PMS and postpartum disorders in that there has been no groundswell on the part of middle-aged women demanding medical help for symptoms. However, now that the baby-boom generation is experiencing menopause, there has been an upsurge in lay publications about the topic. The authors of these books, unlike some of the more vocal sufferers of PMS, are not crying out for validation of their experience or for medical solutions. Rather they are offering information about a normal life transition while pointing out the areas in which medical intervention may be necessary or useful.

To what extent has menopause been medicalized? What do modern medical texts say about the subject, especially with respect to mental and emotional changes? What is menopausal reality for the majority of women? What, if any, symptoms have been attributed to menopause that are actually part of the process of aging, common to both men and women? Like PMS, menopause has been associated with both physical and mental symptoms. Medicalization has encompassed both. Because physical symptoms are irrelevant to legal defences based on state of mind (unless they in turn cause changes in cognition), I will concentrate primarily on mental and resulting behavioral changes said to be caused by menopause.

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474 See Susan Bell, supra notes 67 and 251.

475 See Patricia Kaufert & Penny Gilbert, "Women, Menopause, and medicalization" (1986) 10 Culture, Medicine & Psychiatry 7.

476 For example, the number of books on the menopause, both by feminists and self-help advocates has mushroomed in the last few years: Greer, supra note 58; Gail Sheehy, supra note 368; Janine O’Leary Cobb and The Montreal Health Press, supra note 57.
Germaine Greer has identified two schools of thought about menopause, which could well apply to PMS: (1) nothing of any significance is taking place; and (2) the stress and strain of what is taking place is so acute that sensible behaviour is not to be expected of women. I believe that the latter opinion comes from and reinforces myths about the mental incapacity of all middle-aged women. For instance, if these myths are upheld by medicine and filter into law, they could (and probably do) affect the opinion of judges and juries about the credibility of female witnesses "of a certain age." Does medicine uphold such myths?

Susan Bell argues that a small elite segment of American medical specialists created a menopausal "deficiency disease" construct in the 1930s and 1940s and that the vocabulary of their model persists today. The discovery of hormones, and their extraction and synthesis led to a new etiology "made possible by the paradigm of sex endocrinology." It also made available a plausible "cure." Just as diabetes could be controlled by administration of insulin, menopause could be controlled by administration of estrogen. Some physicians accepted the idea of hormone therapy with open arms. Others, even in the 1930s, expressed concern about the safety of estrogen administration.

Bell notes that medicalization was divided into biological, psychological and environmental models (similar to PMS) and that

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477 Ibid. at 71.
478 Bell, supra note 251 at 45.
479 Ibid. at 47.
480 Ibid. at 49. Also, Mary Lynn Stewart, "Hormones and Hot Flashes: Endocrinology and Menopause" - a paper given at the Women’s Health Across the Life Span Conference, sponsored by the Centre for Research in Women’s Studies and Gender Relations and the Women’s Health Centre, University Hospital, University of British Columbia, October 16-18th, 1992.
The specialists’ implicit message was that all menopausal women should see physicians, who could prescribe the appropriate therapy. In recommending that even talking to a physician could be therapeutic and that all women should seek medical advice, specialists were defining menopause as a medical problem - not just for some women, but for all women. 481

If Bell’s interpretation of specialists’ attitudes is true, then according to recent lay publications their strategy has not been altogether successful. Janine Cobb observes that “important events in a woman’s life have never been taken very seriously by the male political or medical establishments” 482 and that women have been kept in the dark about the mechanisms of menopause. 483

If we look solely at medical literature on the menopause it might seem that women are once again being medicalized. However, in the greater medical scheme of things, concerns of women often receive minimal research funding compared to areas like organ transplants and lung cancer. This might be why the etiology of gynecological disorders is still in the same state of confusion as it was a century ago. The words may sound more scientific and the treatments may have changed (although not much), but causes are as obscure as ever. Medicalization does not necessarily mean more medical knowledge; it means that many women may be receiving treatment for a physical and mental state that may not require medical intervention.

To illustrate what modern texts say about the relationship between menopause and mental disorder I cite the following examples, again chosen at random from a seemingly limitless

481 Ibid. at 60.
482 Supra note 57 at 5.
483 On the other hand, The Montreal Health Press, while agreeing that women have little useful information about menopause, condemn attempts to medicalize the topic via "doctor columns" in newspapers and women’s magazines that leave women “feeling that they are somehow irresponsible if they don’t run to their doctor at the first sign of changes.” Supra note 57 at 9.
number of sources. Contrary to accusations that the medical profession holds up hormone replacement therapy as a panacea, two recent gynecology texts stress possible risks from this procedure. They also distinguish estrogen decrease (i.e., normal menopause) from estrogen deficiency which causes symptoms including osteoporosis.

Although gynecological texts, like those at the beginning of the century, use a small proportion of their space for discussions of menopause, this deficit is amply compensated for by the large number of texts that devote themselves solely to the subject. From these I gleaned the following information: 53% of middle-aged women believe that a woman in menopause is apt to do crazy things she herself doesn’t understand. Most investigations do not support the idea that significant psychiatric distress occurs as part of the "menopausal syndrome." Although there is no evidence that menopause causes depression, there is some evidence that estrogen may alleviate severe depression at the time of menopause but not in perimenopausal or postmenopausal women. Depression "may well be the result of the chance association of


486 Ibid at 203. (Note the use of the word "syndrome" for what is supposed to be a natural process.) Despite studies which have failed to show a direct link between menopause and mental state, Maureen Dalton includes as psychological symptoms, depressed mood and failing memory. See Gynecological Endocrinology: A Guide to Understanding and Management (Houndsmills, Basingstoke, England: Macmillan, 1989) at 117. In contrast, another text on menopause does not even mention depression in its index: Piero Fioretti et al., eds., Postmenopausal Hormone Therapy: Benefits and Risks (New York: Raven Press, 1987).

487 Ibid. at 90 and 203. Perimenopause refers to the time immediately prior to cessation of menses; postmenopause to the period that starts one year after cessation.
menopause and affective disorder and of a third factor, age. 488 Other studies have denied any beneficial emotional effects from estrogen therapy.

Depression results from a situation where a woman either cannot continue rewarding roles, or her role receives negative value... [M]en experience the same depression when after retirement there is no role continuity. 489

Scientific investigation seems to support this statement. 490

I find it interesting that none of the literature refers to what the Victorians called "menopausal mania" - a form of psychotic disorder. It seems to have gone out of fashion, which may explain the absence of modern stereotypes associating the older woman with violence. However, despite medical literature to the contrary, the popular conception of the menopausal woman, especially among younger women, is invariably negative. 491 I have noted that, in the absence of specific infanticide provisions, it would be difficult for a woman to rely on scientific literature to support a defence of postpartum disorder. It would be well nigh impossible for her to rely upon a "menopausal syndrome" defence. No original articles on the psychological effects

488 Ibid. at 91 citing G. Winokur, "Depression in the Menopause" (1971) 130 American Journal of Psychiatry 92. See also Dennis Gath & Susan Iles, "Depression and the Menopause" (1990) 300 British Medical Journal 1287 - "research has found that depressed mood and depressive disorder in middle aged women are related less to the menopause than to the vicissitudes of life."

489 Brian M. du Toit, "The Cultural Climacteric in Crosscultural Perspective" in M. Notelovitz and P. van Keep, eds., The Climacteric in Perspective (Lancaster, Boston, The Hague, Dordrecht: MTP Press Ltd., 1986) 177 at 185. (Yet no one seems bent upon administering extra testosterone to depressed men.) Judith Gold, supra note 426, points out that depression is highest in women in their early 20s and that it is more clearly associated with environmental and social variables than with endocrinological changes. (at 98)

490 For a review of the literature, see Mary Clare Lennon, "Is Menopause Depressing? An Investigation of Three Perspectives" (1987) 17 Sex Roles 1.

491 See J.G. Greene, "Psychosocial Influences and Life Events at the Time of Menopause" in Formanek, supra note 55, at 79. He found that stereotypes were more negative than actual experience of menopause.
of menopause appeared in the journal Obstetrics and Gynecology for the years 1983 through 1986; neither menopause nor climacteric was indexed in the American Journal of Psychiatry for those years. 492

It appears that menopause has not been medicalized to the extent that any expert would be willing to testify unequivocally that a woman should be excused from criminal sanctions merely because she was a "certain age." Kaufert & Gilbert found in a Manitoba study that "the experience of menopause was not a highly medicalized process and was one in which some women involved their physicians not at all."493 The recent publicity about menopause may change this as support groups, similar to those for PMS, take hold and those women who are unfortunate enough to experience negative psychological symptoms demand medical solutions. 494

The PMS defence was unheard of only a few decades ago. Although it may seem far-fetched, the law should be ready for the possibility of a menopausal defence and should learn from the precedent created by PMS.

C. CONCLUSION

When we think casually about modern medicine, we see what seem to be enormous technological advances which assist in diagnoses and cures that would have been impossible a century ago. There is little resemblance between the sterile operating theatre of today and the blood and pus-stained environment of early nineteenth century hospitals; or between scientifically

492 Raphael S. Good, "Estrogen in Menopausal Mood Disorders: A Review of the Literature and Commentary" in Demers, supra note 56 at 173.

493 Kaufert & Gilbert, supra note 475 at 16.

494 Vancouver already has such a group that meets on Tuesday evenings.
researched and produced pharmaceuticals and old-fashioned tinctures and nostrums. The last one hundred and fifty years have seen the development of asepsis, anesthesia, antibiotics, immunization - to name but a few.

There has also been major progress in the prevention, diagnosis and treatment of a number of disorders associated with the female reproductive system; for example, cervical cancer, fertility problems and, to a certain extent, endometriosis and dysmenorrhea. Why, then, have there been so few advances in the diagnosis and treatment of certain other signs noticed by women and identified by the medical profession as disorders, diseases or syndromes? As I have already pointed out, these signs, such as premenstrual irritability and postpartum depression have been noted by women and healers for millennia. However, their importance and fashion as "diseases" seem to fluctuate as widely as the business cycle. In other words, there is a social cyclicity in public attention paid to menstrual cyclicity. 495

Why has there been such an upsurge in public interest in PMS and, to a lesser extent, postpartum and menopausal disorders? Are these conditions, in fact, diseases at all? If we look solely at medicalization of these conditions during the last few decades - the new terminology, the apparent use of objective, "scientific" methods - we may see little connection between these new entities and their nineteenth century precursors. In this section, I have tried to show that modern attitudes and methodology have been heavily influenced by the birth of medicalization during the nineteenth century, which in turn has been moulded by older religions, myths and

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495 I cannot help noticing that society seems to accept cyclicity as perfectly normal when applied to economics, climate and planetary rotation. In women, it is a normal but unfortunate manifestation of inferiority to men. In men it is ignored or denied, despite increasing evidence of its existence, as if it were a bad thing.
stereotypes. The present position could be seen as a point in a spiral, a cyclical continuum originating with the birth of patriarchy.

As an illustration of this connectedness, I refer to a paper by gynecologist Charles King who has traced parallels between nineteenth and twentieth century behavioural disorders attributed to a malfunctioning menstrual system. He calls these disorders "pseudodiseases." To place PMS within its historical context and to refute the idea that it is a brand new medical construct, I will list similarities identified by King:

1. An incomplete and inaccurate understanding of menstruation. Behaviours are identified as symptoms of "disease" because of cultural expectations about women's menstrual behaviour.

2. No identifiable causes or satisfactory pathogenesis.

3. Protean manifestations are expected and found.

4. No specific means of diagnosis (because cause is unknown).

5. No real scientific base for therapy; treatment often ineffective and often having iatrogenic (disease causing) effects; proliferation of "popular" remedies.

6. Once diagnosis made, women's behaviour is confined by personal, professional and societal expectations of the diagnosis.

With some modifications this comparison between nineteenth and twentieth century medicine could apply equally well to postpartum and menopausal disorders.

I have described the internal cyclicity of PMS and the importance of timing in all of the above conditions. However, I have not dwelled heavily on external cyclicity; that is, those social conditions that may have been responsible for the recurrent surfacing of these disorders. There are obvious parallels between the "fashionability" of menstrual disorders and the rise of feminism in the last two centuries. But I feel that it would be too simplistic to identify absolute causal

496 Charles King, supra note 249 at 10.
connections between the two. However, whether or not these disorders have arisen in response to attempts by women to gain equality, a major effect of medicalization is to deny women the autonomy they are striving for. It seems that the more women demonstrate their public capabilities, the more medicine (and women themselves) attempt to deny those capabilities by insinuating that women are physically and mentally incapable of doing a "man"s" job.

Why, in a culture that prides itself on its rationality, does irrationality govern in the interpretation of women's reality? Are the stereotypes about women so strong that they will always overcome even concrete demonstrations of their inaccuracies? 497 If the answer is yes, women might as well give up their struggle for equality. Since such a solution is unacceptable to most women, we must hope that we can take steps to eliminate negative stereotypes. But while we are demonstrating the fallacies of medical theories, we must not trample upon the rights or ignore the reality of those women who genuinely suffer from mentally debilitating disorders.

I, and a large number of other authors, have pointed out ways in which these genuine disorders could be separated from the more benign signs experienced by most women: for example, reclassification and subdivision of signs and symptoms; renaming those syndromes (if they exist as discrete entities) that are severe enough to call for a legal defence; adoption of multidisciplinary research models that use cooperative rather than parallel methodology; the use of controls for gender bias throughout research, diagnosis and treatment. Implementation of such solutions would take political will. Canada has been in the forefront in attempts to eliminate harmful stereotyping in sexual assault law. Hopefully this impetus may carry forward into the

497 Lorraine Code discusses that fact that stereotypes persist in the face of contradictory empirical information, in What Can She Know (Cornell University Press, 1991).
area of medicalization of women's bodies. This should facilitate the formulation of legal defences free of gender bias.

In Part II, I will discuss the medicalization of the male body and attempt to identify similarities, differences and trends that may parallel women's experience.

II. MEDICALIZATION OF MEN

Feminist writers have unearthed a significant amount of historical data about the medicalization of women's experiences. There is no such comprehensive source of information about men, at least where issues of sexuality are concerned. Is this because the male reproductive system provides less interesting topics for study and discussion? Or is the lack of data about the "normal" male merely a reflection of science's preference for studying the abnormal? Alternatively, is the information available but obscured because no one has been motivated enough to look for it? Does the volume of literature about women's bodies give an accurate impression that society was and is more concerned about the control of women via medicine than about possible problems encountered by men? I think, as I will show below, that the answer to this is partly "no" - especially in the nineteenth century when there was a fixation about the evils of homosexuality and a perception that "manliness" must be controlled at all costs.498

It is part of feminism's agenda to promote equality for women by educating society about the unfairness and irrationality of female subordination. It is counterproductive for women to ignore similarities in men's experiences on the ground that they do not fit some preconceived theory. Firstly, lack of investigation, or suppression, of relevant data endangers the validity of valuable work already done by women scholars. It smacks of the gender bias that feminists

498 For example, see Simpson, infra note 72.
justifiably attack in other current ideologies. Secondly, if women leave the interpretation of data about male experience solely to men, the system of male dominance will probably perpetuate itself. For example, men are more likely to interpret their own medicalization in a way that fits present power structures; feminists are more likely to deconstruct the same information in a way that demonstrates the desirability of societal changes for both women and men. Neither interpretation may be "true" but hopefully the latter, stripped of patriarchal myths, would be a greater force for improvement of society as a whole.

I will therefore attempt to illustrate that men have suffered from medicalization, based on myths of the ideal man, that may in a subtle way be just as harmful to society (including women) as the medicalization of women. I will argue that medicine has contributed to the maintenance of patriarchy by classifying men with sexually related problems as lesser beings - more akin to women. This preserves the grand isolation of "real" men and prevents contamination of their dominant image. It also denies legitimacy to the voices of some gentler men by conferring upon them the apparently sympathetic labels of medical weakness or disability, or by applying derisory designations such as "wimps or wankers."

I do not claim that this section will represent as comprehensive a study as Part I. I hope it will show that further study should be done in this area and that it is relevant for a fuller expression of feminist ideas. As before, I will discuss issues surrounding impotence, genetic

\[498\] For example, a number of men in the new men’s movement have used the feminist technique of consciousness raising to blame adult dysfunctions on a lack of child-raising skills by their mothers.

\[499\] I acknowledge that this may be a somewhat simplistic view because it does not specifically allow for class and race difference. It assumes that men who do not conform with the dominant image are somehow subordinated. I am sure that many individuals from supposedly subordinate groups do not fit this picture. However, I believe that the general concept is a useful tool for analysis, as long as I and the reader constantly acknowledge its limitations.
abnormality and pedophilia. However, as an introduction, I will briefly discuss two papers that analyze nineteenth century ideas about diseases of the male will. These ideas were closely tied to prevailing notions about male sexuality which, in turn, depended upon myths and stereotypes about the ideal man described in Chapter 2.

As noted about women, the nineteenth century put medical labels such as neurasthenia and hysteria on what might otherwise have been described as "cop out" behaviour. This form of medicalization allowed women to retreat from futile attempts to live a prescribed but unnatural lifestyle by adopting a mantle of sickness. Women were not alone in this. They were accompanied by large numbers of men, the only difference being the role escaped from.

I have already noted in Part I that nineteenth century physicians believed that excessive use of the brain could detract from a woman's procreative ability; they also believed that excessive use of the sexual organs would detract from a man's ability to think. Writers linked brain power with the idea of "will." John Smith, in his study of abulia (pathological indecisiveness), sexuality and disease, claims that studies on the will constituted "one of the major "discursive facts" of the nineteenth century." Early psychologists and psychiatrists believed that will is not an innate capacity, but something that must constantly reproduce itself out of feeling or from the conjunction of feeling and representation. This idea is similar to those described in Chapter 2 about masculinity itself; that is, men must create and constantly maintain their own masculinity - while women just "are."

Smith argues that nineteenth century expectations about manhood placed men in an impossible position of tension between oppositions of impulse and inhibition, normalcy and

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500 Supra, note 346 at 102.

501 Ibid at 105.
perversity, activity and passivity. "The abulic male in nineteenth-century discourses is literally the pathological exception that marks the rule of the history of male sexuality." Philosophers and psychologists believed that men must will; therefore, medicine created the disease of a abulia to describe men who were incapable of making decisions. Modern laypeople would likely call this phenomenon "burn-out" since it happened most often to those in professions that demanded intense intellectual concentration on one particular field. At the other end of the scale, medicine used the term "hysteric" to describe those (overwhelmingly women) who were unable to control their impulses. Thus, "the healthy (male) subject must find his place between these two impairments of will... between these two types, the depressed older man and the perverse, hysterical woman." Smith identifies two alternatives for men: (1) heterosexuality based on repression (obstructed will); and (2) involuntary homosexuality (explosive will). However, to succeed in nineteenth century society's terms a man must "choose heterosexuality if he is to avoid stigmatization and have access to patriarchal power."

502 Ibid. at 103.

503 Ibid.

504 Ibid. at 107, citing Esquirol. See also Robert W. Taylor, A Practical Treatise on Sexual Disorders of the Male and Female (New York & Philadelphia: Lea Brothers & Co., 1905) at 100, who claims that neurasthenia is a disease of "overtaxed professionals. (Taylor was a clinical professor of genitourinary diseases at Columbia University.)

505 Ibid. at 109.

506 One nineteenth century explanation for homosexuality was that a female brain/will had somehow been included in the body of a man. This idea has recently resurfaced in contemporary studies into brain function.
Potency was vital for the heterosexual male conformist, but what about those who failed to conform?

Abulics were the socially impotent

the hopeless failures, the sentimentalists, the drunkards, the schemers, the "dead beats," whose life is one long contradiction between knowledge and action, and who, with full command of theory, never get to holding their limp characters erect.508

Pathologies of the will included sexual anomalies ranging from impotence to homosexuality and the paraphilias (perverse sexual attractions, including pedophilia). Victorians found themselves caught in a logical paradox. On the one hand, they thought that a man's sexuality had a will of its own; on the other, that men must take measures (sometimes draconian) to control it.

While abulia and neurasthenia were confined mainly to middle and upper class intellectuals, Charcot introduced the idea of male hysteria to describe nervous problems of the lower classes.509 Prior to his work in the 1880s, hysteria was thought to be a specifically female disorder connected in some way with her reproductive functions. Some of the symptoms exhibited by his non-paying patients at Paris' Saltpetriere hospital paralleled those of upper class neurasthenics but, like lower class women, working men seemed to be considered a separate species when it came to medicalization. In fact, it appears from Charcot's statistics that working class women were less prone to hysteria than their male counterparts.510 In effect, working class men could be lumped in with women as a sub-class, not endangering the dominant class in

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507 Supra, note 346 at 118.

508 Ibid. at 110, quoting from American philosopher William James (1890) - emphasis, Smith's.

509 See Micale, supra note 334.

510 Ibid. at 378.
power. This confirms my observation that, whenever men exhibit physical or behavioural
deviance they are likely to be demoted from their status as real men.

As Micale notes:

The complex interactions between diagnostic theory and social class in nineteenth-
century medicine remain an important subject for future investigation.... This
pattern of labelling involves neurasthenia or hystero-neurasthenia for private
upper-class patients; hysteria proper for working-class men; and hysteria and
degeneration for the indigent. 511

In working class men, their inability to work due to nervous disability "defined their sickness
in the eyes of middle-class physicians."512 Thus behaviour defined the disease instead of the
disease causing behaviour. There is a striking similarity between this characterization of male
hysteria and descriptions of the female disorders described in Part I.

Even though Charcot applied the label "hysteria" to men and women, his male hysteric
did not fit the behavioural patterns of female sufferers. He emphasized the "authentically
masculine nature of the disorder" 513 and rejected earlier views that male hysterics were
essentially effeminate. His patients were usually strong men who had suffered from some
physical or mental trauma that had triggered hysteria.

Charcot's use of this one word to describe what could have been separated into two
gender specific disorders is an interesting contrast to the usual medical tactic of using different
names to describe behaviour as disease in one sex while ignoring its occurrence in the other. For
example, incorporating certain behaviour patterns under the label "premenstrual" effectively

511 Ibid. at 379.
512 Ibid. at 378.
513 Ibid. at 380.
precludes concurrent investigation of the same patterns in men. Placing a gender specific label on an illness immediately places it off limits to the other sex.

Although Charcot used the same term, he "knowingly or unknowingly, formulated for the two sexes an essentially separate set of secondary causal factors that were consonant with prevailing notions of masculine and feminine natures." 514 Micale notes that he said little about the mental state of his male patients but gave detailed descriptions of the moods of females. Charcot also departed from the custom of his contemporaries by expressly refusing to link hysteria with pathological sexuality; however, he often described the occurrence of Victorian "vices" ("excess and onanism") in his male patients.515 It therefore appears that even deliberate attempts to remove sexuality and sex differences from medical diagnosis were not strong enough to overcome gender stereotyping. Despite this, Micale argues that

the most striking feature of Charcot’s commentary on the disorder in men concerns not the phenomenon of difference ..., but sameness... At one time or another, Charcot located virtually the entire range of physical behaviours from past conceptualizations of female hysteria in men too.516

I believe that, if researchers were willing to look, they would also be able to locate all the behaviours attributed to PMS in men, including some kind of cyclicity.517 As Micale says,

514 Ibid. at 406.
515 Ibid. at 392.
516 Ibid. at 408.
517 Dalton has already acknowledged that the symptoms of PMS are common to both men and women but insists that cyclicity is specific to women. This is refuted by other researchers (supra note 71) but there appear to be no in-depth studies on male cyclicity.
[i]n the future, we will require in science and gender studies a historiographical model that accounts equally for the relative differences and similarities of the sexes in past theoretical systems and for their combined historical significance.518

Micale believes that, by extending a diagnostic category with strong single-sex associations to the other sex, Charcot has contributed to a process of gender liberalization that has continued into the twentieth century. I think that if he were to examine the literature on PMS, he would find his optimism unfounded, at least in that area. However, the disappearance of abulia as a male disorder shows that, as society changes, it is not impossible to eliminate gender specific categories by incorporating them under a unisex classification.

These studies of nineteenth century medicalization of behaviours described under the categories "abulia" and "hysteria" confirm that male as well as female departures from allotted social roles came under medical scrutiny. Although "hysteria" still appears in medical literature, "abulia" has vanished. Now that women are participating to some degree in all levels of public society and must demonstrate "willpower" as a routine part of their lives, there is no longer room for a gender specific disease like abulia. The modern unisex equivalent could well be "chronic fatigue syndrome."

What about disorders that are still classified as male-specific? In the next section I will describe Victorian ideas about impotence and changes and adaptations that have occurred during the twentieth century.

A. IMPOTENCE

A recent medical history text makes the following observation:

518 Ibid at 409, fn. 182.
Impotence has always been regarded as disastrous, shameful or ridiculous.\textsuperscript{519}

Sexual potency is so inextricably entwined with male sexual identity, that men have regarded the failure of the penis as tantamount to failure of the whole organism - both physically and socially. Like other disorders associated with sexuality, impotence carries with it an element of blame or fault that does not accompany gender neutral diseases such as measles or sinus congestion. Unless the impotent male can project this fault on to some external cause or on to some organic, biologically determined cause, he will be blameworthy. Thus, fashions with respect to causation have swung from organic to environmental and back again. I find it interesting that a fair amount has been written about environmental causes of impotence (for example, chronic unemployment) while little has been said in non-feminist literature about environmental causes of PMS.

Nineteenth century attitudes about impotence were heavily influenced by prevailing ideas about sexual morality and by the notion of the closed energy system. John Haller reports that the U.S. Surgeon General in 1883 attributed the high incidence of impotence among Victorian men "to the voluntary (masturbation) and involuntary (spermatorrhoea) loss of semen, the reading of vile books, and the popularity of sexually suggestive plays." \textsuperscript{520} Some modern feminists are arguing that pornography promotes violent sexual deviance in men. This is a marked contrast from the views of a century ago, when moralizers blamed pornography for male sexual incapacity.

Not surprisingly this element of blame led to extra anxiety on the part of the sufferer and to profitable sources of income for the medical profession. "Sexual impotence... furnished the

\textsuperscript{519} Victor Cornelius Medvei, \textit{A History of Endocrinology} (Lancaster, Boston & The Hague: MTP Press Ltd., 1982) at 78.

\textsuperscript{520} Haller, supra note 102 at 1010)
medical profession, as well as the unscrupulous quack, clairvoyant, mesmerizer, natural healer, and faith curer, a lucrative field for creative solutions.\textsuperscript{521} The concept of spermatorrhoea in men, like the concepts of reproductive disorders in women, led to a variety of torturous "cures." Male cures, in many ways, were just as painful and spurious as those for women.

Although it is impossible to get into the minds of nineteenth century doctors, I like to speculate about the different motivations that led to these cures. Did they fit into sex role stereotypes? I think it could be argued that they do, and that they all stem from the masculine will to control both man and his environment (including women), and from a deep seated fear that such control is liable to slip unless constantly monitored. Part II described medicine’s attempts to control what society perceived as undesirable female sexuality by oophorectomy and clitoridectomy. This undesirable sexuality presumably exhibited itself when the woman was awake and became dormant when she slept.

In contrast, men’s vigilance over their sexual functions had to be unremitting in the nineteenth century. Not only had they to fight against masturbation, they also had to exert control even when unconscious. This was because involuntary nocturnal emissions were thought to exert "a prejudicial influence on the [spermatic] economy." If a man failed to seek treatment for excessive emissions

the system [became] enfeebled both intellectually and physically, the whole character of the individual... changed, the true objects of life [became] perverted, and a goodly number of these [became] the subjects of our lunatic asylums, either as confirmed hypochondriacs, maniacs, or idiots.\textsuperscript{522}

\textsuperscript{521} Ibid.

\textsuperscript{522} Ibid. at 1011, quoting from W. Parker, "Spermatorrhoea" (1864) 8 Am. Med. Times 265.
The symptoms of untreated spermatorrhoea were almost as varied as those for twentieth century PMS and included "capricious appetite ... inability to focus one’s attention on any subject ... and fits of depression." If "leakage" continued for long enough the patient was likely to die - "God alone being cognizant of his crime." 

Haller uses Victorian hyperbole to describe the lot of his nineteenth century brothers. If his study is accurate - and his use of original sources substantiates this - men as well as women could be characterized as victims of the prevailing brand of patriarchal thinking.

Life for the Victorian man had become a battle in which natural talents and capabilities had to be reinforced with powers of concentration, persistence, and physical and moral vigor. But the glory of manhood, lost by solitary abuse at an early age, or by unfettered excesses during marriage, blunted man's "life force," preventing the body and mind from achieving their greatest glories. Generations of youth, wrongly educated and exercising unnatural tendencies, brought destruction to a nation's moral fiber.

The seriousness of the problem may be deduced by the extremity and variety of the measures taken to cure it. As with PMS, the medical profession seemed to "cover all bases." Doctors prescribed treatments such as strychnine in gin for mild cases. Difficult cases required scarification (superficial incisions) of the perineum followed by cupping to remove blood, and accompanied by blistering plasters on the urethra, catheterization, nightly pills.... Even more

523 Ibid. at 1011.

524 Ibid., citing R.N. Barr, "Spermatorrhoea" (1855) 7 Ohio Med. Surg. J. 173, and quoting from J. Hamilton, Nervous Exhaustion, Hints of Vital Importance to Youth and Manhood (London: published by author, undated). Masturbation and spermatorrhoea were thought to be interconnected; thus the "crime" is probably the former.

525 Ibid. at 1012, citing a number of nineteenth century sources. Of course, it is more than probable that lower class men and boys were too exhausted by work to be overworried by excessive nocturnal emissions. In any case it is doubtful whether they were considered to be contributors to the nation’s moral fibre.
dangerous measures were necessary for the "sexually bankrupt" and the "premature impotents [who sought to reintroduce] tropical heat into matrimonial refrigerators."526

Although Victorian women dosed themselves with a number of popular remedies for female distress, I have come across no reports of self-treatment that come close to the physical torture that men imposed upon themselves in their efforts to cure impotence. Sir Astley Cooper’s Vital Restorative may have something in common with Lydia Pinkham’s Vegetable Restorative (probably alcohol) but other treatments were more like the self-punishment meted out in some religious orders. Haller lists the following: electric belts, penis congesting rings, metallic bungs the size of a hen’s egg to insert into the rectum before sleep, wire brushes for the thighs and perineum, and electric shock.

Men who believed without reason that they were impotent were said to be suffering from "genitomania." This is the precursor to the modern notion of psychological impotence. "Writers on male impotence were astonished that the mind exerted such a powerful influence over the virile powers." 527 Robert Taylor in his 1905 text observed that psychical impotence was sometimes seen in "timid men of a retiring disposition" and that "rest and general hygiene [was] usually [enough to] bring these men out of their slough of despond." 528 Taylor also subscribed to a "blame the woman" philosophy when he postulated that physical defects in women or suspicions about their infidelity might cause impotence. This resembles some of the rhetoric of

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527 Ibid. at 1014.

528 Robert Taylor, supra note 514 at 98 and 101.
the 1970s in which a number of writers warned of an increase in impotence due to women’s liberation.

Just as there was some disagreement about causes and cures of nineteenth century female disorders, there was also lack of unanimity about the creation and diagnosis of spermatorrhoea. The following quotation from a nineteenth century criticism of the spermatorrhoea theory is interesting because it could well apply to literature about PMS.

[Lallemand’s] book is a striking example of how an able man can mislead himself when he has a theory to prove, and how he can unconsciously wrest facts and symptoms from their plain simple meaning to interpret his own preconceived idea.539

Despite this disagreement, Lallemand’s theories carried the day, probably because they confirmed and reinforced prevailing ideas about physiology, morality and appropriate sex roles.

Many writers have concentrated upon the differences between men and women. Few focus on similarities. Before moving on to contemporary opinions about impotence I would like to list those aspects of Victorian medicalization that apply to both sexes.

- Diagnosis and treatment of both sexes depended on the notion of a closed energy system.

- Medicalization of both sexes was heavily influenced by prevailing moral values. Diseases were invented to explain behaviour resulting from a conflict with allotted social roles.

- Upper and middle class white men and women were a different species from their working class and coloured contemporaries. Therefore, medical treatments that apply to the former might not be suitable for the latter. However, women were consistently inferior to men.

- Extreme measures, including forms of physical torture in the name of treatment, were necessary to restore both men and women to their proper sexual equilibrium.

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539 Haller, supra note 102 at 1015, quoting from G.G. Gascoven, "On Spermatorrhoea and its Treatment" (1872) 1 British Medical Journal 67. Claude-Francois Lallemand was a French physician who wrote minute descriptions of spermatorrhoea during the mid-nineteenth century.
Men as well as women might be the victims of uncontrollable sexual urges. In women this is usually identified as some form of nymphomania which may be an unconscious articulation of the myth of women as "devourers of males." In men, the focus was on homosexuality which was just beginning to be medicalized.

Sexuality in both sexes was needlessly medicalized and this caused anxiety and harm to men and women. At the same time it may have comforted them to have a medical label apparently validate their experiences.

Despite these similarities, medicalization helped to perpetuate sexual stereotyping by maintaining differences. For example, men could have diseases of the will but, since women either did not need or did not possess willpower, they could not suffer such disorders. Treatments were designed to restore deviants to their ideal place in society: man the procreator and head of the household and woman the nurturer who obeys his commands.

If treatment for impotence were unsuccessful, a woman could recruit the laws of annulment to separate a man from his ideal role as family patriarch. If treatment for sexual deviance were unsuccessful, a man could appeal to the laws of lunacy to rid himself both physically and legally of a nuisance wife. As already noted, the law and medicine formed a powerful alliance to maintain social norms.

There are so many contradictions and paradoxes about twentieth century medicalization that it is difficult to describe a coherent pattern, if there is one to be discerned. On the one hand, the injection of new scientific ideas has led to a form of atomism - concentration upon one part of the body to the neglect of the total human being. On the other, women from the nineteenth century until the recent past have been led to believe that failure of their reproductive system is tantamount to failure of the whole person. Medicine has traced abnormal behaviour to an

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See Edward Shorter, supra note 323 at 13, writing about the prevalence of French proverbs that present women as man devourers. He explains the need for male potency as a means "to shatter a woman's sexual force before it [can] get the better of a man."
abnormal hormone system and, in attempting to restore what it conceives as a normal hormone balance is likely attempting to restore stereotypically acceptable role playing. I say "led to believe" because I doubt whether many women, if they stop to consider it, equate their personas with their sexuality. It may be that some women confirm their identity through motherhood, but I would think that most view their sexuality as an important part of their composite selves not as their *raison d'etre*.

Sexuality seems to be an integral or even central part of a man’s sense of self. In Chapter 2 I discussed the extent to which male sexual competence defines most men’s identity as men, and how disastrous impotence can be to their overall self esteem. It would therefore seem logical that medicalization of impotence would include efforts to treat the whole man; and that, like equivalent failures in women’s bodies, impotence would be causally related to behavioural deviance. However, I should have realised by now that logic plays little part in human reactions to manifestations of sexuality. It seems that the most fashionable "causes" for impotence are now organic and environmental, although psychologists and psychiatrists still stress a psychogenic component. Thus if the "fault" lies within the individual it is due to a mechanical or plumbing defect. Otherwise "fault" lies outside the individual, in external factors beyond his control - like chronic unemployment or, some might say, women’s liberation. This contrasts with medical opinions of the 1960s and 1970s which held that anxiety was the major cause of sexual dysfunction. 531 This change from psychogenic to organic causation parallels the shift from the "all in your head" idea to hormonal imbalance in women.

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The nineteenth century saw the birth of a new specialty, gynecology, which did not hesitate to pronounce on moral and lifestyle issues. The twentieth century has seen the birth of another specialty, andrology, but this discipline seems to be an offshoot from urology and confines itself mainly to mechanistic solutions to problems of impotence and infertility. Leonore Tiefer notes that, in the last decade, medicine has focused on physical causes and treatments for sexual problems but has developed few diagnostic tests to determine one organic cause over another. She believes that

The frequent claim that psychogenic impotence has been oversold and organic causes are far more common than realized has captivated the media and legitimated increased medical involvement in sexuality.532

In some ways this resembles medicine's *ad hoc* approach to women's problems. The "search for the etiology... of... sexual problems seems to have less to do with the nature of sexuality than the nature of the medical enterprise." 533

Tiefer also criticizes the "either or" approach of biomedicine. Patients have to fit into either an organic or psychogenic slot; there can be little or no overlap. Again this is reminiscent of medicalization of women's problems. Bancroft echoes this criticism, noting that vascular and urological surgeons as well as psychiatrists dichotomize health problems into "psychological" and "somatic" and hence evade the undoubted complexity of the holistic "psychosomatic" approach which aims to understand how these two components interact. 534

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532 Supra, note 93 at 588.
533 Ibid. at 590.
534 Bancroft, supra note 531 at 25.
Tiefer argues that the "allure of medicalized sexuality...results from fundamental male
gender role prescriptions for self-reliance and emotional control." 535 Thus acceptance of purely
organic etiology allows application of technological solutions like mechanical prostheses, and
assists in the denial of psychological or interpersonal factors. Technological solutions are the
ultimate way of controlling that part of the male body that "seems to have a life, if not a mind,
of its own;" 536 a part that rises when its owner is unprepared to acknowledge the sexuality of
a situation, or "shrink[s] almost to oblivion" when the occasion would seem to warrant a virtuoso
performance.537

These modern "cures" may be as uncertain as some of the "cures" for PMS. For example,
Bancroft notes a striking lack of careful physiological assessment of their effects and deplores
the paucity of interdisciplinary research, especially between sex therapists and urologists. This
finding offers yet another parallel between research into women's and men's reproductive and
sexual concerns. Other similarities include the appearance of support groups such as Impotence
Anonymous and an increase in "health" articles in the popular media which work on "the
assumption that scientific discoveries improve our ability to manage and control our lives." 538

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535 Tiefer, supra note 93 at 590.

536 Bancroft, supra note 531 at 7.

537 I have wondered in a previous paper (unpublished) whether all men's struggles for power
and dominance within society are a quest for compensation for their lack of absolute control over
that one small part of their body, the penis. Would women be any different if we felt compelled
to place so much importance on the erratic performance of an organ that is often beyond our
control.

538 Tiefer, supra note 93 at 585.
My own research confirms the observations of Tiefer and Bancroft. I obtained three books for laypersons from the public library. Each of them deplores the lack of open public discussion but acknowledges that impotence is now a medical "hot topic." When it comes to organic causation, each takes a technical rather than philosophical approach. Each also discusses psychological factors but stresses that organic causes are much more common than previously suspected. Taguchi makes the following sweeping statement but cites no source for it: "It is a common observation that ninety percent of the chief executive officers of the major corporations suffer from impotence." Just as brain burn-out was blamed for neurasthenia in nineteenth century men, business stress is now blamed for impotence. On the other hand, Berger & Berger claim that sexual insecurity can lead to dysfunction at work and in social life. This is similar to the circular reasoning that blames increased participation in the workplace for PMS and then blames PMS for female incompetence in that same workplace. Thus if a man is a successful businessman he is likely to become impotent; but if he is impotent is likely to become a business failure.

I checked four recent articles from professional journals; two by urologists and two by psychiatrists. One in each category used the word "impotence" in its title; the others used "erectile dysfunction." McClure et al. (urologists) state that "contemporary methods have


540 Ibid. at 24.

found organic contributing factors in more than 90 percent of impotent men" 542 and go on to investigate the use of transdermal testosterone as a cure for the small number of patients suffering from androgen deficiency. (This contrasts with Masters & Johnson’s 1970 assumption that 95 percent of cases were psychogenic.543) Segraves et al. state that they are investigating psychogenic impotence but exclude from their experiment men whose erectile problem is judged to be related to marital discord. They base their proposed therapy or diagnostic procedure on the hypothesis that disregulation of certain brain pathways (an organic defect) can cause impotence.

Alma Dell Smith, who works in a "Biobehavioral Treatment Center," takes a more holistic approach, looking at psychological inhibitory factors, cognitive interference, and psychologic reactions to organic impotence. Like a number of PMS researchers, she uses questionnaires to assess attitudes. Where organic impotence is concerned, Smith advocates detailed psychological investigation to determine which treatment is likely to be most effective. It is apparent from the literature that the diagnostic approaches of psychologists/sex therapists are poles apart from those of urologists just as those of psychiatrists vary from those of endocrinologists in the field of PMS.


542 Ibid at 224.

I found two articles that dealt with social causation, in particular, job loss. Morokoff et al. cite studies that have found that job loss produces a sense of powerlessness in middle-aged men. They found that the chronic stress of job loss was not enough by itself to affect sexual function but that a combination with other stressors commonly encountered in everyday life could result in decreased sexual response. This could be compared to the multiple factors involved in postpartum depression. May & Bobele trace part of the causation of sexual dysfunction in unemployed men to problems in communication between partners, so that each is operating under a disparate view of other's "reality."

I have found no anthropological articles, like Johnson’s on PMS, that discuss whether modern medicalization has constructed impotence as a western cultural-specific disorder. However, the "quick fix" treatments of prostheses and injections would fit such a model.

How do these medical ideas intersect with the law? With very few exceptions, impotence is directly relevant only in annulment cases. However, the mindset that has created the modern model of impotence as an organic disorder that men can control via science and mechanics is the same mindset that pervades our society, including law. It focuses on individual control at the expense of the mutual communication advocated by sex therapists. Because sexual potency and social power are so closely intertwined, the loss of one is likely to mean the loss of the other. This can lead men into fear and anger and may be an important reason for crimes of violence

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545 Ibid. at 546.

546 Supra note 438.
against weaker groups such as women and homosexuals. In an appendix to her book on rape in marriage, Diana Russell quotes from newspaper accounts of marital rape cases, one of which mentioned that the husband had a "sex problem" and another that he was impotent. 547 This is one illustration of the way in which impotence may be an indirect factor in criminal cases. Medicalization also introduces the possibility of an "impotence" defence similar to a PMS defence. This may sound ridiculous, but is it any more far fetched than a homosexual panic defence? I will expand on this topic in Chapter 6.

B. XYY CHROMOSOMES

Although science did not have the capacity to analyze individual chromosomes until recently, attitudes toward the XYY chromosome appear to be an extension of the type of reasoning developed in the late nineteenth century by researchers like Lombroso; that is, the belief that certain physical phenomena indicate a propensity for crime. As far as it relates to a connection between biology and crime, the story of the XYY man resembles in many ways the story of the PMS woman. It depends upon preconceived ideas about the "natural" aggressive tendencies of men as a whole. In Chapter 3, I illustrated the stereotypical attributes that researchers have imposed on the female ovum and the male sperm. It is not surprising that other researchers would hypothesize that the female X and the male Y chromosomes would have, or be responsible for, those same attributes. It does not require a huge leap of faith to postulate that an extra Y chromosome might be responsible for an exaggerated degree of "maleness" - that an XYY man might be some kind of "supermale." An example of "scientific" stereotypical thinking appears in the following:

[It is] no surprise that an extra Y chromosome can produce an individual with heightened masculinity, evinced by characteristics such as unusual tallness, increased fertility ... and powerful aggressive tendencies.

As I will discuss below, this sweeping statement is not borne out by empirical data.

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548 Lombroso, supra note 316.

549 Lawrence Taylor, a lawyer, in *Born to Crime: The Genetic Causes of Criminal Behavior* (Westport, Conn. & London: Greenwood Press, 1984), perpetuates this type of sexual stereotyping in Chapter 8, "The Case of the Super Male." He accepts, without question, results from early studies confined to institutional settings but either ignores or is unaware of later studies of populations at large.

The first man discovered to have the XYY chromosome was a law-abiding citizen who was physiologically and psychologically normal and of average intelligence.551 How did society progress from this discovery to the mythical belief that all XYY men are potential examples of a genetically driven criminal type? Soon after the discovery, surveys began of men in prisons and maximum security hospitals. It is not clear what sparked the idea that the proportion of XYY men in these institutions would be higher than in society at large. However, it is probably safe to say that stereotypical beliefs about the connection between masculinity and aggression played a part - just as common beliefs about the premenstrual woman led to investigations of PMS in prisons. Added to this were world-wide media reports in the 1960s of "lurid crimes of a few men with an extra Y-chromosome" which led to a meteoric rise in interest in a linkage between the XYY chromosome and violence.552 This is similar to the massive public interest in the premenstrual murderers of the 1980s.

Unlike PMS, the XYY syndrome should not be a potential threat to the male gender as a whole. It is, by its very nature, an easily identified genetic abnormality which cannot be attributed to all men. Scientists cannot say, as they do of PMS, that up to 95% of the male population suffer from it. On the other hand, when researchers view the behaviour of men with an extra Y chromosome as an exaggeration of a universal characteristic of all men - the single Y chromosome - they place XYY men at the extreme end of a male continuum that is similar


to the female continuum that ends with severe PMS. For example, one author describes individuals with Y replication as "parodies of maleness - over-tall, over-dull, over-mature." 553

Research and treatment for genetic abnormalities comes within the medical domain. Thus the creation of a causal connection between the XYY chromosome and crime is another instance of the medicalization of deviant behaviour. Although the original idea of a connection may have arisen within the mind of a scientist, it seems that the public, the press and even the legal system were eager to grasp it and turn a hypothesis into established "fact." Medical writers helped in the development of this new truth by making statements such as:

All the data [from a security hospital] lead us to believe that the extra Y chromosome has resulted in a severely disordered personality, and that this disorder has led these men into conflict with the law. 554

It is unlikely that those who wished to make the case for a supermale criminal would have stressed the authors' caution that XYY males in the general population might "show different features from those described [in their study]." 555 Indeed a later writer notes that, despite refinements in methodology, nonsubstantiated generalizations like the one quoted above have remained in the minds of the public. 556

It is interesting that, as soon as sex differentiation is associated with a bodily component, that component, in the lay mind at least, is rarely connected with anything else but sex.

553 David C. Taylor, "Developmental and Behavioural Differences Between Males and Females with Special Reference to Epilepsy" in W.R. Trimble, ed., Women and Epilepsy (Chichester, England: John Wiley & Sons Ltd., 1991) 65 at 84.


555 Ibid.

556 Theilgaard, supra note 552 at 413.
Testosterone is a "male" hormone; therefore the belief arises that excessive exposure in utero must result in a tomboy girl (See Chapter 3). Estrogen is a "female" hormone but how many people know that its presence in the brain of a fetus is essential for the development of male characteristics? The Y chromosome ensures that a child will be male, but does this mean that the Y chromosome is responsible for nothing but sex selection, or that it carries the sole responsibility for sex differences? The medical literature reveals that the XYY chromosome has been associated with disorders such as lymphatic leukemia and motor neuropathy. This is evidence that the extra Y influences more than sexual functions. Yet it seems that the power of stereotyping is such that research which purports to confirm entrenched viewpoints about gender have more public impact than those about a rare form of cancer. Maybe this is the same mindset that so readily grasped the connection between AIDS and white homosexuality and, in the beginning, ignored its impact on the heterosexual members of black and white populations.

If the Index Medicus is an accurate reflection of current research, the XYY syndrome appears to have gone out of fashion in favour of research on the "fragile X" chromosome. The reason for this is not clear. It may be that researchers are reluctant to study links between

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558 The Index Medicus lists a number of articles on these topics.

559 For example, from January to October 1992, there were only four articles listed under XYY Karyotype. None was about men and criminality. There were 15 articles in 1991; only 1 on behaviour. In 1990 under "Sex Chromosome Abnormalities" there was only 1 article on XYY. Most were on Fragile X.
genetic abnormalities and criminality because they are thereby exposed to public harassment. 560

However, I have been able to find a few articles from the 1980s that deal with XYY and
behaviour. The early sensationalizing of the topic appears to have led to conscious efforts to
eliminate bias. For instance, in his first paragraph D.R. Pitcher states that

[i]t cannot be overemphasized that only a very few of those with abnormal
chromosomes are at risk of developing mental abnormalities likely to lead them
into violent or other criminal behaviour. 561

Pitcher observes that men with an extra Y chromosome are twenty times more likely to be found
in maximum security institutions than in the community at large; but he adds that those with an
extra X are ten times more likely. 562 The presence of XXY men has received none of the
publicity given to the XYY men, maybe because the X chromosome is "female" and therefore
XXY men are not so readily associated with criminal deviance.

Most of the reports of the 1980s originate from data obtained from 12 XYY and 16 XXY
men found in a population of 4,139 tall Danish men.563 As well as the XXY men, the
researchers used two other control groups; one matched for age, height and social class, the other
also matched for education level and to scores from a draft board test. They also took a
multivariate approach including: "cytogenic, endocrinological, neurological, psycho-

560 J.L. Hamerton (1976) 28 Amer. J. Hum. Genet. 107, reported that Harvard researchers
studying the criminological implications of chromosome disorders abandoned their project after
they and their families suffered personal harassment.

561 D.R. Pitcher (psychiatrist), "Chromosomes and Violence" (1982) 226 The Practitioner
497.

562 Ibid. at 498. The rate of XYY appearance among newborns is believed to be 1 in 1,000.

563 Theilgaard, supra note 552 at 416. The experimenters surveyed only those men who were
in the top 15% with respect to height.
physiological, psychological, and criminological." 564 This is what has yet to be done in published PMS research.

Results published in 1983 do not "support the notion that XYY men are particularly violent or aggressive," concluding that the "XYYs appear not to be in any greater danger of committing criminal offenses than are XY-men of similar intellectual level." 565 The researchers found that both the XYY and XXY men were, on average, slightly less intelligent than the XY controls but that many XYY men were of average or above average intelligence. 566 The five XYY men convicted of criminal offenses did not differ significantly from convicted XY controls; of the 149 offenses committed by the XYY men, only one involved aggression against a person. 567

Two recent reports have noted results that could be interpreted as conforming to sexual stereotypes. Researchers found that XXY boys have lower and XYY boys have higher activity levels of motor behaviour than controls and that XXYs are more pliant than XYYs. 568 Also, parents of XXY boys reported that they were cautious and hesitant about new experiences. XYY boys did not differ from controls. 569 It seems that both groups exhibit the signs generally

564 Ibid.
565 Ibid. at 420.
566 Ibid. at 417.
569 Ibid. It should be noted that the parents had been informed at birth of their sons' chromosomal abnormalities and that this could have affected their behaviour towards their children. (See discussion of tomboy research in Chapter 3)
attributed to the minimal brain dysfunction syndrome. Theilgaard notes that the XXY men in the Danish study were "markedly more dependent and submissive both in comparison with controls and the XYY group." The XYY men were more impulsive, but aggressiveness when it was present in XXY men took on "more disguised and defended forms." Surprisingly, XYY as well as XXY men showed greater weakness in their sense of masculinity than did controls, despite the elevated testosterone and libido levels of the XYY men. This may explain why the more impulsive XYYs displayed more "aggression toward wife" than XXYs or controls but showed no difference from controls with respect to other forms of aggression.

Although later studies have attempted to control for social class and education, their reports do little to factor in environmental influences such as poverty, single parent family, peer pressure, treatment by and attitudes of parents, teachers, youth leaders, etc. This type of methodological deficiency is therefore not peculiar to studies of women and crime, but rather seems to be a function of studies of both sexes which investigate internal biological causality.

It would be interesting to determine the percentage of wife beaters who have an extra chromosome. Unlike the studies on criminality in general, there seems to have been no rush to link domestic violence with chromosomal abnormalities.

Research on pedophilia may be an exception to this apparent rule. There appears to be more research on external than on biological causes of pedophilia. (See below, section C)
Other criticisms are familiar to analysts of PMS research; for example, sampling bias (only tall men chosen)\textsuperscript{575}

This chapter is devoted to the investigation of medicalization of various functions and behaviour of human beings. However, although it properly belongs to the next chapter, in this section I have been unable to avoid some analysis of the connection between the XYY chromosome and criminal deviance since most of the available literature concentrates on criminal rather than other deviant behaviour. On comparing the medicalization criteria set out in Chapter 3, I notice that the XYY syndrome only partially fulfils them. The type of behaviour classified as deviant is not peculiar to XYY men.\textsuperscript{576} However, some physicians have claimed that they have discovered an etiology by attributing this behaviour to the XYY chromosome. Claimsmaking and counterclaimsmaking has occurred to some extent but there has been no growth of professional or self-help clinics that specialize in evaluating or treating XYY men. It should also be noted that the XYY anomaly does not appear in the DSM-III. If the U.S. experience with post partum disorders is any example, then it would be unlikely that their courts would recognize it as a mental disease without such official sanction. (I will discuss the limited legal recognition of an XYY defence in Chapter 6)

At the end of the day, what do we know about the XYY male? According to available literature, we know that the incidence of this abnormality in the general population is about one

\textsuperscript{575} The Danish study went a long way to silence those who complained that the early studies chose their subjects from maximum security institutions rather than from the population at large. See Sarbin & Miller, supra note 551, for more detailed criticisms.

\textsuperscript{576} In the suicide example in Chapter 3, the behaviour was peculiar to the disease and to the crime. However, the criminal behaviour exhibited by XYY men is also exhibited by XY men and some women (just as the criminal acts committed by PMS women are also committed by non-PMS women and men.)
in one thousand and in security institutions about one in fifty. It cannot be denied that this is a significant difference. But is there a direct causal link between XYY and crime? Or may there be other links such as mental retardation, impulsiveness, poverty? It must be remembered that not all XYY men commit crimes. The arguments put forward against a PMS defence may be equally valid against an XYY defence.

C. PEDOPHILIA

Association of crime with conditions and attributes such as PMS and XXY chromosomes demands considerations of a whole range of deviant behaviours from petty theft to murder. Pedophilia more closely resembles postpartum psychotic baby killing in that it connects what has come to be viewed as a medical or psychiatric condition with a specific criminal act (or closely related range of acts in the case of pedophilic crimes). In both cases the age and identity of the victim are essential in defining the crime. However, as I will discuss later, the age of the victim does not, of itself, indicate that a man who sexually touches children will fall within the medical definition of pedophilia. 577

In Chapter 2, I discussed the prevalence of adult/child sexual contact over the ages and noted that, unless the adult violently forced the child to participate, such activity was not always considered dangerous, criminal or sick. As the science of psychiatry developed during the nineteenth century, several categories of human impulses and behaviour became classified as mental disorders; for example, neurasthenia, hysteria, abulia, homosexuality, and other disorders

577 Pedophilia is a "predominantly male behavior" (Finkelhor & Lewis, supra note 106 at 73) and women pedophiles are "extremely rare and poorly documented." (Bradford, Bloomberg & Bourget, supra note 116 at 217) (But see Loretta M. McCarty, "Mother-Child Incest: Characteristics of the Offender" (1986) 65 Child Welfare 447. However, in this study of 26 mothers, only 6 acted alone without a male accomplice or co-offender)
that affected the will. "Pedophilia" joined this group toward the end of the century when Richard Krafft-Ebing coined the term "to describe a condition in which an adult was erotically attracted to children." 578

In researching the progress of pedophilia from partial acceptance through criminality to sickness, I was struck by similarities to the historical progress of the concept of homosexuality - a term also coined in the nineteenth century. Homosexuality per se is not now classified as either a crime or a mental disorder, largely due to the efforts of the Gay Liberation movement. At least one writer has questioned the validity of pedophilia as a mental disorder; 579 and a group has arisen which questions the idea of pedophilia as a disease - The American Man/Boy Love Association. 580

I was also struck by differences as well as some similarities in the development of PMS as a disorder. The difference that immediately springs to mind is the focus on external causes of pedophilia rather than internal biology. Although biology and individual psychology have received significant attention in the literature, sociological discourse has recently become more prevalent. In this respect ideas about the causes of pedophilia resemble Charcot’s concept of external stress and shock as causes of male hysteria. (See above.)

Maybe this focus on the external is an unconscious attempt to keep intact a patriarchal model of masculinity. This model stipulates that real men must always be in control of

578 Quoted in Bradford, Bloomberg & Bourget, ibid.

579 Frederick Suppe, supra note 20.

580 This association has recently been mentioned in Canadian newspapers in connection with a pedophilic offender who challenged the constitutional validity of an order prohibiting him from loitering in places occupied by children. See R. v. Heywood, (1992) 77 C.C.C. (3d) 502, in which the British Columbia Court of Appeal held that Section 179(1)(b) - dealing with loitering by convicted child molesters - violates Section 7 of the Charter.
themselves and may be excused from responsibility for deviant acts only when self-control is rendered impossible by external circumstances, such as childhood abuse, parental neglect or marital difficulties. This model also expels from the ranks of real men, those whose deviance results from internal causes, such as hormone imbalance, mental retardation or moral weakness. It is interesting to contrast this treatment of male deviance with the position of women; in the latter case deviance is generally ascribed to internal causes that are common to all women.

In this section I will discuss: (1) the development of the idea that pedophilia is a sickness; (2) the various attempts to classify and subdivide according to characteristics of both the pedophile and the children to whom he is attracted; and (3) possible treatments. I will show that pedophilia presents similar difficulties of classification and subdivision as PMS. However, more progress seems to have been made with pedophilia - at least at a medical level.

For centuries physicians have taken an interest in and have interfered in women's menstrual processes. Modern medicalization is an intensification of that process. I have been unable to find a similar body of pre-nineteenth century medical literature concerning men's erotic attraction to children. I have already noted in Chapter 2 that, in many societies, the sexual use of children was not historically considered abnormal or criminal. Therefore, it may be that those men who are now labelled "sick" (i.e. who are not sexually aroused by adults) were not distinguished from "normal" men who merely were "out to have a good time" with children.

Ames & Houston caution that

[w]e must distinguish between violations of sociolegal norms and the more biologically dysfunctional problem of true pedophilia (i.e., sexually attracted by biologically prepubescent children) 581

581 Ames & Houston, supra note 106 at 334.
This is particularly so if the law should ever construct a biological defence for male pedophilic offenders comparable to the PMS defence or infanticide provisions for women. At present, the law must grapple with the problem of distinguishing a mother who kills her baby because of a mental disorder from one who kills through rational premeditation or uncontrolled anger. It would have similar problems distinguishing a "true" pedophiliac from a "normal" man out for thrills or sexual "kicks."

The law and medicine have often been at cross purposes with respect to pedophilia. The law, which is designed to protect children rather than diagnose adults, sets arbitrary limits for childhood which may classify as a pedophile a man who is in fact a rapist. Ames & Houston call this "sociolegal childhood" in contrast to biological childhood. Classifying according to crime charged is not a helpful way to pinpoint pathology. Medicalization has not yet progressed to the point where consensual sex with an adolescent indicates diseased or disordered behaviour. The law, however, prohibits this behaviour if one of the parties is younger than fourteen.

Although the term pedophilia was first used over a hundred years ago, it is only in the last few years that medicine has taken a special interest. For example, the 1960 Index Medicus, under "Sex Deviation," lists one article on incest but none on pedophilia. There were four articles on adult/child sex in the 1964 edition but the term "pedophilia" was not used in the titles. Most of the articles of that period concentrated on transvestism, another of the paraphilias. There was an explosion of articles in the 1980s, and in 1990 the Index Medicus created a special subject heading for pedophilia. There is now also a separate heading for "Sex Offenses." This means that intensive medical research into pedophilia is very recent and that medicalization of this type of behaviour is in a constant state of change.

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582 See Bradford et al., supra note 116.
Exactly how does the medical community define pedophilia? In both DSM-I and DSM-II pedophilia was considered a symptom of underlying personality pathology, and was listed under "sociopathic personality disturbance" and "personality disorders and certain other nonpsychotic mental disorders" respectively. The DSM-III has moved away from a focus on sociopathy and personality disorder and lists pedophilia as one of the paraphilias, being

the act or fantasy of engaging in sexual activity with prepubertal children as a repeatedly preferred or exclusive method of achieving sexual excitement.

The DSM excludes isolated sexual acts with children.

Researchers do not always adopt such a narrow definition. Some include attraction to pubescent and post-pubescent children. Others include transient as well as "fixated" attraction to children. Yet others include incestuous behaviour between father and children.

Review of the literature reveals many of the criticisms levelled at PMS research. These include: imprecise definitions; lack of subdivision of offenders; small samples; lack or inadequacy of control groups; lack of standard measures or procedures; lack of research on

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583 Sheldon Travin et al., "Pedophile Types and Treatment Perspectives" (1986) 31 J. Forensic Sci. 614 at 615.

584 Quoted in Bradford, supra note 116 "The pedophilias are characterized by arousal in response to sexual objects or situations that are not part of normative arousal activity patterns and that in varying degrees may interfere with the capacity for reciprocal affectional sexual activity." DSM-III, p. 261


586 The medical literature may seem to be making moral judgments when it talks about "offenders" but this terminology probably results from the research samples being drawn predominantly from prison settings (cf. early XYY studies).
unconvicted pedophiles, and imprecise knowledge of its prevalence in the community. For example, pedophiles are often lumped together in one large group, but I have noted the following possible subdivisions:

- fixated (exclusively attracted to children) vs. regressive or transient
- heterosexual vs. homosexual
- affectionate vs. sadistic
- empathic (man/adolescent) vs non-empathic (man/prepubertal child)
- pedophilic incest vs. non-pedophilic incest

As a number of authors have pointed out, etiology is difficult or impossible to determine unless pedophiliacs are subdivided into homogeneous groups. Since pedophiliacs are almost exclusively male, this type of methodological deficiency (study of heterogeneous groups) is not gender specific as some feminist critics of PMS research might wish to argue.

Typical characteristics of a non-sadistic child molester include:

- immaturity and low self esteem
- sense of vulnerability and helplessness
- impaired social relationships

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Araji, supra note 108 at 33. Susan Lee Painter, "Research on the Prevalence of Child Sexual Abuse: New Directions" (1986) 18 Canad. J. Behav. Sci./Rev. Canad. Sci. Comp. 323 notes that it is ironic that researchers have been unable to establish reliable rates of occurrence. These presently range from 12 to 54%. This is strongly reminiscent of the situation with PMS. However, this does not help determine the percentage of men that are pedophiles.


One study found that pedophiles, like women, significantly overused descriptive positives (e.g., beautiful, fair, kind) when viewing Blacky psychological test pictures, and concluded that pedophiles use an "immature, feminine approach." (emphasis added) Araji, supra note 108 at 21 citing Stricker. Note the loaded language. "Overuse" implies undesirable. Could it not just as easily be that men "underuse"? Pairing immaturity and femininity shows bias and sexual stereotyping. See discussion on research language in Chapter 3. Another author cited by Araji at 22 (Toobet) finds that pedophiles are higher on femininity and paranoia scales and conclude that they are weak and inadequate.
feelings of isolation
- lack of empathy
- tenuous masculine identity
- misidentification and mismanagement of emotions
- discomfort with adult sexuality
- lack of insight
- issues of dominance and hierarchy are more important in the social relations of pedophiles than for non-pedophiles.

Of course, these characteristics are merely correlative. They could be the cause, the consequence, or merely symptoms of pedophilia.

Identification of etiology is essential if medicalization is to become entrenched. As I have already mentioned, most researchers seem to concentrate on external rather than internal causation.

Prior sexual abuse A number of studies have confirmed that a large percentage of pedophiles have been sexually abused as children, but that not all sexually abused children become abusers. Araji et al. ask an important question: since the greater number of child victims are girls, why do women not become victimizers? The answer probably lies in society’s concepts of masculinity and the conditioning received by boys, but there could also be a biological component. (See Chapter 2)

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590 William Frederick Hobson, Cheryl Boland & Diane Jamieson, "Dangerous Sexual Offenders" (1985) 19 Medical Aspects of Human Sexuality 104. See also Araji, supra note 108.

591 Araji, ibid. at 21, citing a study by Howell.

592 Araji, supra note 108; Berlin, supra note 585 at 188
Pornography Studies on the effects of pornography are inconclusive. Finkelhor & Lewis state that child pornography is certainly associated with some abuse but, since kiddie porn is fairly difficult to obtain, its use probably follows interest rather than causes it.

Alcohol Many pedophiles are alcoholics or have drinking problems, especially those that commit incest. This could be classified as a mixed internal/external correlation.

Castration anxiety, fear of rejection - This theory is put forward by some psychoanalysts. Also pedophiles may expect rejection and sexual failure with adults. A 1951 study reported that a large percentage of pedophilic offenders were afraid to approach women because they are impotent, an interesting observation in view of my earlier discussion of impotence. These last two ideas have more to do with attributes than etiology, since what causes the castration anxiety in the first place?

Lack of impulse control disorder - This is a problem for some but not all pedophiles, but would be an important factor when considering legal defences.

Biological etiology - Araji notes the lack of research into this question and cites conflicting studies about testosterone levels in pedophiles. These levels do nothing to explain why the object of arousal is a child rather than an adult. Cyril Greenland, a Canadian criminologist, is so wedded to the environmental model that he deplores

593 Supra note 106.
594 Araji, supra note 108.
595 See ibid. at 27.
596 A study by Bowman, cited in Travin, supra note 583 at 615.
597 Araji, supra note 108 at 29.
598 Ibid. at 26.
reductionist attempts to locate the causes of sexual aggression within the individual rather than within the structures of our society and its values. He believes that "sexuality is another vehicle for displaced social anxiety." I am sure there is some truth in what he says but he does a disservice to the advancement of knowledge by denying the possibility of internal causes. It is as if, by declaring internal causation politically undesirable, it is expected to go away.

The most thoughtful analysis of biological causation that I could find comes from Berlin who stresses that both biology and environment contribute to behaviour. In his opinion, researchers should ask to what degree is each factor important and how each exerts its influence.

They should also separate violent from non-violent offenders because

[the biology associated with temperamental violence and biology associated with antisocial traits may be very different from the biology associated with the various paraphilic conditions.]

Maybe because biology has received little attention as a cause of pedophilia, it seems as if Berlin has had to go out of his way to justify his experiments when he points out that

[sexual drive is rooted in biology. Therefore it is just as reasonable to ask whether some persons may experience aberrant sexual drives because of biological factors as to ask whether this might be so as a consequence of certain life experiences.]

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600 Ibid.

601 Berlin, supra note 585 at 183

602 Ibid. at 186.

603 Ibid. at 188.
I notice no such urge to justify their research among those who study biological causes of female disorders. Perhaps if biologists paid more attention to environment and sociologists to biology, science would be closer to practical solutions to problems posed by research that is complicated by issues of sex difference. It may never be possible to accurately quantify the contribution of either biology or environment to any particular problem, but it should be possible to make reasonable estimates. Once this is done, the effects of such causes would be more easily understood and treated. Berlin discusses the joint input of these factors in a paragraph worth repeating in full, as it could be adapted to fit all the disorders discussed in this study.

Perhaps it should be noted ... that sexual orientation is much like language. The capacity to learn the language is biologically determined, whereas which language one speaks is related to life experiences. Once language has been acquired, however, regardless of the degree to which biology or environment [missing] that language cannot through psychological methods be erased. Once a man is attracted sexually to women, or conversely to children, regardless of whether this is due predominantly to biology or environmental influences, such attractions cannot simply be made to go away.604

Interestingly, by carefully separating "true" pedophiles from other sexual offenders, Berlin and his associates found in a preliminary study that men with pedophilic orientation showed a different pattern of gonadotrophin release after injection with gonadotrophin releasing hormone. 605 These results, of course, do not identify etiology because the difference could be a cause or an effect of, or be merely related to pedophilia. However, this study does introduce possible biological grounds for the disorder, and thus leaves the door open for future biologically-based defences.

604 Ibid. at 188.

If courts were to accept such a defence, or to use it for mitigation of sentence, they would encounter the same difficulties that the PMS defence presented - how to prevent further harm to the public while maximizing the offender's individual liberty. Again we come down to the availability of a reliable treatment for this new "disease."

Before leaving the topic of diagnosis and etiology, I must briefly mention research that has attempted to distinguish pedophilic from non-pedophilic incest offenders. Most rely on instruments that measure sexual response to various stimuli such as erotic pictures of adults or children. Stermac and Hucker note that fathers who abuse more than one offspring are more likely to be true pedophiles, as they move on to a younger child once the older one matures.606 They note that the problems of non-pedophilic incest offenders usually arise from marital and family relationships and that these offenders do not exhibit an erotic preference for children. They also stress that these two groups must be separately diagnosed because the treatment that is appropriate for one may be ineffective for the other.

Existing treatments for pedophilic offenders incorporate behaviour modification, hormone therapy or a combination of both. Suppression of testosterone is a common therapy. However, this merely reduces libido; it does nothing to change the object of a pedophile's sexual drive.607 Therefore, like insulin for diabetes or dilantin for epilepsy, it controls bodily functions; it does

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not cure them. Its effectiveness also depends upon the willingness of the pedophile to continue
taking such medication.

Other therapists rely on one or more of sexual education, aversion therapy, stimulation
of sexual interest in adult women, intensive peer group therapy, assertiveness training, twelve-
step programs, confrontation with victims, anger control. However, these programs do not
benefit those with underlying pathologies such as retardation, schizophrenia, or substance
abuse. Effectiveness of treatment is even more crucial when offenders are sadistic pedophiles.
Then science moves into the tricky ground of predicting dangerousness and the law has to assess
the validity of these predictions.

Stermac & Hucker have used a combination of cognitive-behavioural therapy and
drugs to treat pedophilic incest offenders. They describe a case study which is interesting because
the offender exhibited many of the traits described above. They describe him as follows:

Mr. R.N., a married and employed tradesman, was referred ... for treatment
following a conviction for several counts of sexual assault and gross indecency
against his daughters, 9 and 11 years old at the time of referral. The patient had
served a short sentence and had been residing outside of the family home since
his arrest. He had very restricted access to his daughters...

R.N. had abused his daughters since they were in diapers and, although he had tried, was unable
to stop. Tests showed that he had a sexual preference for children but was capable of arousal by

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Footnotes:

608 For example, see Edward L. Rowan, "Predicting the Effectiveness of Treatment for

609 Travin, supra note 583 at 616. Hall & Hirshman, supra note 588, speculate that the
current lack of treatment effectiveness is a consequence of the failure to arrive at unified theories
of etiology.

610 Supra note 606.

611 Ibid. at 262.
adult women and had what appeared to be a normal sexual relationship with his wife. Clinical assessment noted that R.N. was withdrawn, socially isolated and prone to mood swings, irritability and intense anger. He also "exercised great control over the family and endorsed rigid and stereotypic attitudes toward both family structure and sex roles." 612 He was highly distressed by his conduct and was anxious to return to a normal family life. His wife supported him in this. It should be noted that his wife had been unaware of R.N.'s problem (maybe because he was able to maintain normal marital relations) and contacted the Children's Aid Society as soon as she discovered it.

After several months of intense therapy, R.N. began to have increased access to his family. However, the long-term effectiveness of this treatment is not known. This case illustrates the possibility of successful therapy for offenders who acknowledge their problem and are motivated to change. Success is less sure for offenders who undergo involuntary treatment and lack family support once they leave prison or hospital; it is also doubtful for fixated pedophiles who have no interest whatsoever in sex with adults. Courts must retain a healthy scepticism about prisoners who appear to be willing to undergo voluntary treatment as hospital programs are often seen as an easy route to earlier release.

Although science seems to have made more progress with classification and subdivision of pedophilia than it has with PMS, treatment strategies may be even more unreliable. As already stated, reliability of treatment and prevention of future crime are crucial factors in determining the practical viability of a psychobiologically based defence which would allow release of an offender to the community. Effectiveness of treatment has been important in the disposition of

612 Ibid. at 262-263.
cases involving epileptic offenders. I will discuss the medicalization of behaviours associated with epilepsy in the following section.

D. SUMMARY AND CONCLUSIONS

If my thesis about the strength and effectiveness of sexual stereotyping is correct, I would expect that any man who deviated from the social and sexual role of the ideal male would be expelled from the ranks of this privileged class; that they would lose the patriarchal seal of approval. In a patriarchal system, the power and exclusivity of the dominant group can be maintained only by ensuring that its members conform to a stereotypical norm and that inferior subordinate groups adhere to laws laid down by those at the top of the heap. Members who fail to behave in accordance with the ideal male norm may be treated in one of two ways; if their deviance is irreversible, they lose their membership but if they are able to return to normality they may be welcomed back into the fold. However, if too many members are expelled, the power base of the group erodes and its authority weakens. How do XYY syndrome, pedophilia and impotence fit into this scheme?

XYY males form a very small percentage of the total male population. They differ biologically, having an extra Y chromosome and elevated testosterone levels. Their behaviour includes a short attention span and higher libido, accompanied by an increased tendency to have difficulties with spousal relationships. They are more impulsive but not necessarily more violent than XY men. The percentage of XYY men in prison is higher than their percentage in the community at large. These men have an obvious biological abnormality; therefore they are not included in defining the male gender. However, they are not necessarily despised by the group
that sets the norms; otherwise literature would not disclose terminology like "supermale." These men offer no threat to the patriarchal ideal of male gender.

Their chromosomal difference makes XYY men a "natural" for medicalization. There has been no need for turf grabbing except with respect to causes of criminal behaviour - the nature versus nurture debate. It is easy in this case to switch from a criminal to a sick model. However, as I will show later, the law has not been eager to accept this switch.

The percentage of pedophiles in the community is unknown but my reading suggests that the number of "true" pedophiles is probably small, while the number of "normal" men who molest children may be higher than previously estimated. It is hard to tell whether the prevalence of child sexual abuse is due to many men molesting a few times or to a few men molesting many times. I should think that normal men would prefer to regard pedophiles as an abnormal minority that is biologically different, since this would keep the idea of the "real man" intact.

The process of medicalization of pedophilia has run into some of the same problems encountered with PMS: unknown etiology, inconsistent classifications and subdivisions, biased sampling, etc. There is some evidence of brain chemistry differences but testosterone levels of pedophiliacs are generally normal. Pedophilia is described as a mental disorder in the DSM-III which might add credibility to a defence based on lack of mens rea. There is a certain amount of turf grabbing in this area with sociologists and psychologists vying with endocrinologists for jurisdiction.

The stereotypical picture of the non-violent pedophile is still the weak-willed, socially inadequate pervert who is not man enough to "get it up" with a woman. Thus some of the mythology of impotence overlaps the child molester stereotype. However, except for the opinions of the Man/Boy Love Association, pedophilia is commonly viewed as a non-reversible
abnormality. Pedophiles are therefore beyond the pale and outcasts from the realm of real men. Like homosexuals, pedophiles present a threat to the male gender ideal and must be placed in a class apart. This contrasts with PMS women who are part of the normal abnormal gender.

Because its incidence is fairly common and happens to most men at one time or another, impotence presents a contrast to the XYY condition and to pedophilia. If men with sexual dysfunction were persona non grata in the male mainstream, there would hardly be enough left to maintain the patriarchal power base. Therefore patriarchy must find a way to both exclude and include these men.

It is difficult to find a coherent pattern in the medicalization of impotence, maybe because of the logical inconsistencies surrounding the concepts of male sexuality and male will. On the one hand, psychogenic impotence could be compared with neurasthenia and abulia as a symptom of a disease of the will; or, like Charcot’s male hysteria, as a symptom of an inability to cope with external stress such as long term unemployment. This classification points to an etiology of internal moral and social weakness - a lack of personal control. It is a model that fits the stereotype of inadequacy of the whole person, described in Chapter 2. As already discussed, this type of man is unwelcome in the ranks of the ideal male.

How then can medicalization include men with sexual dysfunction within these ranks? The obvious solution is to identify reversible physical malfunctions. This removes the stigma of unmanly mental weakness and allows the patient to be restored to patriarchal grace. Lack of control of the body due to a mechanical failure is an engineering problem that can be fixed by calling in the medical plumber or electrician. The untreated impotent man is still considered abnormal (and therefore excluded); but the impotent man who "cures" his problem is more like
a soldier with a war wound. We can sympathize with him but still admire him for taking control
of and beating his "problem."

These alternative descriptions of medicalization are simplistic in that they make no
allowance for overlap of etiology - mixed psychological, environmental and biological causation.
However, I believe that I have given one reasonable explanation for the overwhelming current
popularity of the biological model. Urologists and andrologists are presently crowding out
psychiatrists and psychologists in this field, except where the "psy" professions have to mend the
psychological damage that is a secondary consequence of the organic disease. Mechanical
medicalization has allowed technology to make an errant male sexuality, which is often beyond
the control of its owner, answerable to the male will at the press of a switch or the plunge of a
needle.

How would this affect the theoretical use of impotence as a legal tool? Obviously, if
causation is organic, it cannot be classified as a disease of the mind. This forecloses the insanity
defence. Whether mechanical cures would defeat an annulment action is another subject for
speculation.

III. EPILEPSY

It may seem redundant to talk about the "medicalization" of epilepsy. After all, as
described in Chapter 2, epilepsy has been defined as a disease since the dawn of medicine. But
what disease? Like PMS, it manifests itself in an apparently infinite variety of forms all lumped,
by laypersons at least, under one umbrella heading - "epilepsy." The popular picture of epilepsy
centres round portrayals of the grand mal seizure - the falling sickness - where the sufferer may
lose control of all bodily functions and may appear to be dangerously violent. In fact, epilepsy
may manifest itself in the form of the minor "absences" of petit mal, the automatisms and hallucinatory states of temporal lobe disorder, or a number of other abnormal behavioural and sensory states.

Ernst Niedermeyer, the author of a 1990 text on epilepsy, states categorically that epilepsy is not a "disease." Instead, the epilepsies represent the results of abnormal reactions of the brain; they tend to describe sites of damage or behaviour patterns, rather than causes of that damage and behaviour. For example, "temporal lobe" epilepsy (TLE) describes a brain site; "psychomotor" epilepsy, which may also be TLE, describes a type of behaviour. This is reminiscent of some of the disorders described in Parts I and II of this chapter which are classified by timing (PMS), behaviour or internal inclination (pedophilia), or physiological characteristic (impotence and XYY phenomena). It seems that this type of terminology always emerges when medicine is still guessing at etiology. Unlike the situation of PMS for instance, medicine has managed to identify some, but not all, specific causes of particular behaviour associated with epilepsies. Included in these are physical brain damage, tumours and other lesions, metabolic cerebral impairment and genetic predisposition.

As I will discuss in the next chapter, those who rely on epilepsy as a defence to criminal charges must bring themselves within the ambit of whatever insanity defence applies within the jurisdiction of their trial court. Therefore, in the eyes of the law at least, epilepsy and insanity are closely allied if not inseparable; thus the law continues to perpetuate a form of stigma that

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614 Ibid.
medicine, over the last one hundred and fifty years, has been anxious to remove. This provides an interesting situation in which the language of law refuses to follow the language of medicine despite input from expert witnesses. In the case of PMS, medicine has been largely responsible for the emergence of a new defence, one which stops short of a label of insanity. In contrast, once the law has applied a label of insanity to epilepsy, medicine seems powerless to remove it. Therefore, critics of the PMS defence may have good grounds for their concerns now that PMS (as LLPDD) is included in a manual of psychiatric disorders. The obvious next step for a defence of severe PMS would be its inclusion in the legal category "disease of the mind."

Since the epilepsy defence is usually confined to fact patterns that include automatisms, dissociative states or uncontrolled violence, I will confine this section to an outline of those epilepsies that result in this type of behaviour, the main one being TLE. In keeping with my coverage of gender specific disorders, I will begin by describing the development of knowledge of epilepsy during the nineteenth and early twentieth centuries which led to a shift from psychiatry to neurology. Then I will point out some similarities and differences between the development of theories about PMS and epilepsy. Finally, I will briefly report on what I should have realized before choosing epilepsy as a gender-free control; namely, the overlap between epilepsy and gender difference research.

In Chapter 2, I alluded to the fact that medical ideas about epilepsy followed current fashions of the day, which led to the formulation of such disorders as *epilepsia uterina*, suffered by "hysterical" women, and epilepsy in men caused by sexual excess or abnormal continence. However, two of the most interesting developments of the nineteenth century were the transfer of epilepsy from psychiatry to neurology and the recognition of TLE as a form of epilepsy.
During the first half of the nineteenth century epilepsy and the insanities were considered to be closely related "neurotic" disorders. Theodore Herpin, a French physician, was "the first to challenge the view that epilepsy and insanity are closely associated." By the 1860s, Paul Broca, a French anthropologist and surgeon was able to demonstrate that a local lesion in the brain could impair one function but leave others intact. This discovery helped to fuel the ascendancy of neurology whose focus on organic factors "created the mistaken impression that all that mattered was the cerebral alteration." By the 1880s, prominent neurologists like William Gowers of the National Hospital in London, were distinguishing organic from idiopathic epilepsy and were trying to separate hysteria from "true" epilepsy.

Psychiatry, however, did not surrender without a fight. It developed the idea of "masked epilepsy" used to describe seizure-free conditions in which the patient experienced excitation and depression and exhibited such behaviour as motiveless and explosive anger, amnesia for aggressive periods and auditory hallucinations. Although this diagnosis went out of favour before the end of the nineteenth century, a number of recent papers on possible links between epilepsy and psychosis show that some branches of medicine, perhaps for good reason, are unwilling to

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615 German E. Berrios, "Epilepsy and Insanity During the Early 19th Century: A Conceptual History" (1984) 41 Archives of Neurology 978 at 978.

616 Ibid. at 980. See also, Dieter Schmidt, "Theodore Herpin: A Mid-19th Century View on Epilepsy" (1988) 45 Archives of Neurology 1042.


618 Berrios, supra note 615 at 978.

relinquish old notions about epilepsy and mental disorder.\textsuperscript{620} This may in large part be due to the fact that a number of epileptic seizure disorders cannot be separated from their psychiatric aspects.\textsuperscript{621}

Some of these "masked epilepsies" may in fact have been manifestations of what became to be known as psychomotor epilepsy, a condition that "had usually gone unrecognized because no provision had been made for it in the diagnostic classification."\textsuperscript{622} This is further evidence of the power of medical labelling; until it is named (or after its name is taken away\textsuperscript{623}) a disease has no separate existence in medicine and likely no credibility in law.

Hughlings Jackson, an English physician practising in the second half of the nineteenth century, is credited with the recognition that certain symptoms that fall short of a full generalized seizure may be a form of epilepsy, now known as TLE. He realized that epilepsy is due to "occasional sudden, excessive, rapid and local discharges of grey matter" in the brain.\textsuperscript{624} Thus if the discharge occurs in an area that controls the sense of smell, the patient will experience changes in olfactory sensation; if it occurs in an area controlling movement of an arm, that arm might go into spasm; if the discharge spreads to the whole brain, a generalized seizure, affecting the whole mind and body, will occur.

\textsuperscript{620} I will discuss some of these papers below.

\textsuperscript{621} Niedermeyer, supra note 613 at 4.

\textsuperscript{622} Thornton, supra note 617 at 33.

\textsuperscript{623} For example, the removal from the DSM of postpartum disorders as specific psychiatric disorders.

\textsuperscript{624} Thornton, supra note 617 at 28.
Further studies identified certain trance-like states, accompanied by automatism and followed by amnesia, as symptoms of TLE. However, it was not until the invention of the electroencephalogram (EEG) in 1929 and its refinement in the 1940s and 50s that these states were fully identified as TLE. Although the symptoms of TLE are "virtually innumerable" the most common are the psychomotor automatisms. These usually last from thirty seconds to five minutes although longer automatisms followed by amnesia have been reported. Irrational rage, sometimes popularly associated with the idea of epilepsy and known as "episodic dyscontrol syndrome", is very rare.

Abnormal behaviour associated with epilepsy is the result of disorders of the brain. Since this behaviour is caused by an internal rather than external agency, the law equates it with a disease of the mind and therefore makes no distinction between an organic and a psychological disorder. It is hardly surprising that the law has followed this path when neurologists and psychiatrists are again speculating about possible relationships between the two and some psychiatrists are calling for the reinclusion of epilepsy to the DSM. This may be partly due to recent moves to expand the jurisdiction of psychiatry into new disciplines such as "biopsychiatry."

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625 Ibid. at 33.
626 Niedermeyer, supra note 613 at 61.
627 Ibid.
628 Tu, supra note 613 at 516, notes that "[i]f the DSM-III could indeed justify the inclusion of as many as 21 subcategories of sexual disorder, including five types of ejaculation and orgasm problems, it should certainly have found a place for epilepsy."
One writer seems to assume that all epilepsies are accompanied by emotional and behavioural problems. This is similar to the attitude of some physicians toward menopause. The difficulty with this perspective is that it may well be self-fulfilling, especially in view of studies that state that people with epilepsy tend to live up to society’s expectations of them. This may also be true of many women. It may be comforting to blame emotional disturbance on an organic illness since it places responsibility on a physical cause beyond the conscious control of the sufferer. This attitude is especially understandable in Western society because we have been conditioned to believe that a mental disorder is a sign of character weakness, a flaw that we could somehow correct if we would only pull ourselves together and stop complaining.

Can epilepsy be classified as a disease of the mind in the medical sense? Tu argues that "[a] neglect of epilepsy can be considered as a neglect of reality and may create pitfalls in the path of our [psychiatry’s] future development." Like a number of researchers into PMS, he argues for an interdisciplinary approach and total psychosocial care as opposed to mere control of fits. This sounds eminently sensible and I may be overly cynical in my impression that the author is more concerned about the need of psychiatry "to consolidate [its] rightful place among the medical sciences" and avoid "pitfalls in the path of [its] future development" than about the stigmatization of epileptics as a class. Although he makes many valid points, he lumps the

629 Ibid.
630 See Chapter 2.
631 Tu, supra note 613 at 516.
632 Ibid.
epilepsies under one umbrella so that an uninformed reader would assume that all varieties carry equal dangers of psychiatric disturbance.  

There is some evidence that particular forms of epilepsy carry the danger of associated psychopathology and that this danger has been ignored in well intended attempts to destigmatize epilepsy. However, experts disagree about the nature and the extent of the relationship between epilepsy and psychosis. Michael Trimble, a leader in his field, points out that schizophrenia, manic depression and TLE are three separate disorders but that there is a great deal of overlap in their symptoms. Also, patients with TLE often exhibit psychiatric symptoms in the interictal (between seizures) period that may resemble mania or schizophrenia. He argues that this overlap has led to the stigmatizing concept of the "epileptic personality" which, I would think, is merely a "scientific" extension of old mythology. Trimble speculates that these similarities between TLE and psychiatric disorders indicate a yet unidentified organic cause for the latter and that, if medicine finds a biological basis for disorders like schizophrenia "the myth of mental illness" will someday disappear.

Those who relate psychoses with epilepsy divide them into ictal and interictal groups. Symptoms commonly include auditory hallucinations, paranoid delusions and disturbances of

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633 Again this is strikingly similar to much of the writing on PMS which reinforces popular assumption that all women are irrational once a month.


636 Ibid.
affect, including suicide attempts.\textsuperscript{637} A few patients with seizure disorders also suffer from dissociative states\textsuperscript{638} - a phrase that often comes up in legal cases involving insanity and automatism. Some researchers have noted that depressive symptoms are more related to lesions of the right temporal lobe and schizophrenic symptoms to the left.\textsuperscript{639} Although both epilepsy and psychoses are manifestations of brain dysfunction, and seizures originating in the limbic system of the brain mimic symptoms of psychoses, drug studies suggest that they are activated by different sources. For example, drugs that control psychosis often precipitate seizures and patients whose seizures are decreased by epilepsy drugs seem to run an increased risk of developing psychoses.\textsuperscript{640}

However, not all psychoses lead to behaviour that society classifies as criminal. In the next chapter, I will briefly describe some medical studies that have investigated possible links between violence and epilepsy. The above, very superficial, discussion of research into epilepsy

\textsuperscript{637} Trimble, "Phenomenology of Epileptic Psychosis: A Historical Introduction to Changing Concepts" in ibid. at 1.

\textsuperscript{638} O. Devinsky et al., "Dissociative States and Epilepsy" (1989) 39 Neurology 835, believe that, although the two disorders have many symptoms in common (about one fifth of their patients with epilepsy had significant dissociative experiences), epilepsy does not trigger the psychiatric disorder.

\textsuperscript{639} P. Flor-Henry, "Psychosis and Temporal Lobe Epilepsy" (1969) 10 Epilepsia 363; M.R. Trimble & M.M. Perez, "The Phenomenology of Chronic Psychoses of Epilepsy" (1982) 8 Adv. Biol. Psychiatry 98. However, it should be noted that "the concept of "schizophrenia" has been particularly controversial, with gross differences in its usage in different parts of the world..." (cited by Shirley M. Ferguson & Mark Rayport in "Psychosis in Epilepsy" in Dietrich Blumer, ed., \textit{Psychiatric Aspects of Epilepsy} (Washington, D.C.: American Psychiatric Press, Inc., 1984) 229 at 232). Thus, a patient who is diagnosed as schizophrenic in the U.S. may be diagnosed as manic in the U.K. Ferguson & Rayport's review of the literature also discloses disagreement about the lateralization of schizophrenic type symptoms.

\textsuperscript{640} Janice R. Stevens, "Risk Factors for Psychopathology in Individuals With Epilepsy" in Koella & Trimble, supra note 634, 56 at 71.
and psychoses indicates a number of similarities between work on epilepsy and work on conditions such as PMS. Many of the deficiencies listed on pages ?? apply to epilepsy. For example, psychiatry has failed to reach an international consensus about the definition of psychoses. Over the years, neurology has changed its classifications and definitions of epilepsies but one author points out that "[n]ew terminologies are not necessarily remedies for preexisting problems of communication." Another criticism of epilepsy research points to the prevalence of biased samples. As with XYY research, many of the populations under study have been inmates of psychiatric and penal institutions, or have been specialized groups suffering from a severe form of epilepsy requiring surgery.

Other problems include the use of retrospective data, lack of appropriate control studies, and the use of a variety of questionnaires to determine emotional states. Sample size is sometimes small, but populations seem to be larger than in PMS research.

Treatments for epilepsy are much more specific than for PMS, having developed from the bromides of the nineteenth to the complex drugs of the twentieth century. However, drugs for both epilepsy and psychosis seem to run the risk of producing iatrogenic effects and their precise interaction with the chemistry of the brain is not completely known. Also some epilepsies

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641 Also the incidence of psychosis in epilepsy is unclear because of the huge variety in results from different researchers. For example, see Bettina Scmitz & Peter Wolf, "Psychoses in Epilepsy" in Orrin Devinsky & William H. Theodore, eds., Epilepsy & Behavior (Wiley-Liss, 1991) at 97 who report that the prevalence of psychosis in patients with epilepsy has been found to range from 0-41%. There are also huge differences in figures reported for the incidence of epilepsy in patients with psychosis, perhaps because psychiatrists are not trained to recognize symptoms of TLE. Ira Sherwin, supra note 634, reports that the incidence of epilepsy in the general population is about 1% while that in mental hospitals is about 12%.

642 Niedermeyer, supra note 613 at 54. He believes that the recommendations of the Commission of Classification and Terminology of the International League Against Epilepsy have led to terminology that is less powerful than the old; for example, "generalized tonic-clonic seizure" instead of "grand mal" and "complex partial" instead of "psychomotor."
fail to respond to drug treatment. As I discussed previously, effective treatment is an important issue in the legal disposition of any particular case.

The similarities between PMS and epilepsy are even more marked when the comparison is narrowed down to PMS and TLE. Both seem to have biological and psychological components but it is not clear what behaviour is caused by what component. In any case it is probably impossible to separate one from the other since they seem to be interdependent. Theoretically it is unnecessary to distinguish the two when formulating defences under the present Canadian justice system since, in the case of epilepsy at least, both would lead to an insanity defence. But would the attitudes of judge, jury and lawyers differ depending upon whether the disease of the mind is caused by epilepsy or medical insanity? Both carry stigma and prejudice that have similar bases. However, there still seems to be something more "respectable" about an organic disorder. The legal verdict might not be different but final disposition may well be. For example, a person charged with committing a crime while under the influence of epilepsy can often plead guilty and go free, whereas a person suffering from a recognized psychosis may not have the freedom to plead guilty.643

PMS is further complicated by gender myth. In that case the competing prejudices involve sex and mental disorder. What would be likely to happen if a woman were to plead catamenial epilepsy (seizures consistently occurring during the premenstruum) as a defence? I will finish this section with a brief description of research into epilepsy that has focused on sex differences, in particular as it relates to PMS.

In Western countries there is a slightly higher incidence of epilepsy among men and TLE is more common in boys than in girls; in developing countries, slightly more females than males

643 See next chapter.
have epilepsy. Generalized "definite" epilepsy is more common in males; female epilepsy is often less clear cut so that there is a possibility that women's symptoms may be wrongly diagnosed as something other than epilepsy.

David Taylor, reviewing sex difference studies, notes that females with epilepsy run a greater risk of developing psychoses than males, and that the risk of epileptic psychosis is increased by: femaleness, left-handedness, left brain location of the lesion, alien tissue lesion, and late childhood/puberty onset of epilepsy.

Although epilepsy is cyclical in both men and women, a relationship with menstruation has been postulated for centuries. In 1964, Dalton noted that grand mal and, to a lesser extent, petit mal commonly occur with increased frequency in the premenstrual period. In 1980, Trevor Price claimed that the regular occurrence of TLE in the premenstrual period had not been previously reported. He described the case of a 44-year-old white female nurse who had many PMS symptoms in the two to three day period prior to onset of menses. In addition, she experienced partial amnesia, a feeling of unreality and a sense of deja vu. She also had a history of affective disorder that had been treated with lithium carbonate. A neurologist diagnosed her

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645 Ibid.

646 David C. Taylor, "Developmental and Behavioural Differences Between Males and Females With Special Reference to Epilepsy" in Trimble (1991), supra note 644, 65 at 73.

647 Pamela Crawford, "Catamenial Seizures" in Trimble, supra note 644 at 159, reports one study that found that 29% of men had cyclical increases of tonic-clonic seizures at between 8 and 56 days.

symptoms as being psychiatric; a psychiatrist diagnosed manic depression but resumption of lithium therapy made no difference; a gynecologist suggested that "the premenstrual association was probably not real." Finally, a second neurologist suggested TLE despite only mild abnormality in her EEG and she was successfully treated with an anti-epileptic drug in association with lithium. On two occasions when she had to discontinue treatment for epilepsy, her premenstrual symptoms returned.

Price uses this case study to suggest that TLE must be considered when diagnosing premenstrual disturbances. There is evidence to bear out his opinion that many such cases may be misdiagnosed as psychiatric disorders or as severe PMS. In 1980, when Price wrote his paper, deep electrode EEG was not as far advanced as it is today. This tool plus the use of brain scanning techniques has greatly facilitated the positive diagnosis of TLE.

Animal studies bear out the hypothesis that catamenial seizures may be related to changing sex hormone concentrations during the menstrual cycle. Research on patients has disclosed that there is a marked drop in the premenstrual concentration of anticonvulsant drugs and an increase in seizure frequency in women who have catamenial epilepsy. There is no such change in women with non-catamenial epilepsy. Since progesterone has anticonvulsive properties, some writers have suggested that catamenial epilepsy may be related to progesterone deficiency; others believe that the governing factor is the estrogen:progesterone ratio, since some (but not

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649 Ibid. at 960.
650 Crawford, supra note 647 at 160.
651 Ibid. at 161.
all) catamenial seizures have been eliminated by administration of birth control medication and others have been decreased by the use of progesterone suppositories.652

These therapies are strikingly similar to some that have been advocated for the treatment of PMS. Crawford speculates about the relationship between catamenial epilepsy and menstrually related mood changes. She notes that an increased incidence of premenstrual tension has been reported among women with catamenial seizures (75%) compared to other women with epilepsy (43%).653

The nature of this study prevents in-depth analysis of each topic and each discipline covered, but I find it strange that I have come across no paper on PMS that asks whether the severe form exhibited by the English "pre-menstrual murderers" might have been a form of catamenial TLE. It is not clear from the literature whether EEGs were used in the diagnosis of PMS or whether they are ever used today. It would be ironic if we were to be analysing and philosophizing about a condition that would qualify under an existing non-sex-specific epilepsy defence.

For the sake of completion, I will mention studies that have attempted to relate epilepsy to male sexual dysfunction, principally impotence. Taylor states that all studies have "reported a reduction in sexual interest, awareness and activity in patients with epilepsy."654 However, he could not have read the work of Jensen published a year earlier.655 Jensen, unlike most other

652 See Philip N. Patsalos, "Anticonvulsive Drugs, Hormones and Seizure Threshold" in Trimble, supra note 644, 135 at 138.

653 Ibid. at 162.

654 Taylor, supra note 646 at 137.

655 Per Jensen et al., "Sexual Dysfunction in Male and Female Patients with Epilepsy: A Study of 86 Outpatients" (1990) 19 Archives of Sexual Behavior 1.
researchers, included female subjects, control groups (disease-free subjects and patients with diabetes), and did not confine himself to subpopulations with severe epilepsy. Moreover, he excluded patients who had psychiatric illnesses in addition to epilepsy. He found that frequency and symptoms of sexual dysfunction in patients with epilepsy did not differ from the control group. There was a relationship between medium to poor disease acceptance and sexual dysfunction in women. Those with high acceptance functioned normally. Jensen could find no simple correlation between low sexual desire and pharmacologically induced androgen deficiency.

Although the studies on sexual function are inconclusive, I have included them to illustrate that many researchers will look for sex-differences, especially those related to women's menstrual cycles and male sexual dysfunction. Far fewer will examine male cycles and female sexual dysfunction. Thus, in many ways research into epilepsy treads the same well-worn semantic and philosophical paths as research into basic reproductive biology or research specifically directed toward sex differences.

IV. DIABETES

In this section I will merely gloss over the cause and treatment of diabetes mellitus and describe common behavioural patterns that result from (1) hyperglycemia (excessive blood sugar) and (2) hypoglycemia (low blood sugar). I will show that, despite similarities to epileptic seizures, insulin reactions of diabetes carry no connotations of insanity in the popular or medical mind.656

656 The information in this section largely comes from my personal knowledge as a mother of a son with diabetes.
In Type I diabetes (formerly called juvenile onset), the pancreas ceases to produce sufficient insulin to regulate the metabolism of sugar within the body. At present, Type I can be controlled, but not cured, by injection of insulin. Failure to take insulin will slowly lead to hyperglycemia and eventual death. Mental symptoms of hyperglycemia include confusion, disorientation and finally coma. Blood sugar is now easy to measure with daily in-home testing; therefore, unless a patient neglects to monitor her condition, behavioural disturbances due to hyperglycemia are rare.

Some people with diabetes, because of neglectful lifestyle or erratic metabolism, have difficulty in maintaining their blood sugar at a normal level. This results in unpredictable swings from hyper- to hypoglycemia. Excessive intake of alcohol will seriously disturb the balance between insulin and blood sugar. Since the brain depends upon fairly steady levels of glucose for normal functioning, it is vulnerable to sudden swings. Glucose deprivation, in particular, may cause a wide range of behavioural changes that vary from patient to patient and within the same patient.

The amount of insulin required to maintain normal blood sugar changes in accordance with exercise patterns, infections, psychological stress and metabolic changes. For example, some women with diabetes have to change their dose during the perimenstruum and during pregnancy. Insulin requirements rise during acute infections to cope with elevated blood sugar. Hypoglycemia often results when the infection is cured faster than expected. Stress occasioned by worry about exams or anticipation of a new job may also lead to hypoglycemia unless the

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657 Type 2 diabetes (formerly, adult onset) may be controlled by dieting or by oral medication. This discussion is confined to Type 1.
individual is aware of the danger and reduces his dose accordingly. Hypoglycemia may also occur for no perceivable reason and is often completely unpredictable.

Almost everyone with diabetes will experience hypoglycemia at one time or another. Frequency of attacks and type of symptoms may differ from person to person and with type of insulin used. Some common symptoms are sweating, palpitations, dizziness, blurred vision, confusion, irritability and aggression. Treatment consists of immediate intake of sugar, either in the form of soft drinks, sweetened juice, candy and sugar or in the form of special fast-acting glucose preparations. Usually there is some warning of a hypoglycemic attack but occasionally onset is so rapid that it is too late for self-treatment. If help is not available, an attack can escalate to the point where it resembles a grand mal epileptic seizure. In that case, if bystanders interfere they may be hurt. When an attack reaches this intensity, the sufferer will lose consciousness and will have complete amnesia for the event.

I will discuss the legal implications of this condition in the next chapter, when I compare it with epilepsy. However, to summarize briefly, it raises issues of insanity, automatism, voluntariness, recklessness and specific intent - many of the same issues raised by an epilepsy defence.
V. CONCLUSION

To conclude this chapter I would like to return to the people I described at the beginning of this study and ask how medicine would characterize their behaviours. Would a physician define them as sick or as criminal? Obviously, she or he would require more information to make a diagnosis.

1. **Maxine - Possible PMS**

Maxine is a single mother whose child, Stephanie, was three years old when she met her boyfriend, Rick. He moved in with her three months later - two years before the stabbing. Maxine suffered moderate postpartum depression after Stephanie’s birth and had to go on welfare as she was unable to work until her daughter was 18 months old. When Maxine’s periods resumed she noticed that she was much more irritable and nervous each month than she had been before becoming pregnant. However, her best friend, Cathy, says that she has always been "a bit odd" and "hard to get along with" before her periods. Maxine’s "PMS," as she describes it, was not so bad when Rick first moved in but it became worse when he started drinking, lost his job, and began to go into uncontrollable rages. Maxine became edgy and depressed all the time but was much worse during the two or three days before she menstruated. Rick began to beat her up regularly and occasionally slapped Stephanie when the child got in his way. Rick blamed Maxine’s "PMS" and yelled that she was nothing but a "mindless space cadet" and a "raging bitch" once a month. Maxine says she remembers very little about the stabbing and that "it was all like a bad dream." It is not clear whether Rick was threatening or abusing her at the time of his death. Maxine’s lawyer talks to a number of experts about possible defences that might be applicable.658

An endocrinologist from a PMS clinic says that all the symptoms point to severe PMS and that Maxine was probably in a dissociative state caused by hormone imbalance at the time of the stabbing. He wants to try progesterone therapy right away.

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658 The following diagnoses are obviously simplistic. No physician would diagnose or treat without further tests and evaluations. However, I include them to illustrate how different disciplines, working in isolation, may apply their own assumptions to come to totally different conclusions; conclusions that would vitally affect defence strategy.
A British psychiatrist, who is familiar with Dalton’s work, believes that PMS should be ruled out because Maxine’s symptoms do not entirely disappear for the rest of the month. She diagnoses manic depression and suggests treatment with lithium carbonate. Her American partner agrees that classic PMS is not an appropriate diagnosis but argues that Maxine is suffering from schizophrenia which is "complicated" by a premenstrual mood disorder. However, he does not rule out possible arguments based on Late Luteal Phase Dysphoric Disorder now that it is in the DSM-III-R. He recommends neuroleptic drugs to control schizophrenia with perhaps additional medication during the perimenstruum.

A neurologist brings up the possibility that Maxine might have catamenial temporal lobe epilepsy and that her "dream like state" might be a symptom of an underlying organic disease. He suggests depth EEG to test for limbic lesions and, if the results are positive, treatment with anticonvulsant drugs.

A psychologist/sociologist believes that Maxine is the victim of physical and mental stress precipitated by her home environment. She does not rule out PMS, but would like to explore the possibility that she is suffering from the Battered Woman Syndrome and may also have been driven to desperate action to defend her daughter from escalating harm. She suggests psychotherapy and counselling to help Maxine come to terms with her own reality and to learn techniques to build self esteem. She feels that Maxine should be treated as a victim of violence rather than a violent criminal.

Maxine’s lawyer is naturally puzzled by this variety of responses and will have to decide whether to raise PMS, insanity, epilepsy or BWS as a defence.
2. **Gina - Possible postpartum psychosis**

Gina immigrated to Canada from Italy when she was 17. At the time of the car crash, Gina had been happily married to Andrew, a successful accountant, for six years. Until the birth of her first child, Tony, Gina worked full time as a computer graphics artist. Although she and Andrew had recently moved to a new town and hadn’t yet got to know their neighbours, Gina’s pregnancy was a healthy and happy time for her. After Tony’s birth Gina stayed at home to look after the baby. When he was about two weeks old she started to become anxious about her parenting skills and suffered a number of panic attacks. These symptoms disappeared when she became pregnant again. Two weeks after the birth of her second baby, Gina told Andrew she thought she was "going round the bend" and was "hearing messages about the baby." During the next few days she told a friend that the "family would be damned if they did not surrender to God" and that she "would have to do something about it even if it was against the law." Gina was not aware at the time of the car crash that Andrew had made an appointment for her to see a psychiatrist. Gina has been charged with three counts of murder. She is now completely sane and is appalled at what she has done.

Gina’s lawyer consults a psychiatrist who explains that her client may have been the victim of postpartum psychosis and that the problems encountered after the first pregnancy might have been a milder form of the same disease. On the other hand, her symptoms after Tony’s birth might have been due postpartum depression caused by life change and isolation. He points out that the prosecution will probably be able to find an expert who does not believe in the existence of such a disorder, but who might characterize her symptoms as schizophrenia. He also points out that postpartum psychosis is not a specific category in the DSM and that a number of U.S. courts have been reluctant to recognize it as a disease of the mind.

Gina’s lawyer knows that she could probably get the prosecutor to reduce the charge from murder to infanticide with respect to the death of the baby. However, this could not apply to the deaths of Tony and Andrew. Because of this she may have to rely on an insanity defence.
3. **Cheryl - possible psychotic state caused by the trauma of giving birth**

Cheryl has been brought up to believe that sex is sinful and that no man will marry her unless she is a virgin. She has had very little sex education. Her parents have told her that alcohol comes from the devil and that any family member who drinks will be flung out of the family and the church. When she was fourteen, Cheryl was attracted to an older boy at school and began to sneak out at night to meet him. One evening he took her to a party and she got drunk. She can’t remember much about the party but now says she "must have had sex." She says she noticed her periods were "getting irregular" but thought it might have been because she was upset that her boyfriend had dropped her. She also noticed that she was fatter but put it down to overeating because she was depressed. When the baby was born she says she "couldn’t imagine where it had come from." She was terrified that her parents would be angry with her and "just hoped the baby would go away."

Cheryl’s lawyer is fairly confident that Cheryl will be charged with infanticide and not murder but is worried that the prosecution might bring up the question of insanity. She consults a psychiatrist who says that Cheryl was not suffering from postpartum psychosis but may have been in a temporary psychotic state because of denial of the pregnancy and the shock of suddenly facing reality.

A psychologist states that Cheryl’s strict religious background has made her unable to cope with modern living and that she has been existing for months in a state of suppressed fear because she has "sinned." This has created a susceptibility to mental disorder in the presence of extreme stress. However, he does not think that Cheryl was "insane" at the time of the baby’s death.

4. **Haruko - Possible menopausal depression**

Haruko, a second generation Japanese Canadian, has been looking for a job but, because she has stayed at home for years as a traditional wife and mother, she finds she has no marketable qualifications. She has become severely depressed but has not talked about it as she feels guilty about it. She says she has "everything" and has no right to be sad. She has also been experiencing hot flashes and has difficulty sleeping. She admits she has stolen from stores before and that it is the only thing that lifts her depression.
Haruko’s lawyer thinks that she must be a typical menopausal shoplifter and looks for medical evidence that will substantiate this theory. One gynecologist tells her that Haruko’s symptoms are not unusual for a woman of that age and that she is probably suffering from an estrogen deficiency. Another gynecologist says that menopause and depression are not causally related.

A psychiatrist suggests that Haruko’s condition could be classified as kleptomania and that it could be cured by administering antidepressants. A psychologist suggests behaviour modification therapy and self-esteem counselling. A social worker talks about the "empty nest" syndrome and recommends a shoplifters therapy group and a job finders club. She believes that the problem has arisen because of social isolation and lack of family understanding, rather than the "change of life." She encourages the whole family to go for joint counselling.

5. **Stavros - Possible provocation defence because of attack on manhood**

Stavros grew up in an extremely macho culture in a small village in Greece. He married there and soon after immigrated to Canada. His marriage was traditionally authoritarian; his word was law, he controlled the family money and no one could go out without his permission. If his wife and children disobeyed his orders, he would beat them. He spent most of his leisure time with male friends at a billiard hall or with women he picked up in bars. He had a high sex drive and boasted of his prowess in bed. His children escaped by leaving home early and as soon as the last one was gone, his wife walked out and went to live with another man. Stavros went on a sexual rampage but increasingly found problems in sustaining an erection. He says he can’t trust any women and that they’re only out for what they can take from a man. He feels they’ve robbed him of his manhood. He can no longer face his friends and thinks there is no purpose in living. All he can remember about the killing is the woman lying there laughing at him and then lying there dead.

Stavros’ lawyer would like to argue provocation but might want to fall back on an insanity defence. One physician says that Stavros may have been unable to control his violence because of an elevated testosterone level; another says that impotence suggests a lowered
testosterone level. A psychiatrist diagnoses a dissociative state brought on by borderline personality disorder which has escalated into psychosis due to extreme life stress and feelings of inadequacy. A sociologist blames Stavros’ cultural background and macho lifestyle. He says that Stavros was lashing out against a sense of powerlessness brought on by his impotence, and that such a reaction was virtually inevitable since Stavros’ whole sense of identity is connected to his macho ideas about masculinity.

6. **Mike** - *Possible XYY syndrome and/or pedophilia*

Mike comes from a poor inner city background. His father has been in and out of jail for years. His mother’s brother came to live with them when Mike was 6 years old and sexually abused Mike until he ran away from home at 14. Mike has always been tall for his age and was a disruptive and slow learner at school. He has never been able to hold down a job for more than a few months. He has tried to go out with girls but says he always "turns them off somehow." He admits having sexual contact with young boys since he was 14 but is not turned on by adult men. He says he is frightened by his feelings of violence but he acts on the spur of the moment and can’t seem to help himself.

Mike’s lawyer is in total confusion about the number of factors that may have contributed to his crime. One expert tells her that the XYY characteristic predisposes Mike to violent crime and that he might have a genetic defence; another says that XYY men are impulsive but not violent except, perhaps, with spousal partners.

A pedophilia specialist says that, had Mike been a "true" pedophile, he would not have been attracted by girls. He believes that Mike may be a good candidate for aversion therapy and medication to reduce his testosterone level. A psychologist is of the opinion that Mike’s behaviour has been caused by poverty, lack of parenting, low intelligence and the abuse he suffered as a child. He believes that Mike is a danger to the public and, if released, may escalate his violence.
A neurologist would like to conduct tests like those of Berlin\(^{69}\) to determine whether Mike has abnormal brain chemistry that might have caused his aberrant behaviour.

7. **Marie - Possible Temporal Lobe Epilepsy and/or Psychosis**

Marie is an aboriginal Canadian who lives in the city. She has been in successful recovery from alcohol addiction for more than ten years and presently holds down a job as a native counsellor. She has a history of mood swings and complains of PMS but none of this has led her to seek medication. About four years ago, Marie was attacked by one of her clients and suffered severe concussion. Since then she has had periodic "black outs." A neurologist has diagnosed left-sided TLE and has prescribed anticonvulsants. At the time of the accident Marie had been seizure free for almost two years. One witness who had been driving behind Marie states that she had been driving erratically "for almost fifteen minutes" and that he had intended to stop at the first phone box and report her as a drunk driver. He says that Marie could easily have stopped for the pedestrian but instead seemed to "drive right at her." When her car stopped by hitting a parked van, Marie just "sat there and mumbled."

Marie's lawyer wants her to plead guilty and ask for mitigation of sentence. Otherwise she will have to rely on an insanity defence whether it is based on epilepsy or mental disorder. Marie’s neurologist is convinced that his diagnosis of TLE is correct but admits that the period of automatism was much longer than normal. He thinks he should consult with a psychiatrist to determine whether Marie may have developed a psychosis as well as epilepsy. An endocrinologist would like to test for catamenial epilepsy although Marie has not been conscious of an increase in symptoms premenstrually. Another doctor brings up the possibility of a defence of somnambulism which would avoid the stigma of insanity and might lead to a complete acquittal.\(^{60}\)

\(^{69}\) Supra, note 585.

\(^{60}\) See next chapter for brief reference to somnambulism defences.
8. **Kurt - Possible Hypoglycemia defence**

Kurt has had diabetes since he was 3 years old and has been generally responsible about controlling his condition. After one drinking episode as a teenager, Kurt discovered that alcohol made his diabetes difficult to control. Since then he has rarely taken more than one drink a week. Kurt has held down a job as an appliance repairer for seven years and, apart from a few minor insulin reactions, his diabetes has not affected his performance at work. The victim, Darrell, was a close friend of Kurt's. The night before the stabbing was Kurt's birthday and he adjusted his insulin dose so that he could have more drinks than usual. He felt slightly hung over the next morning but his blood sugar measurement was normal and he injected his usual morning dose. He was late for work and forgot to take his morning snack with him. Just before lunch time he remembers feeling "low" - his expression for the symptoms of low blood sugar - and asked Darrell to help him to the pop machine. He remembers nothing else. Witnesses say that he seemed to have "some kind of fit" and when Darrell tried to calm him, Kurt stabbed him with the screwdriver he had been working with.

Kurt's lawyer is worried that she might have to rely on an insanity defence and consults a diabetes specialist. The doctor tells her that Kurt's behaviour is the result of deprivation of glucose to the brain. He says that Kurt's drinking contributed to abnormally high insulin levels and that the situation was worsened by lack of his usual mid-morning snack. He also says that, once Kurt's blood sugar dropped below a certain level, he had no control over his behaviour and would have no memory of his actions.

These summaries highlight the possible diversity of medical and psychological opinion about causation and treatment. For any one expert opinion, there may be another opposing it. Several questions arise about the use of these diagnoses in court. One that comes to the fore: if PMS is admitted as a biological defence to crime should not biological causes of pedophilia also be admitted as a defence to child sexual abuse? If epilepsy, an organic disorder, is a "disease of the mind" in the eyes of the law, should not PMS also be a disease of the mind? I will examine these, and other questions in the next chapter.
CHAPTER 5 - BIOLOGY, SEX AND CRIME: INTERSECTION OF SCIENCE, GENDER AND LAW

I. INTRODUCTION

In previous chapters I have examined the nature of mythology surrounding the related concepts of sexuality and gender, and how this mythology has influenced the language of human discourse at all levels including that of scientific research and medicine. Language of ideologies that have arisen under patriarchal systems have largely excluded the voices of women. Western law, in particular, has been until lately the sole preserve of a small number of privileged men who have set and implemented rules to govern the rights, obligations and behaviour of every segment of society without much regard to the wishes and perspective of those they see as inferior; including people of colour, of supposedly lower class, of different sexual orientation, and women. Therefore, if we graft male-dominated medicine on to male-dominated law, the resulting hybrid will merely perpetuate the paternalism and prejudice that a number of feminists have already criticized in our present justice system.

In Chapter 4 I examined medical opinion and knowledge about a number of specific "disorders" associated almost exclusively with either one sex or the other. In the next two chapters I will discuss the impact of this opinion on existing and possible future legal defences and attempt to assess whether such gender specific laws help or hinder the progress of women toward substantive equality within our society. For example, I will ask questions like the following: would a defence designed to apply only to women (like the PMS defence) serve merely to preserve a discriminatory status quo; or could it be formulated and applied in such a way as to recognize a legitimate need of a small number of women without relegating the majority to a position of inferiority?
Before attempting to answer such a question, I will briefly review what criminology and science have theorized about connections between biology and crime. This is an extension of parts of my discussion in Chapter 3 about gender-based assumptions of science on the one hand, and the idea of medicine as a tool of social control of deviance on the other. The research that I will refer to asks a variety of questions that carry value-loaded - and often sexist - assumptions within them. Examples of such questions include the following: Is there something about the biology of women that makes them less likely to commit crime than men? What, if any, part does hormone imbalance play in the crimes that women do commit? Do violent male criminals have higher testosterone levels than the average man? If so, is this why they commit violent crimes? Are people with epilepsy inclined to be more violent than the population at large? In short, to what extent does biology affect the number and types of crime committed by women, men and people with epilepsy?

Once I have gained some insight into reasoning about possible connections between biology and crime, I will examine how this reasoning may be translated into law via the expert witness. This is a vast area that is worthy of a study of its own and I can make only superficial mention of problems encountered when science and law meet in the courtroom. However, I cannot omit this topic entirely as it is expert opinion, in the form of medical reports and viva voce testimony that can make or break a defence based on human biology or psychology. It is here that lawyers, legislators, judges and juries may adopt or reject the language of science. It is here that we must ask why they adopt or reject. Is it for policy reasons; or because the law fails to understand the communication; or because court procedure prevents the expert from telling the "whole truth" as she sees it; or because those who apply the law are blind to or wish to perpetuate stereotypes; or for any number of other reasons? I will argue that a doctrine akin
to that of "informed consent" should operate when legal practitioners evaluate the evidence of
science. That is, they must consciously and consistently control for gender bias whenever
apparently gender-specific issues are before them - a form of risk/benefit analysis. They must
inform themselves or be made aware of the kinds of problems I have discussed in previous
chapters.

In the next chapter I will describe how gender-specific defences have already been applied
in Canada, Great Britain and the United States and attempt to identify shortcomings and
advantages in present law. Following this, I will address criticisms of a number of feminist
writers who have identified dangers to women in these defences. Finally, I will explain why I
believe that some form of these defences deserves recognition so that women and men who
genuinely lack the mens rea necessary for conviction may be helped rather than punished.
However, recognition and application are two vastly different concepts. It may be that application
without bias, prejudice and paternalism will be a utopian dream until there is a revolution in our
ideas about gender, class and race.

II. THEORIES ABOUT WOMEN, MEN AND CRIME

A. EVOLUTION OF THEORIES ABOUT WOMEN, CRIME AND VIOLENCE

Women offenders have been variously described as childlike, manipulative,
mentally deficient, and morally depraved.66

Examples of myths described in Chapter 2 include characterizations of women as evil,
as harmfully seductive, as raging viragos and, at the other end of the spectrum, as maternal.

66 Laura Crites, Women Offenders: Myth vs. Reality, in Laura Crites, ed., The Female
Many of these myths depict woman as killer. There seems to be an age-old fascination with the idea of the violent woman. Is such a woman the unconscious representation of misogynous fears that all women are inherently dangerous, or does she have the perverse attraction of the abnormal - a kind of circus freak that draws the leering crowd because she is the exception to the normal gentle rule? In myth, as in real life, the nature of the crime and the identity of the victim affect the characterization of woman as either bad or mad. For example, Clytemnestra who kills her husband in revenge for his sacrifice of their daughter, is not mad but is "a woman with a man's will." In contrast, Medea, who kills her children, does so in "the throes of a monstrous and irrational passion" which overcomes her "natural" maternal feelings.

In criminology, as in mythology, there appears to be confusion about whether female criminality is linked with stereotypical female traits or with deviance from these traits. This has resulted in inconsistent, illogical arguments about female crime - "a confusing patchwork of images." This mirrors similar ambivalent attitudes among the medical profession, illustrated in Chapter 4. Some scholars argue that this confusion about the nature of woman affects the attitudes of judges and juries and leads to disparities in sentencing. A woman offender who is viewed as a victim because of her biology or other inherent traits may be "rescued" by a paternalistic or chivalrous judge and given a lenient sentence, while an "evil" woman who is

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663 Ibid. at 29.

664 Ibid. at 29-30.

viewed as a threat will be treated harshly. Women who become threats to established (male) order are treated harshly. Women who are not seen as threats - even though they commit criminal acts - are treated leniently (chivalrously). Illustrations of such uneven sentencing can be found in studies of infanticide in the United States which lacks the protection offered by statute in Canada and England.

Interest in female criminals has intensified in recent years. In contrast to the scarcity of information about this topic evident only a few years ago, there is now a "rogues gallery" of writers contributing to the literature about women offenders. A number have surveyed criminological opinion as it has changed over the decades starting with Lombroso’s work and progressing through Thomas, Freud, Kinsley Davis, Pollack and Adler. Reviews

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666 For discussion of this topic see, for example, Candace Kruttschnitt & Daniel McCarthy, "Gender, Criminal Sentences and Sex Role Stereotypes" (1985) 5 Windsor Yearbook of Access to Justice 306.

667 Klein, supra note 216 at 84, describing the theories of criminologist W.I. Thomas. See also, Elizabeth F. Moulds, "Chivalry and Paternalism: Disparities of Treatment in the Criminal Justice System" in Datesman & Scarpatti, supra note 216 at 177.

668 I will discuss this further in Chapter 6.

669 Gelsthorpe, supra note 665 at 29, n.1.

670 For example, see Klein, supra note 216; Leelamma Devasia & V.V. Devasia, Female Criminals and Female Victims: An Indian Perspective (Nagpur, India: Published by Vinod Nangia for Dattsons J. Nehru Marg, 1989)


672 Kingsley Davis, "The Sociology of Prostitution" (1937) 2(5) American Sociological Review.

of criminological literature reveal that the nature versus nurture debate is particularly evident in this field. However, researchers seem to be more ready to ascribe biological causes to female criminality and to crimes committed by people with epilepsy, whereas they focus more on environmental causation when it comes to male crime. They seem to be saying that the "normal" man is pushed into crime by his social conditioning but female and "abnormal" male criminals are victims of their internal chemistry. This parallels my earlier discussions about the polarization of "normal" men on the one hand and women and "abnormal" men on the other when it comes to health and disease.

Klein argues that studies of women and crime begin with Lombroso who believed that there was a direct connection between physical characteristics and criminality. Susan Edwards warns against the current preoccupation with Lombroso as the "godfather" in the field and argues that he was merely influenced by longstanding medical opinion that there is a connection between female rhythms and crime. Not all contemporaries of Lombroso agreed with the "born to crime" theory. For instance, Hargrave Adam, writing in 1912, disagreed with many popular theories of his time and presented a strange mixture of adherence to old myths and to new theories that became popular decades later.

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674 Freda Adler, "The Interaction Between Women's Emancipation and Female Criminality: A Cross Cultural Perspective" in Datesman & Scarpitti, Supra note 216 at 150.

675 Supra note 216.

676 Susan Edwards, supra note 297, Chapter 3.

677 Adam supra note 345 He believed that women criminals are as a whole "as it is generally admitted, much worse than male criminals" (at 7). (This idea is repeated almost 70 years later in Devasia, supra note 670.) He also subscribed to such ingrained myths as "woman as evil," "woman as seductress," "woman as amoral," "woman as deceiver." He foreshadowed Pollack's theories about masked crime and suggested that extravagant women "by their reckless expenditure and self-indulgence, compel their husbands to resort to dishonest means to keep them supplied
certain people who get credit for being "scientists" by adopting obscure methods of investigation and clothing their conclusions in linguistic "fustian." 678

If not "born to crime," women have historically been "born to a role," - a "natural" subordinate role that scientific theory has sought to preserve. Perceived increases in female crime have therefore been attributed to breakdown in family values679, women’s emancipation in the workplace, and neglect of maternal and spousal duties. Although authors like Adler have interpreted crime statistics as supporting a connection between women’s liberation and increasing rates of female crime, all are faced by the incontrovertible fact that men, not women, perpetrate the vast majority of crimes.

Crites points out that female criminals are usually poor and from minority groups°; in fact, anything but liberated. As Heidensohn puts it:

Rather than emancipation playing a large part in female crime, it is social and economic marginalization which emerges as among the most significant factors.681

When it comes to violent crime, there has been virtually no change in the male to female ratio in decades. Further studies note that much of women’s violence is an outgrowth of structural

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with funds" (at 12). On the other hand, he believed that fathers of illegitimate children should financially support them.

678 Ibid. at 21.

679 For example, authors in Devasia, supra note 670, writing of female criminality in India, argue that women commit crimes when they have contradictory or ill-defined roles within the family.

680 Crites, supra note 661.

inequalities between men and women and is a response to violence initiated by men.682 Why do so few women commit crimes? Why is this true cross-culturally?683 Danielle Laberge and Shirley Roy identify two popular theories: (1) women are inherently law abiding; and (2) women have fewer opportunities.684 The first implies biological causation; the second, environmental (role theory).

As I discussed in Chapter 3, behaviour becomes criminal only when those with decision-making power in society decide that it deviates from their definition of what is normal and acceptable for that society to such an extent that perpetrators must be punished by the state. Thus the definition and classification of female criminality must depend on society's definitions of normal behaviour for women. The normal woman is already abnormal with respect to male guidelines.685 Therefore, for a woman to be considered "normal," her behaviour must deviate from that of the normal man. The deviant woman suffers the consequences of "double abnormality." As a woman, she is already abnormal; as a deviant woman she is twice cursed. If she is violent and "masculine" she may be tested for the presence of excess "male" hormone. If she is irritable, depressed or suicidal, the search focusses on her "female" hormone system.

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682 Nancy Jurik & Russ Winn, Gender and Homicide: A Comparison of Men and Women Who Kill, (1990) 5(4) Violence and Victims 227. See also Alison Hatch & Karlene Faith, The Female Offender in Canada: A Statistical Profile, (1989) 3 Can. J. Wom. Law 432, who note that the number of women charged with crime is increasing but that key causal factors for women charged with violent crime (11% of total violent crime) are situational - wife battering, economic powerlessness, psychological abuse.

683 Devasia, supra note 670, notes that female crime rates are low no matter what culture is under study.


685 I have discussed this concept in detail in Part I of Chapter 4.
The first type of woman usually ends up in jail, labelled "bad." The second often ends up in the hands of physicians, labelled "mad" - or "sick."

It is difficult to write coherently of these concepts as much of the research and writing exhibit incoherencies or contradictions of their own. Laberge has suggested that deviance and normality are intimately aligned, deviance being a distorted manifestation of normality, with separate characterizations for each sex.686 One person's deviance may be another's normality. For example, a single mother may rationally choose prostitution as a way out of poverty for her family. She might see nothing deviant about this behaviour and, even if she does not enjoy her occupation, may regard it as a sensible alternative to social assistance. However, decision-makers have traditionally viewed prostitution as deviant and solicitation as criminal, in part because prostitutes do not conform to woman's allotted role as monogamous helpmeet; and, in part, because many criminologists have been wedded to the notion that prostitutes are inherently promiscuous and crave sex - an abnormality for women but a necessity for men - rather than need money.687

Those in authority may treat women criminals as doubly deviant. That is, "they have transgressed both the criminal law and social regulation of "proper feminine conduct"."688 Heidensohn differentiates these offenders from women excused by the justice system because of "sickness." Chunn & Menzies use a slightly different definition of double

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686 Supra note 684.

687 See Klein's review of criminological theories of female crime, supra note 216.

688 Heidensohn, supra note 681 at 52.
deviance as describing a woman who is both criminal and mad. The following case study illustrates how class and race issues can reinforce this idea of double deviance.

A, a recent immigrant to Canada from a third world country, was refused welfare because her case worker believed (erroneously as it later turned out) that her husband had undeclared funds. Because she was desperate and could not feed her children, on her third fruitless visit to the welfare office she became hysterical, screamed and screeched, and refused to leave until someone helped her. The police arrived, wrestled her to the ground and took her off in handcuffs, reportedly making derogatory comments about her racial origins. Charges of causing a disturbance were later dropped, in part because A had to receive medical treatment for nervous stress.

When A’s actions failed to conform to the proper picture of subdued female supplicant, authorities deemed her criminal. Probably because she harmed no property or person but herself, it was easy to channel her later into the medical stream. Had she harmed someone, she may have been, as Chunn & Menzies observe, caught up in both the medical and criminal systems. Once biology was established as the cause of her supposedly aberrant behaviour, it was easy to ignore the social and cultural reasons for her actions.

Since this study focusses on biological defences to crime, the rest of the present section will concentrate mainly on research into biological causes. Unfortunately, a great deal of such research ignores, or merely acknowledges in passing, the contribution of social and environmental factors. This is a mistake I do not wish to replicate. However, I lack the space to do justice to the various environmental theories to be found in recent literature. Instead, when evaluating papers of biological theorists I will attempt to follow the suggestions of the Biology

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690 Personal communication from poverty advocate.
and Gender Study Group691, by checking for bias about gender and about biological
determinism. Hopefully, I can then avoid the simplistic uni-causal approach condemned by
authors such as Devasia.692

Of the authors who discuss multiple causation in the context of biology, Diana Fishbein
presents what may be the most credible theory.693 She postulates a "diathesis-stress" model of
psychopathology which asserts that some individuals are more vulnerable to psychopathology as
a result of inherited or acquired tendencies or a combination of conditions.694 She is careful to
separate the majority of women from a small subgroup who become criminal because they are
"doubly disadvantaged by poor environmental and biological conditions that interact to increase
the propensity for physically aggressive behavior."695 She argues that studies must focus on:

(a) neurological systems responsible for inhibition of extreme behaviours and emotions;
(b) ability to learn from modeling and experience;
(c) availability of family and community support mechanisms.

If all of the above are present and intact, then a person is unlikely to be violent. Even if
inhibitors of violence are absent, she is less likely to be aggressive if (b) and (c) are strong, since

691 Supra note 208.

692 Supra note 670 at 30, where the authors observe that most theories of female crime take
a unicausal approach whereas the etiology of male crime is considered more complex.
Unfortunately women criminologists have not been able to destroy the sexist
misconceptions and prejudices that have remained implicit and unaddressed,
because their validity has almost been taken for granted.

693 Fishbein, supra note 233.

694 Ibid. at 103. Similarly, Benedek & Farley (psychiatrists), supra note 662 at 35 state that
"violent behavior is multidetermined and results from a complex interaction of psychological,
social, cultural, environmental, and biological determinants."

695 Ibid. at 103.
a nurturing environment may insulate an individual somewhat from biological disadvantages and, conversely, biological stability ... may minimize the effects of environmental hazards.\textsuperscript{696}

Fishbein gives a good overview of present theories of physiological causation, including exposure to testosterone in utero, hormone release in puberty, and interactions between hormonal and neurotransmitter systems.\textsuperscript{697} However, she appears to accept the results without criticism. For example, she states that women suffer affective disorders - depression, anxiety, hysteria, mania - more frequently than men. She does not consider that diagnoses of the same behaviour might differ according to sex. This does not mean that her conclusions are necessarily wrong, but they would carry more weight if they were accompanied by the gender bias analysis advocated by the Biology and Gender Study Group.

She notes that high testosterone levels have been reported in depressed women and that thyroid disorders may place an individual at risk for aggressive or maladaptive responses\textsuperscript{698}. Since more women than men are supposed to suffer from depression and thyroid disorders, it is strange that more men than women are violent - if violence has underlying biological causes. Either there are as yet undiscovered biological causes for male violence or the environment plays a greater role in precipitating violence than it is given credit for.

Fishbein, like many others, acknowledges but does not discuss environmental factors. She accepts but does not analyse or criticize biological research. Her approach is useful but does not

\textsuperscript{696} Ibid. at 102.

\textsuperscript{697} Ibid. at 109. Fishbein does not mention criticisms of the methodologies of testosterone studies. See discussion of "tomboyism" theories in Chapter 3, supra. She argues that Lombroso's studies may have been methodologically flawed but that recent findings suggest that mesomorphic constitutionality may be related to masculinizing effects of exposure to testosterone during pregnancy or puberty.

\textsuperscript{698} Ibid. at 115.
go far enough or deeply enough. For example, she points out that female crime is low cross culturally as if this were evidence of the predominance of biology over environment. But low rates may be partially due to the pervasiveness of patriarchal models of social ordering. Although they may differ superficially - democracies, autocracies and religious states - their common core is the idea of male superiority. Thus culture could well be a more important factor than biology.

However, it should be emphasized that Fishbein concentrates on a subgroup of violent women and argues that their extreme behaviour is not a product of environment alone. For them, if not for others, biology is a large component. She concludes with a number of useful and specific questions:

(1) What is the incidence of psychological, psychiatric, and biomedical disturbances among female offenders relative to non-offending females?

(2) To what extent do these disturbances among female offenders contribute to violent female crimes?

(3) How do biological conditions interact with social factors to lead to female aggression, and what are their relative contributions?

(4) How can this subgroup of female offenders be identified?

(5) What treatments are available, and can clinical trials be instituted to determine their effectiveness?\(^{69}\)

Number (3) is an important question that few researchers seem to be trying to answer. Unlike the biological determinists on the one hand and environmental determinists on the other, it acknowledges the possibility of complex multiple causation. Dalton has attempted to answer (1), (2) and (5) in the context of PMS. Other physicians and scientists have tended to concentrate almost exclusively on hormonal causes of female violence. As with causation of female

\(^{69}\) Ibid. at 116.
"disorders," willingness to consider environmental factors varies with the specialty of the researcher; psychologists and psychiatrists being more open to ideas of social and cultural causation than endocrinologists and biologists.

This is particularly evident in studies of causation of female violence. Benedek & Farley define violence as "destructive aggression involving the infliction of physical damage on persons or property."\(^{700}\) Binder & McNiel examine the relationship of gender to violent behaviour in psychiatric inpatients\(^{701}\) and assume differences when they ask which sex is more likely to be violent before admission, and which sex is more likely to be violent during early hospitalization. They found that men were more likely to be violent outside the hospital setting and women more likely to be violent during early hospitalization. They speculate that males may be more violent before admission because of genetic and cultural factors. It did not seem to occur to them that men may have decreased violence in hospital because the normal object of their aggression - their spouse, girlfriend or child - is no longer available, even though they noted that there was more violence in males who were in spousal relationships than those who were single.

Evan Stark identifies three dominant theoretical models relating to violence: biopsychiatric, engineering, and sociological. About the first, he states:

While theoretically gender-neutral, in practice the biological model supports the stereotypes of males as naturally more aggressive than females, hence more violent.\(^{702}\)

\(^{700}\) Supra, note 662 at 35-36.


He argues that researchers should not equate aggression with violence but should consider that the first may be an alternative to the second; that healthy outlets for aggression might prevent violence. There appears to be no similar philosophy about aggression and violence by women. Both are considered aberrant for women; witness the kind of language used to describe women politicians like Margaret Thatcher.

Scientists have long been interested in testosterone levels in violent men. Apart from previously cited studies on tomboyism, there are few similar studies on women. One, by James Dabbs et al., looked at eighty-four female prison inmates, using 15 female college students as controls. The authors found that, as with men, women’s saliva testosterone concentrations were related to criminal violence although the pattern was more complicated with women. They also found that levels were lowest in defensive violence and highest with unprovoked violence. Unlike some other researchers, Dabbs et al., did not jump to the conclusion that there is a direct causal connection between the level of testosterone and the degree of violence. They acknowledged that this hormone, like others, affects behaviour but is, in turn, affected by experience; noting that levels can rise markedly within a few minutes of certain experiences. This suggests that violent actions may cause a rise in testosterone level which may then cause a rise in violence. Thus we are back to the chicken-and-egg arguments presented in the discussion about the relationship between progesterone levels and PMS symptoms.

Dalton, in her most recent book about PMS, refers briefly to a study of female teenagers in detention centres who were referred for medical examination because of histories of violence. Examiners discovered that there was a group of girls who did not suffer from PMS but who exhibited excess body hair of the masculine type. They also had high testosterone levels. When treated with an anti-testosterone drug, cyproterone acetate, they lost their excess hair and their
violent tempers and went on to lead normal, law-abiding lives.\textsuperscript{703} If these results are substantiated elsewhere, it would appear that there is some kind of definite correlation between testosterone levels and violent lack of self-control. However, the criticisms of most XYY studies apply here, as there is lack of evidence about violent tendencies among non-incarcerated hirsute women.

Scientists may have neglected research into relationships between "male" hormones and female violence but they have made up for it in their attempts to connect "female" hormones with criminal tendencies. Since I have covered medical research on PMS, postpartum disorders and menopause fairly thoroughly, in the next section I will only briefly refer to additional literature that attempts to find a causal connection between women’s hormone levels and female crime.

\textsuperscript{703} Dalton (1990) supra note 411 at 147.
B. FEMALE "DISORDERS" AND CRIME

(i) PREMENSTRUAL SYNDROME(S)

As I have already argued, "scientific" literature on this topic tends to perpetuate ingrained stereotypes about appropriate "feminine" behaviour. If questionable research were to remain within the narrow confines of medical specialties, its influence could be restricted. The danger to women of biased findings increases when they find their way into criminological texts and legal literature that report them as if they were "gospel truth."

For example, Lawrence Taylor, in his chapter entitled "The Chemical Woman," states that "there appears to be a direct correlation between the premenstrual syndrome and the incidence of criminal behavior"\(^\text{704}\) (emphasis added). He asks the value-loaded question: "Is this genetically transmitted syndrome a cause of criminal behavior?"\(^\text{705}\) and goes on to answer: "[T]he syndrome is increasingly being isolated as a primary factor in the incidence of criminal behavior among women"\(^\text{706}\) (emphasis added). He also goes on to claim that there is "a much higher incidence of criminal conduct among women of their thirties and forties than among men ... [and that] PMS appears to be most common among women after reaching the age of thirty."\(^\text{707}\) Like the Victorians before him, Taylor, writing in the 1980s, is not deterred by the

\(^{704}\) Lawrence Taylor, supra note 549 at 88.

\(^{705}\) Ibid. at 89.

\(^{706}\) Ibid. at 93.

\(^{707}\) Ibid. at 89. It is interesting that Taylor, who co-authored a paper with Katharina Dalton, is at odds with Dalton's findings, reviewed in her recent book The Premenstrual Syndrome Goes to Court, supra note 411, where she reports that 53% of offenders diagnosed with PMS were under 25, thus refuting the idea that PMS is primarily a disorder of middle-age (at 15). Far from being a primary factor, Dalton stresses that PMS, as she strictly defines it, is rarely an explanation for female crime.
effects on his theories of cessation of menses. He seems to see menopause as a renewed opportunity to wreak havoc on any remaining law abiding tendencies, citing a U.S. study that claims that "female criminality may show significant increase during the menopausal period..." Taylor is so wedded to the biological/genetic model of crime causation that he pays little attention to criticism of PMS research. To be fair, his biological determinism is not restricted to women but extends to men, as I will point out below.

I cite Taylor at some length because he is a lawyer and may have influence on legal thinking, and because his views present a striking continuity with those of a century ago. To those familiar with alternative theories, his work may appear ridiculously dogmatic and one-sided. However, to those educated to believe all the old myths about men and women his work may be comfortably familiar and reassuring - a convenient rebuttal of feminist criticisms.

Peter Vanezis in his paper "Women, Crime and the Menstrual Cycle," offers more cautions than Taylor about the connection between PMS and criminal activity. However, he too is fond of the sweeping statement; for example:

It is accepted that some women become unaccountably argumentative and aggressive during their paramenstruum and violent activity is well recorded. Accepted by whom? Recorded by whom? It is interesting how many authors attempt to validate categorical statements by using the passive voice.

To be balanced, I must add that not all criminological texts are as biased as Taylor’s.

For example, a 1991 volume by Curt Bartol states that "[t]he relationship between the


premenstrual syndrome and crime has yet to be convincingly documented.710 However, Bartol tends to go to the other extreme when he claims that "there is no evidence to date that PMS or, for that matter, excessive testosterone levels in men, cause, facilitate, or encourage criminal behavior"711 (emphasis added).

Numerous modern researchers have attempted to link the menstrual cycle with criminality.712 Numerous others have attacked the interpretation of data gathered from these studies.713 I will refer to these criticisms further when I discuss feminist critiques of the PMS defence. However, I think it necessary to emphasize once again that modern theories have not arisen in a vacuum. In the last chapter I showed that modern medical theories are largely current version of old ideas. So, too are current criminological theories that so heavily rely on medicine.714 Bruce Harry and Charlotte Balcer, U.S. psychiatrists, after examining


711 Ibid. at 195.

712 Vanezis, supra note 710, lists a number of studies including those by Dalton which conclude that women are more liable to commit crimes of violence during the paramenstruum than at other times in the menstrual cycle.


714 Authors who focus on modern theories in their historical context include Susan Edwards, "Mad Bad or Pre-menstrual?," (1988) 138 New Law J. 456 and supra note 297; and Carol Tavris, The Mismeasure of Woman: Why Women Are Not the Better Sex, The Inferior Sex, or The Opposite Sex (Simon & Schuster, 1992)
relevant research from 1945 through 1980, conclude with a passage that is worth repeating in full as it summarizes the problems that result from taking a narrow atomistic approach:

[N]one of the studies on menstruation and crime examined the many attributes that have been demonstrated to be associated with criminality. Sociodemographic variables such as race, employment, and education histories, and socioeconomic status were largely overlooked. Elements of criminal history such as prior arrests and incarcerations, or the use of weapons generally were not included. The subject's psychiatric histories of substance abuse, intellectual status, personality disorder, or other mental disorders were seemingly ignored. Finally, the subjects' developmental histories of abuse, neglect, and family histories of crime or mental disorder were not included. These glaring absences indicate that this body of work is severely limited regarding the basic relationship between menstruation and crime.

The authors go on to conclude that "there is no scientific support for an association between any phases of the menstrual cycle and criminal behavior" (emphasis added). Even if their conclusion is accurate, lack of scientific support should not negate the very real experiences of women who, for one reason or another, suffer adverse mood changes premenstrually. However, it does mean that the justice system should be wary of relying on such dubious data.

Dalton would disagree with Bruce and Balcer, as she relies on a very narrow definition of PMS; one that she claims would exclude malingerers from asserting her idea of the PMS defence. Indeed she states that

the very purpose of the rigid definition ... is to prevent the malingerer and her legal advisers from jumping on the bandwagon and falsely claiming premenstrual syndrome where it does not exist.

Thus it seems that her definition is legally rather than medically motivated. In order to claim PMS as a mitigating factor, she argues that the court and investigators should look for particular

715 Harry & Balcer, supra note 713 at 312.
716 Ibid. at 318.
717 Dalton (1990), supra note 411 at 144.
distinctive qualities about the offender and her crime(s): (1) Recurrence of the offence or similar
behavioural disturbance on a cyclical basis that can be tied statistically to time of menstruation.
If this requires retrospective data, it should be corroborated by independent evidence such as
medical records, police reports, prison records, observations of family members, co-workers and
friends. (2) The PMS offender commits her crime alone. (3) The crime is unpremeditated and
there is no apparent motive. (4) There is no attempt to escape detection. (5) She often commits
the offence after a long interval without food. 718

Dalton also differentiates symptoms of PMS that most often lead to crime and claims that
they differ from non-PMS symptoms. For example, she states that PMS depression differs from
clinical depression because of its shorter and predictable timing; weight gain and food cravings
instead of weight loss; rapid, instead of gradual, mood swings from manic symptoms to
depression; absence of depression at other times in the menstrual cycle.

Probably the key to the acceptance by British courts of Dalton’s theories has been her
insistence on demonstrating effectiveness of treatment - and this she seems to have been able to
do in numerous cases that have gone through the justice system. As I discussed in earlier
chapters, if doctors and lawyers can show the courts that treatment of a particular offender will
prevent or reduce the likelihood of recurrence of crime, pleas for mitigation will probably be
successful whether or not precise etiology is known. If progesterone will prevent premenstrual
violence in a small body of women offenders who meet Dalton’s criteria; or if cyproterone
acetate will prevent recurrence of more general violence in women offenders with elevated

718 Low blood sugar causes the body to release spurts of adrenaline which raises sugar levels.
Adrenaline is responsible for "fight or flight" reactions. It also prevents uptake of progesterone
by progesterone receptors. In women with PMS, adrenaline is released at higher than usual sugar
levels. Therefore a woman with PMS should eat complex carbohydrates more frequently in her
premenstruum than other women and men. [Ibid. at 123-126]
testosterone, then provided treatment does not unduly harm the woman, it would be better to release her under supervised treatment than to incarcerate her without treatment and allow her to walk out at the end of her sentence to live in misery and offend again.

(ii) POSTPARTUM OFFENCES

Before beginning this section, I had problems trying to compare it with the section before, in form as well as substance. But then it occurred to me that there is a vast difference in the criminological approach to the two topics. Because there is as yet no recognized defence or mitigation factor connected with any postpartum crime but baby killing, the principal focus is on the offence. We look at the result - the death of a child - and then try to classify the perpetrator as an "infanticide" or "non-infanticide" killer. Once we identify the former, all kinds of medical suppositions and theories come into force. On the other hand, in studies of PMS crime, the focus is on the disorder and the offender who may have committed a whole range of offences, including but not confined to killing - including, presumably, child killing. Therefore, in the previous section, I mentioned few specific offences, concentrating mainly on biological explanations for violence. In this section, I am forced to concentrate on the offence of baby killing and extrapolate backwards, as there is little or no data about other crimes attributed to postpartum symptoms.

A number of questions immediately spring to mind when contemplating the crime of infanticide: (1) What is the legal definition of infanticide? (2) How can, and do, members of the justice system distinguish between infanticide and the non-infanticide killing of a child under one year old? (3) What is the incidence of arrests and convictions for (a) infanticide; (b) non-infanticide baby killing by mothers; (c) baby killing by fathers; (d) baby killing by persons other
than parents? (4) Has the ratio of (a) to (b) changed since the advent of women’s liberation? (5) What, if any, is the role of cross-cultural factors in baby and child killing? (6) What other crimes do women commit during the post partum period?

1. **The Legal Definition of Infanticide**

In Canada, Section 233 of the Criminal Code provides:

A female person commits infanticide when by a wilful act or omission she causes the death of her newly-born child, if at the time of the act or omission she is not fully recovered from the effects of giving birth to the child and by reason thereof or of the effect of lactation consequent on the birth of the child her mind is then disturbed.

Section 2 of the Code defines a newly-born child as a person under the age of one year. As I discussed in Chapter 4, there is a difference in kind between the killing of a baby within twenty-four hours of its birth and the killing of a child between the age of one day and one year. However, the legal definition makes no distinction between these two types of homicide. This definition of infanticide has been the subject of extensive criticism, both in Canada and in England where the present Canadian provision originated.\(^719\)

2. **Infanticide vs. Non-Infanticide**

Not all women who kill their "new-born" children are charged with infanticide; some are charged with murder or manslaughter. Intrinsic to the definition of infanticide is the element of mental "disturbance" which itself is not precisely defined. It would therefore be logical to assume that all new mothers who kill their babies and are mentally disturbed would be charged with infanticide, while those who appear to be mentally normal or just plain "bad" would be charged

\(^719\) See infra, discussion in Chapter 6.
with murder or manslaughter. However, a 1979 English study by D'Orban concluded that not all women convicted of infanticide are mentally ill.720

Is this "disturbance" a mental illness or merely an emotional upset? Freedom to interpret mental disturbance in accordance with maternal and female stereotypes allows police great discretion to channel offenders into one stream or another at the very beginning of criminal proceedings. This will influence attitudes of other members of the justice system from charging to sentencing.

According to one recent Canadian study, police in their homicide returns, classify only 36% of infanticide mothers as "mentally ill" in terms of motive; in contrast to 67% of mothers who kill their children in ways that the police do not characterize as infanticide.721 The low figure for infanticide may be due to an assumption of a "motive" of mental illness in stereotypical case involving neonaticide by young girls. It would be interesting to know whether the specific diagnosis of mental illness is more likely in cases of postpartum illness in mothers who kill slightly older babies. Judging by the high "mental illness" motive rating (67%), the stereotype still seems to be an important factor in noninfanticide killing (defined by Silverman & Kennedy as any child killing by mothers that does not fit the infanticide criteria).

What factors operate to separate women who kill children under one year into infanticide and noninfanticide? It interesting to note that police returns for the killing of children under

720 P.T. D'Orban, "Women Who Kill Their Children" (1979) 134 Brit. J. Psychiatry 560 - dealing with neonaticide. On the other hand, D'Orban found an increased prevalence of psychiatric disorders in older, married homicidal women, noting that 83% of them tried to kill all of their children, not just the newborn.

721 Silverman & Kennedy, supra note 469 at 120. They note at 125 that only 6% of women who kill their spouses are declared as having a mental illness.
twelve months record a ratio of infanticide to noninfanticide of 3:1. This ratio may reflect police belief in the stereotype that women do not kill their children unless mentally ill. It is not clear whether the stereotype operates with greater strength when the mother is very young, single and has concealed the birth than when she is older, married and suffering from postpartum psychosis.

Other writers distinguish killing as a result of battering and abuse (committed by fathers and mothers) from infanticide by mothers. For example, Ian Wilkey et al., in an Australian study covering 1969-1978 found that the largest number of baby killings resulted from the battered baby syndrome and that it was often impossible to determine which family member caused the death. Bourget & Bradford, in a study of thirteen offenders referred to a forensic psychiatry service, found that accidental filicide (death from battering) was twice as common as pathological filicide.

Noninfanticide mothers may hit their children simply because they cannot control their anger and frustration. They may hit, as well, because they cannot cope with children or because violence is directed against them. They may be untrained in child care, not knowing what to do with or expect from an infant or toddler. Overwhelmed by the situation, they may strike out at the object of their frustration.

Bourget & Bradford, Resnick, and Wilkey et al. note that child killing is quite

722 Ibid. at 119, Table 2.
723 For a review of the literature see N. Prabha Unnithan, "Children as Victims of Homicide: Part II - Research on Child Homicide in Contemporary Societies" (June, 1991) Criminal Justice Abstracts 315.
724 Supra note 467.
725 Silverman & Kennedy, supra note 469 at 124.
726 Ibid.
different from adult homicide. Apart from infanticide due to mental disturbance and homicide due to active battering, baby deaths may result from mercy killing of a severely deformed child, deprivation and neglect, murder/suicide and murder.

What slot a mother may be put into may depend not so much upon the mechanics and surrounding circumstances of the crime, but upon the impression the mother makes upon those who have the power to fill the slots; whether, as Ania Wilcynski puts it, they see her as "mad" or "bad." She notes that in a study of twenty-two cases, fourteen women were classified as mad; being viewed as essentially good women for whom something had gone tragically wrong. They were sentenced to probation or sent to hospital. Eight were considered bad; exhibiting behaviour inconsistent with maternal stereotypes by appearing neglectful, uncaring or sexual. All eight went to prison. Thus the distinction between infanticide and noninfanticide killing may well depend more upon police or prosecutor perception than upon legal definitions.

3. **Incidence of Arrests and Convictions**

It must always be kept in mind that women commit only a very small percentage of homicides. Of these women, only a small number kill their children; and, again, of these, only a small number kill children under twelve months as a result of mental illness. The victims of women who kill are more often their spouses and lovers than their children. Silverman & Kennedy’s study of Canada over a twenty-three year period disclosed that 24% of homicides

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727 Supra note 362.


729 Supra note 463.
perpetrated by women were directed against their children (excluding infanticide). During the ten year period for which separate infanticide statistics were kept (1974-1983) only 45 cases of infanticide were reported. The equivalent noninfanticide number for children under 12 months was 15 and the most common method of killing in this group was beating to death.

Silverman & Kennedy reported no change in the proportion of infanticide to other homicides committed by women in Canada. Parker & Goode, on the other hand, note a reduction in the incidence of convictions for infanticide in England between 1967 and 1978 - even taking into account decreasing birth rates. They ask, but do not answer, whether this indicates that women previously convicted of infanticide are now being convicted of manslaughter. However the figures are interpreted, the overall picture discloses that infanticide makes up a very small proportion of violent crime.

With respect to baby killing by fathers, Silverman & Kennedy note that less than 0.7% of killings of children under twelve months were carried out by fathers. It would be interesting to know whether these killings resemble noninfanticide killings by mothers of children under twelve months; for example, caused by accidental death following battering, alcohol and drug factors, poverty, overcrowding, etc. If some circumstances lead to killings only by women, what are they and are they explainable by medicine?

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730 Silverman & Kennedy, supra note 469 at 117.

731 Ibid.,


733 Supra note 469 at 119, Table 2. This may not present an accurate picture. Stark, supra note 702 at 17, points out that virtually all research on physical child abuse (including child homicide) focusses on mothers and that there are no child abuse prevention efforts specifically targeting males.
I did not search out data on baby killing by non-parents, and this phenomenon was rarely mentioned in the literature on infanticide which naturally concentrated on killing by mothers. There seems to be no evidence that the rise of women’s liberation has increased or decreased the incidence of infanticide. Changes in frequency of infanticide are more likely attributable to implementation of permissive abortion laws and reduction of stigma attached to illegitimate birth. It is interesting that recent Canadian court judgments on infanticide have involved young girls from cultures that still place a high value on female virginity or older, married women who have positively demonstrated some degree of mental illness.\textsuperscript{734}

I should also comment on the claim that infanticide figures are so low because a large number of child homicides go unreported, being recorded as accidental death or Sudden Infant Death Syndrome. Homicide immediately after delivery may still be hard to prove, and death from natural and deliberate suffocation may be impossible to distinguish.\textsuperscript{735}

4. \textit{Racial, Cultural and Class Factors}

The main focus of this study is biological causation. However, many writers tend to examine this type of causation in isolation from other factors. Without going into great detail, I will simply point out that factors such as race, culture and class cannot be ignored. The following authors give examples of some of the issues involved.

In the Canadian context, Silverman & Kennedy report that both infanticide and noninfanticide mothers are overwhelmingly caucasian, and although aboriginal women may kill

\textsuperscript{734} See infra, Chapter 6.

\textsuperscript{735} For example, Silverman & Kennedy, supra note 469 stress that their figures represent only those women who are arrested for homicide and not all situations where mothers may have killed.
their spouses or "others," they rarely kill their children. When they do, police do not record the crime as infanticide. This could be taken at its face value to mean that aboriginal women do not commit infanticide or, since infanticide is a more lenient charge than murder or manslaughter, it could indicate racial prejudice or stereotyping by police when they encounter such child killing.

Despite previous cultural customs surrounding infanticide, very few Inuit women commit this crime. However, in contrast to aboriginal Indian women, police seem to be more likely to classify infant killing by an Inuit woman as infanticide rather than noninfanticide.

Ann Goetting, in a study of 93 people arrested for killing persons under fifteen years of age in Detroit between 1982 and 1986, found that homicide victims and offenders were predominantly black, two thirds of victims were under two years of age, and 80% of offenders were parents. Out of sixty-one children, only two were killed at birth.737 Pointing out that homicide is one of the five leading causes of death among young children in the United States, she noted that

> the grisly descriptions of varied victim-offender relationships and circumstances of offense are chilling precisely because there is no common denominator other than indifference to life.738

It must be remembered that this study was carried out in a predominantly black urban location "with an inordinantly high homicide rate." Therefore it is impossible to extrapolate her results to the population at large. Lack of education and poverty are almost certainly major factors in

736 Ibid. at 119.


738 Ibid. at 294.
causation. Most of the offenders had less than average education and over two-thirds were unemployed.

Robert Fiala and Gary LaFree, in a cross-national study, concluded that it is economic stress associated with a low societal status of women that most effectively explains child homicide. They concluded that homicide rates for children under four increased when women were forced to work outside the home because of economic necessity. Interestingly, they found little support for social disorganization, culture of violence, or isolation perspectives as contributors to child homicide in developing or developed nations.

Frank Bates in a study of the "Kerry babies" case, where the press took an excessively prurient look at the background behind a case of infanticide in Ireland, stressed the harm that comes from rigid adherence to the idea of the family as the "natural primary and fundamental unit group of Society... when the family is all too often a perilous and damaging unit for its weaker members, who are usually women and children." The idea of family also includes the idea of value to be given to children. Some children have value for the future labour they will provide; others are considered a burden because of future cost. The former are usually male; the latter female. In many cultures children are still "perceived as part of, or physical extensions of their parents, not as discrete entities with independent souls or rights." This


741 For example, see Julie Jimmerson, "Female Infanticide in China: An Examination of Cultural and Legal Norms" (1990) 8 Pacific Basin L. J. 47 - boys more useful for working the land - girls would require future dowries.

742 Ibid. at 56.
attitude parallels the "child as property" rationale of pre-twentieth century Canada and England, as described by Constance Backhouse\(^{743}\) and Katherine O’Donovan\(^{744}\) respectively.

The last area I would like to touch is the phenomenon of child murder/suicide. In our culture, such actions are seen as either sick or criminal. However, in Japan, for example, mother-child suicide - *Oya-ko shinju* - is a concept that is completely separate from the Western (and the Japanese) idea of infanticide.\(^{745}\) What happens when such cultural values intersect with Western law? Should our present infanticide provisions incorporate this type of child killing or should foreign customs be grounds for mitigation or special treatment under our legal system? Examination of these questions are beyond the scope of this study, but readers should constantly be aware that biology may be only one of many relevant factors.

5. Other Postpartum Crimes

Apart from writers who criticize the rationale behind the infanticide provisions, little has been said about crimes committed postpartum, perhaps because the date of birth of her last child is a piece of information that does not seem relevant to charges of lesser crimes such as theft or common assault. It is possible that a negative state of mind caused by biological changes due to childbirth could be a mitigating factor. Few courts, however, have considered this.

When questions of other crimes do arise in this context, they are usually related to other homicides. As I have already stated, it seems illogical to be lenient when the victim is a child

\(^{743}\) Supra note 54.


under twelve months and apply the full rigors of the law when the child is older, if the other factors necessary to prove infanticide are present. I will go into more detail about specific Canadian cases later; however, there are indications that judges will apply infanticide-like criteria to other homicides that occur during the postpartum period. For example, Mary Lentz describes a 1987 English case in which a mother of twins stabbed her lover to death while suffering from postnatal depression. Her sentence was three years probation.\textsuperscript{746} In the case of Ann Reynolds who murdered her mother, the English Court of Appeal in 1987 substituted a verdict of manslaughter for murder because she suffered from both postnatal depression and PMS.\textsuperscript{747}

These cases both come from England, a jurisdiction that seems to be more ready to accept biological defences than Canada or the United States. The question for this study is whether the medical basis is sound enough to justify an extension of a postpartum defence to cover other homicides and lesser crimes such as shoplifting and petty violence. Or are the social criteria that underpin infanticide law inapplicable to other situations?

(iii) MENOPAUSAL OFFENCES

Many explanations of what are obviously economically motivated offences, such as ... shoplifting, are explained in sexual terms, such as ... shoplifting being "kleptomania" caused by caused by women's inexplicable mental cycles tied to menstruation.\textsuperscript{748}

There is little concrete to write about this topic, save to reiterate some of the mythology that may have entered into judicial treatment of women offenders "of a certain age." In Chapter

\textsuperscript{746} Mary Lentz, "A Postmortem of the Postpartum Psychosis Defence" (1989) 18 Capital University Law Review 525 at 538.

\textsuperscript{747} Discussed in Edwards, supra note 297.

\textsuperscript{748} Klein, supra note 216 at 74.
4, I discussed Victorian ideas about menopausal mania. The twentieth century has seen a shift of stereotypes from the raging psychotic granny to the senile shoplifter - neither of which reflect the reality of middle aged women.

Scientific studies of twenty to thirty years ago seemed to support the idea that most women convicted of shoplifting were white, middle aged (51-60) and depressed. Of the younger women offenders, most were immigrants.\textsuperscript{749} Gibbens et al. believed that sexual frustration played an important part in shoplifting because many had "marital difficulties with sexual dysfunction."\textsuperscript{750} It is interesting that Gibbens et al. do not identify the source of this dysfunction; whether it originates with the female shoplifter, her spouse, or both.

More recent studies do not support the menopausal stereotype. A 1983 Canadian paper by Bradford and Balmaceda reports that, in a group of shoplifters referred for psychiatric assessment, the mean age of female offenders was 37. Of the twenty-one persons diagnosed as Depressive Neurosis, twenty were female.\textsuperscript{751} These authors noted a sharp contrast with Gibbens' results and point out

\begin{quote}
a general tendency to generalize these findings in the psychiatric literature and regard adult shoplifters as typically female and over the age of 40.\textsuperscript{752}
\end{quote}

Mary Russell in 1978 Canada, and Anita Kolman and Claudia Wasserman in 1991 United States all report that the average woman who joins a shoplifting support group is in her thirties, is


\textsuperscript{752} Ibid. at 251.
likely to be single and an immigrant. They may also suffer marital problems or social isolation which lead to depression. Kolman & Wasserman's figures disclose that only 9% of women shoplifters were between the ages of forty and sixty, while 48% were between twenty and twenty-nine and another 21% between thirty and forty. A 1992 study of Icelandic shoplifters revealed that, while there were differences in reporting and convicting this offence, 11.5% of women offenders were between the ages of fifty and seventy and almost 83% were between ten and twenty. As far as the psychopathological age group is concerned, these results are similar to the previous study. The focus of most papers on shoplifters who steal impulse or through compulsion, rather than need or greed, is on psychiatric or neurological causation. Kleptomania, a diagnosis of the DSM-III-R, is defined in the DSM-III-R as the recurrent failure to resist impulses to steal objects not needed for personal use or their monetary value. Increasingly this behavior is seen as a symptom of other underlying psychiatric disorders such as anxiety or eating disorders, obsessive-compulsive disorder, alcoholism, or drug abuse. 


Ibid. See also Gudjonsson, supra note 750.


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events. 756 Another woman with a twenty-year history of compulsive shoplifting "shortly after the birth of her first child." 757 Some might argue that, if you can't blame menopause, you can always fall back on postpartum depression or PMS. Whatever the cause, it can be blamed on hormones or psychiatric weakness. However, the typical shopper is similarly dismissed. … Another axiom, that shoppers are perimenopausal, is similarly challenged. 756 Bradford and Balmaceda describe a different reality:arguing that the Elizabeth Fry shoplifters' support group.

The above survey does not constitute an exhaustive survey of the literature on shoplifting. However, it does serve to explore the myth that the typical shopper is a woman with a twenty-year history of compulsive shoplifting. Other studies note that shoplifters are middle-aged and female. 758 One recent Canadian case exemplifies a number of these reported criteria. M, an immigrant woman, was charged with stealing a steak that she could have afforded to pay for. Her husband's main concern was, and always had been, for his own reputation and his family's. Her's was one of the more obvious cases for help that hopefully could be satisfied by the shoplifting behavior. Her's is similar to the more recent cases of postpartum depression or PMS. Whatever the cause, it can be blamed on hormones or psychiatric weakness. However, the typical shopper is similarly dismissed. … Another axiom, that shoppers are perimenopausal, is similarly challenged. 756 Bradford and Balmaceda describe a different reality: arguing that the Elizabeth Fry shoplifters' support group.

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Along with hormone assays and chromosome measurement, female criminals often have their environment and social factors taken into account in their criminality. However, biological explanations of male criminals are more prevalent in self-contained compartments. Despite this, old ideas linger. Chunn & Menzies record the description of a psychiatrist who examined an uncooperative 56-year-old woman charged with theft of $46.19 using a stolen credit card; according to him, she was a "cankering, demented, babbling old lady...". It is doubtful that a 56-year-old man would similarly be described.

C. THEORIES ABOUT MEN, AGGRESSION, VIOLENCE AND CRIME

Although similar theories have been described, the behavior of male criminals is rarely labeled as mad unless it is obvious. In contrast, women, if their behavior deviates from social stereotypes, are often assumed to be mad. At this point, I make no value judgment about advantages or disadvantages of being labeled mad. However, female criminals are rarely labeled as mad, whereas males are. I have talked about how female criminals may be labeled either mad or bad. Male criminals, however, rarely have the benefit of madness unless it is obvious as to be undeniable.

761 Chunn & Menzies, supra note 689 at 47.
I will first examine some research that has attempted to find a connection between hormone levels and competition, aggression and violence. Then I will compare these with a recent interdisciplinary study that takes a more holistic approach. On reading recent literature on this topic, I was immediately struck by a sense of déjà vu when I encountered a note in Lawrence Taylor’s work. He seems to be so keen to find simple genetic causes for crime, hostility and physical violence:

Most biological researchers have been concerned with finding a link between hormones and a range of behaviors from competitiveness to systems such as aggression and violence. Do XY men have different levels than XX men? Do homosexual males have lower levels than heterosexual males? Do pedophiles have lower levels than violent males? There is a gap between men’s behavior and hormone levels. The studies that correlate levels have been concerned with finding a link between men’s violence, but the real reason may lie more likely in the numbers of concurrent disciplines that interpret these terms such as aggression and violence. The same lack of precision or consensus about the meaning of terms was obvious in my reading on PMS and other women’s interpretations of words such as aggression and violence. The problem is exacerbated when I encountered a recent interdisciplinary study that takes a more holistic approach. On reading recent literature on hormone levels and competition, aggression and violence, I will compare these with a
assessment when the add detectionally label egressive has a "strong, perhaps even deterministic,
influence on the existence of antisocial conduct [in men]." 199


Brian A. Gladue, Michael Boechier & Kevin D. McCaul, "Hormonal Response to

Competition is... defined as an apparent intent to achieve or maintain a status
level. To Gladue et al.

This study posits a connection between dominance, rather than aggression, and T
levels. To Gladue et al.

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levels. To Gladue et al.
This differs from a more diffuse definition by Schiavi, who states that aggression may be abstracted in one context but not in another. For example, pushing and shoving may be aggressive in one context, but a make’s right to steal human beings as personal property (at 12) is usually a learned, highly ritualized, gender-specific... When young men lose control... it is usually a learned, highly ritualized, gender-specific...

Some biologists like Gladue see aggression as different from or an alternative to other forms of violence. Yet others fail to define what they mean by aggression. For example, aggression involves a heterogeneous grouping of phenomena involving behavioral, emotional, and motivational aspects. The term aggression covers a heterogeneous grouping of phenomena involving behavioral, emotional, and motivational aspects. The cumbersome definition by Schiavi, who states that aggression is dependent upon the context in which it occurs and on the people present rather than on the act itself. For example, pushing and shoving occurs and on the people present rather than on the act itself. For example, pushing and shoving may be abstracted in one context, but not in another. For example, pushing and shoving may be aggressive in one context, but not in another. For example, pushing and shoving...
Studies of prisoners tend to bear out some kind of correlation between T levels and violent behaviour. Barn et al., endocrinologists and psychiatrists, ask the fundamental question: Are men who commit murder and other acts of physical violence biologically different from non-violent men? They point out that alcohol abuse can affect hormone levels and that, since many violent criminals use alcohol, researchers must control for this factor. James Dabbs & Robin Morris, psychologists, look further than alcohol use to identify important variables and argue that socioeconomic grouping may affect a man's reaction to elevated testosterone. They treat elevated T as a risk factor for, not a cause of, antisocial behaviour. However, these authors did not separate violence from other antisocial behaviours which included "many sex partners" and "alcohol abuse." A value judgment determination that could be imbedded in prejudice.

Trends in bio-psycho-social correlates of violent prisoners' (1989) 7 Med. Law 60. See also Fenwick, supra note 770 at 419.

The most comprehensive and wide-ranging paper that I found on the topic of hormones, violence and prejudice is "Sex Hormones in Murders and Assassins" (1987) (3) Behavior. Scattered evidence on the position that violence is related to all levels of human functioning and may be linked to biology, personality and social norms. Shoham et al. take the position that violence is a multivariate approach that applied ideas similar to those articulated by Dabbs & Morris. [The etiology of violence is related to all levels of human functioning and may be linked to biology, personality and social norms.] Biopsychological Science 209.

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The authors postulate the idea of a "behavioural hierarchy" in which the relative contribution from each level varies. No behaviour is caused solely by biology or personality or environment, so that each pattern of behaviour has a "behavioural hierarchy" in which the relative contribution from each level varies for each pattern or behaviour. No behaviour is caused solely by biology or personality or environment. The relative contributions from each level increase with primary influences linked to each. For example, Matsubara et al., found that

1. The EEG results indicated imbalance in the limbic system which may be similar to hypopituitarism: close relations to the immediate family, and negative attitudes towards normal. If this idea is transposed to women, for many who are trapped in stereotypically passive role playing, they argue that one of the factors separating violent criminals from the rest of the population is never totally lacking.

2. They also investigate the neurological profile of violence, finding that impulsiveness seems to be related to a high probability of violence. Other parameters studied included EEG and endocrine hormone levels. They found the following composite profile of the violent prisoner: alternating energy of thalamic waves in the temporal lobes; high prolactin; boredom, tension, and hypochondria; and closer relations to his immediate family. The EEQ results indicated imbalance in the limbic system which may be similar to hypopituitarism.

3. They also study the influence of family background on violence but conclude that it is not the sole cause. They also found that in many cases the immediate family of the violent prisoner was disturbed or non-existent. PMS may provide a "legitimate" outlet for their feelings of violence and frustration.

4. Prolactin levels in women are increased in pregnancy and the post-partum period, and Matsubara et al. found that prolactin levels in pregnant women are higher than in non-pregnant women. They conclude that prolactin levels may be related to the occurrence of violence in women.

5. They suggest that high prolactin levels may be a factor in the occurrence of violence in women. They also suggest that prolactin levels may be related to the occurrence of violence in men.

6. They also suggest that prolactin levels may be related to the occurrence of violence in women. They also suggest that prolactin levels may be related to the occurrence of violence in men.

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15. They also suggest that prolactin levels may be related to the occurrence of violence in women. They also suggest that prolactin levels may be related to the occurrence of violence in men.
Possible connections between epilepsy, aggression and violence. A physical condition can be an excuse for violence or other crimes. In the next section, I will investigate at the moment, the criminal law may classify these people as insane if they try to use their.

What happens if the general propensity includes a tendency to suffer epileptic seizures?

A genetic propensity to violence and is therefore not guilty. When "this person, because of his family background and low intelligence, is unable to overcome much more straightforward to be able to say: "This person is insane and therefore not guilty" should a combination of the two constitute a defense or at least a route to mitigation? It is so that "rotten social background" and the "raging hormones" defenses are not enough by themselves. If the proponents of multivariate causation are accurate, what does this do to theories of criminal responsibility? Should more biological susceptibility provide an excuse for criminal behavior or must it be coupled with environmental and psychological triggering factors? How could these be measured? Where would the cut-off point be between culpability and excuse? It could this be measured? Where would the cut-off point be between culpability and excuse? If the proponents of multivariate causation are accurate, what does this do to theories of criminal responsibility? What is the relationship between epilepsy, aggression and violence? Why this approach has never been applied to studies of women prisoners is a mystery. It may be that simplistic ideas, coupled with deeply rooted stereotypes provide a more narrow focus. Why this approach has never been applied to studies of women prisoners is a mystery. It may be that simplistic ideas, coupled with deeply rooted stereotypes provide a more narrow focus. Why this approach has never been applied to studies of women prisoners is a mystery. It may be that simplistic ideas, coupled with deeply rooted stereotypes provide a more narrow focus. Why this approach has never been applied to studies of women prisoners is a mystery. It may be that simplistic ideas, coupled with deeply rooted stereotypes provide a more narrow focus. Why this approach has never been applied to studies of women prisoners is a mystery. It may be that simplistic ideas, coupled with deeply rooted stereotypes provide a more narrow focus. Why this approach has never been applied to studies of women prisoners is a mystery. It may be that simplistic ideas, coupled with deeply rooted stereotypes provide a more narrow focus. Why this approach has never been applied to studies of women prisoners is a mystery. It may be that simplistic ideas, coupled with deeply rooted stereotypes provide a more narrow focus. Why this approach has never been applied to studies of women prisoners is a mystery. It may be that simplistic ideas, coupled with deeply rooted stereotypes provide a more narrow focus. Why this approach has never been applied to studies of women prisoners is a mystery. It may be that simplistic ideas, coupled with deeply rooted stereotypes provide a more narrow focus. Why this approach has never been applied to studies of women prisoners is a mystery.
Most violent people do not have epilepsy. Similarly, most individuals suffering from epilepsy are not violent.

In earlier chapters I have described common attitudes and assumptions about epilepsy.

Between 529 and 522 B.C., King Cambyses of Persia, alleged to have epilepsy, killed the son of one of his servants without provocation or apparent motive. This is the earliest known connection between epilepsy and violence.

Between 529 and 522 B.C., King Cambyses of Persia, alleged to have epilepsy.

What is the origin of the perceived connection between epilepsy and violent crime? What is the reality behind the belief in a causal connection between epilepsy and violent crime? To retain their power, most myths must have at least a small seed of apparent reality within them. Just as violence behind the belief in a causal connection between epilepsy and violent crime, and concludes that epilepsy are capable of committing violent crimes. Reports that 50% of the population believes that people with epilepsy are violent. Fenwick cites an Australian survey that from seizure disorders are not violent.

From seizure disorders are not violent. Similarly, most individuals suffering from epilepsy or due to lack of knowledge and misunderstanding of the etiology of epilepsy, the public at large are often in error. In the core of many of these beliefs, the public at large hold by both medical professions and the public at large are often in error. In the core of many of these beliefs, the public at large hold by both medical professions and the public at large are often in error. In the core of many of these beliefs, the public at large hold by both medical professions and the public at large are often in error.
connection between epilepsy and violence. As they say:

Toward the end of this study, I will refer to the work of some feminists who deny any

connection between epilepsy and violence. They appear to be support in their rejection of the possibility of a causal

sociobiological disease, they question the reality of the effects of acceptance of

epilepsy. Because of their justifiable concerns about the effects of acceptance of

studies of XYY in prison inmates, they question the validity of results of studies of prisoners

and their presence of a causal link between inheritable violence and epilepsy. Like critics

called out prior to 1986, conclude that not one study substantiates the existence of a causal

has traditionally attached to epilepsy. Whiteman, King and Cohen, in an analysis of research

women have PMS. The same fears surface among researchers concerned about the stigma that

such a connection will further stigmatize and downgrade all women - because "almost all

connection between PMS and crime. One reason for this attitude is the fear that acceptance of

epilepsy, such investigators look

women to explain apparently aberrant behavior. This attitude also persists in the study of

between epilepsy and violence. I have noted several times that medical men look for causes within

question the biological determinism of Lombroso, a number of researchers still seek a connection

anomalous which are associated with criminality. Despite the rise of sociological theories that

propensity for criminal behavior, he also concluded that people with epilepsy exhibited various

- 328 -
different points in the epilepsy cycle and in different types of epilepsy. He identifies three major
violence when epilepsy per se. His recent papers examining aggression that may occur at
Fenwick notes that brain damage and social factors are more often causal factors of

epilepsy.

Fenwick who acknowledge biological and social components in the causation of violence in
the fear of stigma expressed by Whitman et al., I will here outline the views of writers like
is a profile writer on both medical and legal issues surrounding epilepsy. While keeping in mind
monthly mental cases. Curiously, Whitman et al. do not mention the work of Peter Fenwick who
women who have behavioural swings with PMT but who wish to avoid labelling all women as
violent. I have already discussed a similar dilemma encountered by those who would like to help
The problem lies in ensuring that all people with epilepsy are not deemed to be potentially
patients with epilepsy.

in a small number of unusual cases but stresses that these do not represent the vast number of
studies described by scientists like Peter Fenwick who acknowledge the existence of violence
productive. Such belief will not stop research designed to find a link, and thus in the face of case
refusal to believe in any relationship between epilepsy and violence will be ultimately counter-
complex, multivariate causal chain such as those described by Fishbein and Shoham. Dogmatic
and go need not remain constant; social roles need not be deemed "natural," if we accept a more
However, such inevitability exists only if we accept an either/or philosophy. The status

Ibid. at 422.

Ibid. at 198.
Types of aggression: (1) aggression caused by brain disease that causes seizures; (2) aggression directly related to seizures; and (3) interictal aggression - between seizures but related to epilepsy. 85

Patrick Fenwick, "Agression and Epilepsy" in Devinsky & Theodore, supra note 641, 85

...
A 52-year-old man with a long history of seizures woke one morning after a grand mal seizure to the symptoms of postictal psychosis. Fenwick gives a particularly violent example: A postictal violent episode can lead up slowly after a grand mal seizure. The sufferer may experience paranoid delusions and auditory hallucinations, similar in many ways to the symptoms of postpartum psychosis. Fenwick observes that postictal automatisms are associated with slow EEG activity in the theta range. He or she may become more violent if physical restraint is attempted. Fenwick confuses these with a person may push away or strike anyone who tries to interfere with his automatic state. If violence occurs during this phase it may be due to postictal psychosis. In the majority of the cases that come before the courts involve post-seizure confusion or having contributed to the trigger of violence, just as it may do in people without epilepsy.
by epilepsy but could also be caused by social and psychological factors, such as a violent family background. When these extraneous factors are taken into account, the connection between epilepsy and interictal violence is less clear. In a 1988 study, Herzberg and Fenwick found that those patients with epilepsy who showed violence were only minimally and intellectually violence is less clear. In a 1988 study, Herzberg and Fenwick found that those patients with epilepsy who showed violence were only minimally.
In Chapter 2, I examined myths and stereotypes in general. I will show in the next chapter that in a number of cases an excess of insulin has caused people with diabetes to injure those around them. In the links between diabetes and violence, although I was unable to find a criminological discussion of any increase or decrease in criminal tendencies, I was unable to find a criminological discussion of any crime committed by persons with epilepsy, while attention has been paid to other factors that might incorporate both sexes. Because it is so easy to point to physical causes for violent crimes has been no concerted effort to compare or test multivariate causation in experiments that few writers recognize multiple causation. The gap in logic.

facilitating criminal behavior. These opposing but oscillating views create inconsistencies and to mean. The prevalent view in the latter case is that environment is largely instrumental in determining (rules the face of women are often less likely to accept this argument with respect to nature versus nurture. However, those who are adamant that nature (philosophical Superimposed on mythologies of gender and abnormality of which are the two opposite connected with disease.

assumption is hard to break even when criminologists are dealing with behavior that could be crimes are committed by men. There is an assumption that men act from free will and this main focus of criminology has been on deviant behavior by men, since the vast majority of criminology which forms a bridge between science and applied law. It is only natural that the epilepsy. In this chapter, I have shown that these same myths have influenced the discipline of behavior, physiological and sociological research and, in particular, gender specific "disorders" and discussed the effect these myths have on the way scientists deal with topics such as deviant

In Chapter 2, I examined myths and stereotypes in general. In Chapters 3 and 4, I
In this section I plan to concentrate on the interaction of applied science, principally medicine, and applied law - as distinct from "pure" science and "academic" law. I will briefly outline why applied science matters in the context of court evidence, and why it does so especially to laypeople, to lawyers, and to the public generally.

In any adversary process, there is a tendency for lawyers to ask questions and then rely on the answers for support. This is reflected in the actual selection of experts, the way lawyers interact with them, and the way experts interact with them. There is no ready way for lawyers to acquire an informed primary level of understanding of the areas of law they are required to know about in cases involving the disorders that are the subject of this study. In the next section I will show that both lawyers and scientists are aware of this problem, and that the role of expert evidence is often limited by the nature of the questions lawyers ask, and by the nature of the answers they receive.

Evidence is presented in court. Few of these links to gender issues are conscious or deliberate. Most women are conscious of a number of deficiencies in the way expert evidence is presented in court. The sex of the expert witness and the sex of the lawyer are significant factors in the quality of evidence presented in court. In this case of PMS and people with epilepsy, researchers seem to find it easy to assume violent tendencies, perhaps because of the absence of a mythological framework surrounding the subject of epilepsy, as such an assumption is not so easy with respect to that case of men, women with PMS and people with epilepsy.
and applied because, on reading various papers about the difficulty of applying scientific concepts in a legal setting, I have noted marked conceptual differences between academic and applied research in both fields. Researchers in pure science purport to seek knowledge for its own sake; they create a study and choose empirical data by means of cases, statistics, etc. The manner in which they create a study and choose empirical data by means of cases, statistics, etc. differs from that of academic legal researchers, who also ask questions or state a viewpoint about specific subject matter. They create a study and choose empirical data by means of cases, statistics, etc. Consequently, researchers in pure science purport to seek knowledge for its own sake; they want to know and explain. To this end, they formulate a question or state a hypothesis. To verify their theory, they create an experiment and construct facts by collecting empirical data produced through measurement by sophisticated instruments. They then analyze and evaluate the data and draw conclusions - scientific "facts" deduced from analysis.

Academic legal researchers, in contrast, are currently building with an approach that differentiates the difficulty of applying scientific concepts in a legal setting. For deeper discussion about scientific methodology, see John Ziman, "Rules and Norms" in An Introduction to Science Studies.
The use of expert witnesses in court is not as straightforward as in law reform or legal research. The question of which is open to the researchers. Even if they exhaustively review all sources, they are bound to give more weight to some than to others, whether they or not they are attempting to be objective and neutral. For example, a researcher may have a bias towards the conclusions of a particular decision maker or text writers because of personal relationships, because of similar political leanings or because of general respect accorded to these people by other legal and political decision makers. Forensic scientists also seek new knowledge, but for a more utilitarian purpose, be it a new prescription for action. Applied scientists also seek knowledge, but for a more utilitarian purpose, be it a new prescription for action.
reaching philosophical conclusions. In the criminal process, their research is directed toward a concrete final goal—determination of the guilt or innocence of an accused. This means that applied lawyers have fewer options than applied scientists; they lack the freedom to say, "I don't know." Obviously, conflicts with law's need to know now.

It is important to distinguish trained forensic scientists who raise "reasons to be" answers, from other scientific experts who have little or no court experience. A number of them may well conduct research for non-trial purposes, such as Royal Commissions, educational seminars, and independent papers. However, when they are carrying out their principal role within the trial process, their research is directed to a "yes" or "no" disposition of a particular case.

When legal and medical experts communicate, there are many reasons why they may be at cross purposes, for example, language, perceived roles of their professions, perceptions of their own roles and those of medical experts (and vice versa), methodologies and the very values of their profession. This is not so for the non-forensic expert who is the focus of this section.

Denis Barrett in "Scientific Evidence in an Adversarial System With a Lay Audience: A Problem for Justice?" (1991) 31(2) J. Forensic Sci. Soc. 271, comments that scientists can also say "we may know in a few years' time," or "we'll probably never know." Such testimony may know in a few years' time," or "we'll probably never know." Such testimony obviously conflicts with law's need to know now. Such testimony obviously conflicts with law's need to know now.

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It is important to distinguish trained forensic scientists whose raison d'être is to answer questions for court purposes from other scientific experts who have little or no court experience.
As I will note below, when gender issues are superimposed on an already confused forum, the results may not always accrue to the advantage of women.

The sole commissioner lacked any scientific experience and had no knowledge of the type of Australian Royal Commission on Agent Orange, which tried to assess harm to Vietnam veterans.

One vivid illustration of misunderstandings that can arise comes from the fact that language has developed and is presented in different forms and using different forms of reasoning with different interpretations, and (2) the use of specialized vocabularies. Each scientist is familiar with different everyday words (for example, mental abnormality) and so are lawyers.

Richard Shepherd has identified two particular problems that surface when medicalization, that is, employing a medical exclusive utter, leads to a lack of clarity and language of communication between disciplines. These difficulties are increased by language of communication between disciplines. The following will illustrate some difficulties that arise in court settings when there is no common area of expertise. As I will note below, when gender issues are superimposed on an already confused forum, the results may not always accrue to the advantage of women.
inquiry appropriate to scientific matters. As a result, the government accepted a report that was
full of scientific errors.803

Another example occurs in the application of welfare legislation as it relates to the "handicapped." In British Columbia, an applicant for the extra benefits provided under the "handicapped" category must show that his condition is apparently permanent; that it requires extensive assistance or supervision for daily living; or that he incurs extraordinary expenses.804

Application (personal knowledge)

In one case, a woman suffering from severe arthritis and clinical depression was denied the extra $200 available under GAIN for handicapped because the doctor was unwilling to state that there was no known medical therapy that could improve her medical condition. All that could be done was to maintain her present ability to function at an optimum level. The doctor, as part of his treatment for depression, did not want his patient to lose hope that medical solutions are inadequate in such cases. Thus the legal definition of a simple word is at war with medical and social definitions. In this case, the doctor must educate the advocate about medical solutions and social implications. They may also be unconsciously unwilling to admit that the disease of an illness, but the advocate must also educate the doctor about the legal definition of "handicapped." They also want to protect patients against what they see as the negative connotations of the label "handicapped." They usually acknowledge that the disorder is apparently permanent but wish to encourage patients to take a positive view of their condition by denying their need for extensive assistance. They also want to protect patients against being denied their need for rehabilitation in their reports. They usually acknowledge that the disorder is apparently permanent because of his condition or application for superannuation or his income exceptionally low. In British Columbia, an applicant for the extra benefits provided under the "handicapped" category must show that his condition is apparently permanent; that it requires extensive assistance or supervision for daily living; or that he incurs extraordinary expenses.805

For example, in one case a woman suffering from severe arthritis and clinical depression was denied the extra $200 available under GAIN for handicapped because the doctor was unwilling to state that there was no known medical therapy that could improve her medical condition. All that could be done was to maintain her present ability to function at an optimum level. The doctor, as part of his treatment for depression, did not want his patient to lose hope that medical solutions are inadequate in such cases. Thus the legal definition of a simple word is at war with medical and social definitions. In this case, the doctor must educate the advocate about medical solutions and social implications. They may also be unconsciously unwilling to admit that the disease of an illness, but the advocate must also educate the doctor about the legal definition of "handicapped." They also want to protect patients against what they see as the negative connotations of the label "handicapped." They usually acknowledge that the disorder is apparently permanent but wish to encourage patients to take a positive view of their condition by denying their need for extensive assistance. They also want to protect patients against being denied their need for rehabilitation in their reports. They usually acknowledge that the disorder is apparently permanent because of his condition or application for superannuation or his income exceptionally low. In British Columbia, an applicant for the extra benefits provided under the "handicapped" category must show that his condition is apparently permanent; that it requires extensive assistance or supervision for daily living; or that he incurs extraordinary expenses.
Both lawyers in the court setting and doctors in the diagnostic setting see themselves as seekers after "truth." This, however, is not always the way in which they see each other. As one physician/writer has put it, lawyers look for proof rather than truth. He believes that for lawyers, the truth is "unessential incidental;" what is important is proof, or even more important, whether the other side can provide proof. 806 Another scientist believes that lawyers look for "proof." Lawyers, he says, are not "the neutral expert." 807 Humphrey, supra note 802 at 307.

Whether they want the role of or not they are denied, sometimes against their will, into adversarial systems, lawyers have developed a cynical view of the law and lawyers, especially in the context of the adversarial system. They have begun to question whether they believe in the "whole truth," many scientific experts have is necessary to complete their education. Because they feel that they are often denied the opportunity to convey what they believe to be the "whole truth," many scientific experts have tended to disease about what information and justice about issues beyond their knowledge, but they lend to disease about what information both lawyers and scientists agree that the role of the expert witness is to educate judges to new knowledge. 808

"Conservative and backward-looking to precedent and scientists as "radical and forward-looking" communications difficulties are exacerbated by differences in outlook. He sees lawyers as important whether the other side can provide proof. 809 Another scientist believes that lawyers the truth is an "unessential incidental." What is important is proof, or even more important, whether the other side can provide proof. Lawyers look for "proof," he says, lawyers look for "proof." He believes that for one physician/writer has put it, lawyers look for "proof." The neutral expert. The neutral expert. A plausible threat to justice. 809 For interesting papers that compare the roles of expert witnesses in inquisitorial and adversarial systems, see M. N. Howard, "The Neutral Expert: A Plausible Threat to Justice," (1991) 3 Forensic Sci. Rev. 29.
allexpertshavesomeaxetogrindandthatlawyerscanalwaysfindatleastoneexpertwitness
tohelptheir sidewin. I am sure that this is an accurate reflection of the attitude of a
number of litigation lawyers. Some lawyers and scientists deplore the tendency of some
lawyers to encourage witnesses to testify beyond their areas of expertise. Others point
out the tendency of some lawyers to extrapolate the results too far to stretch clinical
definitions in tragic cases. Some lawyers and scientists deplore the fact that a number of experts are willing to
help their side win. All experts have some axe to grind and that lawyers can always find at least one expert witness
who is biased in one direction or another.
though his qualifications be mediocre. If he is ill-informed upon facts and hasty in opinions, he will seldom escape discomfort. (1) "Expert" testimony is communication with a lot of restrictions which make the job even more difficult. (2) Failure to hold (common in the adversarial system) is a more effective way to reach a conclusion. Truth will win out because the other side is doing the same. Spencer would argue that peer review beliefs will be helpful to his case and to deal with what he may not like in his own way. (3) In public, "truth" favors in favor of an adversarial system that can expose scientific fallacies. A few lawyers who believe firmly in the effectiveness of cross-examination as a tool for their own cases, "expert" testimony is communication with a lot of restrictions which make the job more difficult. (4) In opinion, he will seldom escape discomfort. (5) For a detailed critique of the quality of forensic science laboratories, see James E. Stanko. 817 Alistair R. Brownlie, "Expert Evidence in the Light of Preece v. H.M. Advocate" (1982) Med. Sci. Law 238 at 239 quoting from a 1962 textbook by Witty and Stallworthy. 818 "Serious...". 819 Those who believe that the adversarial system is flawed in its handling of expert testimony cite (1) potential bias of expert witnesses; (2) lack of resources available to the expert not being presented with all the data; (3) the restrictions on the expert's ability to give freely expert opinions; (4) the expert not being presented with all the data; (5) the restrictions on the expert's ability to give freely expert opinions; (6) the expert not being presented with all the data. (7) The restrictions on the expert's ability to give freely expert opinions. (8) The restrictions on the expert's ability to give freely expert opinions. (9) The restrictions on the expert's ability to give freely expert opinions. (10) The restrictions on the expert's ability to give freely expert opinions.
and ethical issues of their profession. I have cited some of their papers in this section. Although
many women work in forensic laboratories and in medicine, not one of these writers is a woman.

A Canadian criminologist, C.H.S. Jayewardine, could be either male or female, comments
that forensic science operates as an adjunct to the Criminal Justice System and, therefore,
or operates within a reality dominated by the idea that "man" is endowed with free will. He or
she argues that forensic scientists must contribute their own viewpoints to the legal
definition of reality.

This argument applies even more strongly to the viewpoints of women. Margaret Lowe
Benston, who combines work on computing science with women's studies, points out that
women who are part of the forensic science system are confined within its world view and when
they speak they must speak in its accepted language. Women who are the object of scientific
discussion in court have little standing or voice. Most of them lack the funds to hire an expert
who would be able to speak on their behalf.

Even if the women could hire their own expert, they would still be completely
dependent on their personnel. The expert is still the one defining the terms of the
problem and, particularly, the terms of any solutions. For a scientist, as essentially
dependent in addition, science, as presently practiced, has much to do with domination and control.

The ideal characteristics for a man in this society and the characteristics required
Benson, who combines work on computing science with women's studies, points out that
women whose viewpoints are ignored have fewer strengths to contribute.

Margaret Love,


Law & Technology 109.

see Randolph N. Jonakait, "Forensic Science: The Need for Regulation" (1961) 4 Harvard J.

Law & Technology 109.
Although there is still a long way to go in presenting women’s reality to Canadian courts,

Carol Smart notes that the law remains a site of struggle and that women’s accounts are

permanently at the edges being swept away.

In summary, the role of the expert witness in the criminal trial process. However, if women’s reality is filtered through the lenses of male scientists and lawyers, and judges who are present, or at least validate, these viewpoints in court, much is lost in the translation, especially when they believe they are speaking the same language.

In summary, the role of the expert witness is vital to the criminal trial process. However, if women’s reality is filtered through male scientists and lawyers, and judges who are present, or at least validate, these viewpoints in court, much is lost in the translation, especially when they believe they are speaking the same language.
in distortion of women’s reality by educating experts and persuading them to check their methodology and conclusions for gender bias.

Women must assist doctors and scientists to redefine their concepts to incorporate women’s experience. Smart argues that "the legal forum provides an excellent place to engage in [the] process of redefinition." But, if medical experts must give their opinions in court, redefinition must start in the doctor’s consulting room and remain consistent as it is translated into the legal system. In the end it is to be hoped that justice can be carried out by a system that listens directly and gives credence to women’s own voices.

In this section I have referred indirectly to criminal defences. In the next, I will examine the idea of criminal defences in more detail.

IV. CRIMINAL DEFENCES: THE BODY AS EXCUSE

Richard Delgado, a law professor at U.C.L.A., has written an interesting analysis of the use of a defence of severe environmental deprivation to excuse or justify criminal acts committed by people with a "Rotten Social Background" (RSB). Although his paper concentrates on environmental, rather than biological factors, much of what he has to say is applicable to defences such as PMS and his paper provides a useful framework for the following discussion. Like most of the defences discussed in the next chapter, RSB is not accepted on its own as a complete defence even though researchers have proved a strong correlation between environmental deprivation and crime.

825 Ibid. at 165.

Criminal responsibility revolves around the ideas of free will and rational action. Men, but not always women, are assumed to act by rational choice unless they can show otherwise. However, when an accused is able to show that factors beyond his control have prevented him from exercising free choice, most juries would be reluctant to punish them. For example, should a normal law-abiding citizen be punished for assaulting someone while unconscious of her actions due to some chronic or acute illness? Surely such a factor should excuse, or at least mitigate, criminal responsibility. "Responsibility," therefore,

refers to the defendant's capacity to appreciate the criminality of the conduct (i.e. cognitive-emotive capacity) or to conform the conduct to the requirements of the law (i.e. volitional capacity).

Many scholars have written in great detail about the nature and application of various criminal defences ranging from those that they classify as justifications (such as self-defence) to those they define as complete or partial excuses (such as insanity and necessity). An accused can rely on a defence of justification only when the social good that is the focus of the action outweighs the evil produced by the action.

I do not believe that any of the scenarios presented in this study would fit the justification model. In theory, it could be argued that the social good of freeing a poor, ostracized, teenage mother from the care of an unwanted child is greater than the evil of letting the baby die at birth. This idea may have been behind the ready acceptance of a medical model for infanticide in an era when the life of a newborn was given little value. It could also be argued that a woman may be justified in reacting with violence when environmental and social conditions are such that they

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827 For further discussion of criminal responsibility see J. Ralph Lindgren, "Responsibility Revisited" 6 Law & Philosophy 89.

828 Delgado, supra note 826 at 15.
drive her to such rage and despair that she is unable to control the effect of her hormones. The social good that might be derived from recognizing such a justification would be the recognition of the poor position of a number of women in our society. However, it is all very well to theorize but it is unlikely that justification would be a practical argument to put forward in this context.

Since the voluntary choice model is the one widely accepted by those in the criminal justice system, I will confine the rest of this section to discussion of possible excuses. Delgado cites Bazelon J. in United States v. Alexander who, unlike his brother judges, would have allowed evidence of the black defendant’s socially deprived and troubled background as relevant to his ability to control his behaviour. He declared that the "law’s aims must be achieved by a moral process cognizant of the realities of social injustice." He believed that society would ultimately benefit if this type of evidence were exposed in court.

However, before the public can appreciate the "realities of social injustice" as it pertains to crimes committed by women, they must be able to appreciate these realities from a female point of view. If this were possible, perhaps PMS could eventually be removed from the disease to the social model. From a practical point of view, the disease model is much easier to implement as it is more readily accepted in court. Even the BWS defence concentrates on weakness and disorder within the individual woman as much as the criminal conduct of her abuser.

The disease model denies women the dignity of being viewed as independent rational actors. While it may produce a short-term gain for a small number of women, it perpetuates the

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830 Ibid. at 386.
notion that they are so constituted that it takes very little for them to lose their ability to make free choices. This notion may well have some foundation in fact, because for centuries women have been denied the right to make any choices at all without referring first to a man in authority over them. It is only recently that a few women have had the means to become economically and personally independent. No wonder they are reluctant to promote defences that might push all women back to the inferior status that they have been struggling against.

Delgado speaks about the "principle of personhood" which states that the law should allow all people to act like humans. People in power within mainstream society have not always applied this principle to women, the poor or people of colour. It is not so long ago that black people were slaves and women were denied the legal status of "persons." If certain groups are not treated like persons, should they have to meet the same standard of responsibility as those with full autonomy - usually white men? Women have fought to become persons in law but are not fully accepted as equal persons in most societies. Gender-specific defences, even if scientifically justified, run the risk of working against the goals of independence and substantive equality for which feminists continue to strive. An RSB defence, based on environment, would raise consciousness about issues of poverty and mass hopelessness. A PMS defence, based on biology, would mask environmental factors unless it was constructed so as to incorporate them.

Delgado lists a number of criminogenic factors that apply to the RSB defence, such as poverty, unemployment, inadequate education, alternative value systems and the like. Some of these factors could also apply to women, especially to women of colour.

The poor, especially the minority poor, are rejected and scorned by a society which still clings to myths attributing failure to individual shortcomings.831

831 Delgado, supra note 826 at 34.
The myths pertaining to women and "weak" men also concentrate on individual shortcomings such as insanity and diminished mental capacity.

Traditional defences that rely on an abnormal state of mind include insanity, automatism, lack of mens rea and provocation, the last being only a partial defence. As these defences have been extensively discussed by other scholars, I will merely summarize important points, especially with respect to women's issues. As Canadian law now stands, in the absence of a gender-specific charge such as infanticide, a woman who seeks to use a defence based on biological abnormality must either plead mental disorder, automatism, or lack of specific intent. (Unlike the U.K., Canada has no statutory provision for diminished responsibility.) Alternatively she may seek mitigation of sentence because of her mental condition.

The Canadian mental disorder (previously insanity) defence codified in Section 16 of the Criminal Code leads to an acquittal if an accused lacks the cognitive ability to comprehend the consequences of her actions or know they are against the law. It does not cover irresistible impulse or lesser degrees of mental impairment. Psychoses caused by postpartum illness or PMS could possibly come under Section 16 since the defence is not limited to diseases of the mind but extends to diseases that affect the mind. Therefore, even if the medical community does not classify a disorder such as PMS as a disease of the mind, it could be so classified in law. (See discussion about diabetes and epilepsy in Chapter 6.)

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832 For example, in the context of P.M.S., see McArthur, supra note 71. I will more fully discuss particular applications of specific defences in Chapter 6.

833 McArthur, supra note 71 at 852.
If conditions such as PMS are legally classified as diseases of the mind, it is unlikely that they can be used to put forward the defence of non-insane automatism. \textit{R. v. Rabey}\textsuperscript{834} indicates that, if these conditions have an internal cause such as hormone deficiency, rather than an external cause such as concussion, the court would have to make its decision within the framework of insane rather than sane automatism. McArthur suggests that

a creative defense counsel should be able to mount a challenge to \textit{Rabey} by questioning the applicability of its social policy concerns to premenstrual women [since they] can adapt their lives to minimize premenstrual effects [if they seek treatment].\textsuperscript{835}

However, the same argument could be applied to psychomotor epilepsy. There is no indication that the courts are presently willing to allow the defence of non-insane automatism for that condition.

However, this area of law seems to be driven largely by policy (reluctance to free unconditionally those who may re-offend if not treated). Application of such policy is often inconsistent and may appear ludicrous to a lay observer. Why, then is epilepsy defined as a disease of the mind and diabetes is not when they might both lead directly or indirectly to the same criminal behaviour?\textsuperscript{836} Why should crimes committed during sleepwalking be excused because of sane automatism when there is a possibility of recurrence? Why is a man who murders his mother-in-law after driving across town in a state of somnambulism not suffering


\textsuperscript{835} McArthur, supra note 71 at 855.

\textsuperscript{836} Discussed further in Chapter 6.
from a "disease of the mind" in law⁸³⁷; while a person with epilepsy who unconsciously drives half a block before crashing into a lamp post is labelled "insane?"⁸³⁸

Those writers who agree that the law should provide some kind of relief for sufferers from conditions like PMS do not agree on the proper solution. Osborne believes that

Diminished capacity or responsibility is the preferred option because, unlike insanity and automatism, it does not carry the risk of indefinite confinement and, unlike PMS as a mitigating sentence factor, it is not merely a discretionary judicial matter.⁸³⁹

McArthur feels that mitigation of sentence is "an attractive compromise for courts faced with conflicting medical views on premenstrual effects, and the conflicting needs of the accused and society."⁸⁴⁰

Chait argues that

"forcing" the symptoms of PMS to fit the mold of the insanity model is likely to have the effect of dredging up old myths and stereotypes about the inherent biological weakness of women.⁸⁴¹

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⁸³⁸ For a detailed comment on Parks, see Isabel Grant & Laura Spitz case comment in (1993) 72 Can. Bar Rev. 224. For a discussion of cases involving epilepsy, see Chapter 6.


⁸⁴⁰ McArthur, supra note 71 at 856. See also Candy Pahl-Smith, "Premenstrual Syndrome as a Criminal Defense: The Need for a Medico-Legal Understanding" (1985) 15 N. Carolina L.J. 246, who agrees that mitigation is the best choice among present remedies.

⁸⁴¹ Chait, supra note 44 at 286.
She prefers the defence of diminished responsibility. She also points out that "sentencing rules allow the greatest individual consideration of a defendant, since the court does not sentence the act committed but sentences the whole person."\textsuperscript{842}

Surely it is better to take the whole person into account before conviction. If so, this would have to be done by introducing evidence at trial about the reality of women's lives as is done with respect to BWS\textsuperscript{843}; or it would necessitate the introduction of gender-specific crimes or defences. Osborne leans towards the latter solution and believes that criminal law should be creatively realigned to become "responsive to what might be a significant factor in female criminality." She continues

As Boyle et al., indicate, rejection of decontextualization is one of the major aspects of the feminist method in those spheres in which gender is very material. If it is determined that premenstrual syndrome is a relevant factor in the determination of criminal responsibility, then perhaps a new legal category should be created along with an appropriate legal response such as short-term, periodic confinement with the option of treatment if an effective one can be established.\textsuperscript{844}

I have used PMS as an illustration of one "disorder" that could fit into existing defences or might be suitable for the construction of a new gender-specific defence. Much of what I have said could apply to the theoretical defences I have postulated for male "disorders." I will discuss these in more detail in Chapter 6.


\textsuperscript{843} See R. v. Lavallee, supra note 14.

For a comparison of the PMS with the battered-woman's syndrome defence, see Joann D'Emilio, "Battered Woman's Syndrome and Premenstrual Syndrome: A Comparison of Their Possible Use as Defenses to Criminal Liability" (1985) 59 St. John's Law Rev. 558.

\textsuperscript{844} Osborne, supra note 838 at 179.
Construction of a new defence that will not ultimately be harmful to women must take into account current knowledge and acceptance of women's reality, adherence to old myths, level of scientific knowledge about biological and psychological factors influence free will (in men as well as women), willingness of those in power to listen to new ideas and implement them. Recent changes to Canadian sexual assault law occurred after lengthy debates in Parliament and in committee. Many women, M.P.s and representatives of women’s groups were able to have their voices heard and their experiences validated. Such was not the case in the Congressional committee hearings in the U.S. into a similar issue, probably because that chamber is overwhelmingly male. It remains to be seen whether the Canadian amendments will help women to educate those in the criminal justice system about the reality of events such as date rape or whether evidence that the law now excludes will still gain entry through some as yet unseen back door. We should watch the application of the new laws closely in order to determine whether the creation of a gender-specific PMS defence is likely to be an exercise in futility.

Even if such defences are desirable and practical, what should be done about disposition? This is the policy question that drives many of the above defences. Delgado, in the context of the RSB defence, quotes John Hospers as follows: "It is amost inevitable that the prisoner will be considered "unimproved" or "unrehabilitated" until he shares the values of the person treating

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845 Sections 273.1 and 273.2 of the Criminal Code.

846 For example, see debates over second and third readings of Bill C-49 which introduced a definition for "consent" in cases of sexual assault (Hansard, April 8 and June 15, 1992).

847 For example, the hearing before the Select Committee on Children, Youth, and Families: House of Representatives: One Hundred and First Congress, Second Session, June 28, 1990 - Subject "Victims of Rape."
him. 848 How would this affect the treatment of a PMS offender? Would a therapist refuse to consider her "improved" until she became traditionally passive and compliant? Would a therapist recognize the significance of factors such as domestic oppression in designing a therapeutic program? Does existing hormone therapy achieve its goal or does it merely mask societal causes and suppress justifiable reactions in many women to unbearable backgrounds and living conditions?

Many questions, both legal and social must be asked and answered before it is possible to come to an informed opinion about the desirability of gender-specific defences. In the next chapter I will examine what case law I have been able to find and will try to reach conclusions about the outcome, under current law, of the hypothetical cases presented at the start of this study.

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848 Delgado, supra note 826 at 74.
CHAPTER 6 - THE APPLICATION OF BIOLOGICAL DEFENCES - MYTH AND REALITY

I. GENDER-BASED "DEFENCES" - INQUIRING ABOUT "WHAT IS" AND WHAT "SHOULD BE."

I started this thesis with a quotation: "to inquire about what may be, is the best way to understand what is." I have come to realise that this seemingly simple statement can lead to all manner of circular arguments. It would be just as easy to state that, in order to formulate what may be (or what should be), one must first understand what is. How can I speculate about what "may be" without first inquiring about "what is?" How can I inquire about "what is" without some understanding of present reality? How can I understand without some speculation about what "may be?" and so on.

Rather than bog down in a philosophical morass, I will examine what case law I have found on gender-specific issues and discuss it in the light of information accumulated in the previous chapters. Since infanticide provisions contain the only legislative recognition of gender-specific biological factors as grounds for mitigation of penalty, I will reverse my previous order of discussion and deal with infanticide before discussing PMS. By comparing jurisdictions that have such provisions (Canada and England) with one that has not (the United States) I hope to reach some conclusions about the desirability of retaining some form of statutory protection for women who kill their babies. Then I may, or may not, be able to extrapolate these conclusions to cover situations where women have raised PMS as a factor for the court’s consideration. Finally, in dealing with female "defences," I will briefly refer to cases in which menopause has been raised as a ground for mitigation.

840 Supra, note 1.
There is very little in mainstream law reports about cases based on female biological issues; there is even less about male biology. Therefore, what I write about male-specific "defences" will be very sparse and probably speculative. In contrast, a lot has been written by judges and legal academics about defences based on epilepsy and diabetes. The reason for such disparity is unclear. All of these defences rely on biology, all are subject to some degree of medical uncertainty and all involve issues of voluntariness and responsibility. Do journals like the All England and the Dominion Law Reports deliberately steer clear of cases involving sexual biology, or are these cases considered "fringe" elements not suitable for serious analytic consideration? I have noted that medical concepts receive legitimation by inclusion in sources such as the DSM or by discussion in prestigious journals such as The Lancet. Similarly, legal concepts receive legitimation by inclusion in established law reports and by discussion in mainstream journals such as the Canadian Criminal Law Quarterly or The Harvard Law Review. Since printed law reports are still the main source of precedent, the absence of gender-based cases means that judicial reasoning on issues such as PMS must be conducted largely on an ad hoc basis unless counsel manage to root out the few cases that exist from their obscure hiding places in unreported judgments.850

Before considering cases, I should stress that the use of the word "defence" is misleading in the context of past criminal trials. In no case has postpartum illness, PMS or menopause provided a complete defence. Yet many academic articles on the topic of women's biology and

850 Computer data bases such as Quicklaw and Lexis have increased the scope of available precedent. However, the subject matter of these sources is limited for many researchers by their expense and by the nature of their programming. For example, when I searched the phrase "premenstrual syndrome" and the word "premenstrual" on Quicklaw, I was unable to find directly a case that discusses this topic.
crime talk about the infanticide "defence" or the PMS "defence" as if they would allow women to go free with no responsibility for their actions. In fact, the infanticide provisions are really a statutory form of mitigation for murder. The PMS "defence" is really a common law form of mitigation of sentence.\textsuperscript{851} Thus these so-called "defences" have philosophically more in common with provocation than with complete excuses.\textsuperscript{852} They allow for a reduction of penalty, not an acquittal. In practice, in the case of women, the accused often goes free, but instead of supervision by a jailer she must submit to supervision by a doctor, especially if the crime involved violence to a person. In this way the alliance between medicine and law continues after the court case is over.

A. FEMALE "DISORDERS" IN THE COURTS

(i) INFANTICIDE AND RELATED CASES

In this section, I will first examine the provisions in the Canadian Criminal Code that deal with infanticide and discuss the difficulties they present to judges and scholars who attempt to find a logical pattern in their formulation and application. Secondly, I will discuss individual cases, with particular attention to the differences that occur when the Crown proceeds by way of a charge of manslaughter rather than infanticide; for example, length and type of sentence. Within this discussion, I will note (1) typical examples of neonaticide by young girls and infanticide by older women to determine whether they follow separate patterns; and (2) cases in

\textsuperscript{851} Or in the case of homicide in England, a statutory form of mitigation due to diminished responsibility.

\textsuperscript{852} Unless otherwise stated, when I do use the word "defence" in connection with infanticide, PMS, etc. I will be using it in a broad sense to incorporate mitigation that is so extensive that it avoids incarceration and imposes only probation or medical supervision.
which the trial judge has used the criteria of infanticide to extend mitigation to mothers who have killed children who were older than twelve months. Next, I will compare the Canadian situation with that in the United States where there is no statutory offence of infanticide. Finally, I will analyse a number of critiques of postpartum defences and infanticide legislation in order to highlight the possible dangers of abandoning the present statutory provisions.

Statutory Provisions

Since the starting place of any Canadian judgment on infanticide must be the wording of the infanticide provisions of the Criminal Code, I will first refer to analytical difficulties caused by the format chosen by Parliament. Instead of formulating a special gender-based defence to the crime of murder, legislators followed the English route of creating a new crime that is a gender-based species of culpable homicide. The analytical difficulties stem from the fact that this new crime incorporates many elements of a traditional defence, thus creating confusion and overlap between the elements of actus reus and mens rea. Some of these difficulties have arisen because of Parliament’s "band-aid" approach to dealing with deficiencies in the original infanticide section passed in 1948, some of which had been recognized in England ten years before in the 1938 Infanticide Act.

853 Much of the following was formulated after discussions with Christine Boyle and Isabel Grant, during their preparation of the infanticide section of The Law of Homicide, forthcoming Carswell, 1994.

854 See page 307 above for the wording of section 233 of the Code that sets out the present elements of infanticide. This section is an adaptation of the 1948 section which read: A woman who by a wilful act or omission causes the death of her newly born child shall be deemed not to have committed murder or manslaughter if at the time of the act or omission she had not fully recovered from the effect of giving birth to such child and by reason thereof the balance of her mind was then disturbed, but shall be deemed to have committed an indictable offence, namely, infanticide. [S. 262(2)]
McRuer J. in *R. v. Marchello*855 pointed out anomalies in trying to apply the 1948 provisions. Since the Crown has to prove all the elements of a crime beyond a reasonable doubt, prosecutors had to establish (a) that the accused had not recovered from the effects of childbirth; and (b) that she was mentally disturbed - both elements that would normally be raised by the defence in answer to a case of intentional homicide. This led to the ridiculous position that, if an accused could raise a reasonable doubt about her *lack* of mental disturbance (that is, produce evidence to show that she was mentally healthy), she would be acquitted.

For example, X kills her baby at birth but knows what she is doing and has good reasons in her mind for killing it. If the Crown were to assume mental disturbance and charge her with infanticide rather than manslaughter or murder, she could agree with the Crown that she has not recovered from the effects of giving birth but argue, in defence, that her mind was not in the least disturbed and that she intended to kill (that is, she had the *mens rea* for murder). If X were charged only with infanticide, she would have to be acquitted. And, as McRuer J. points out, she could not thereafter be accused of murder or manslaughter because of the rules of double jeopardy. This is an extreme example and unlikely to happen in practice. However, it creates a theoretical absurdity.

In answer to McRuer J.'s criticisms Parliament, instead of reformulating the law of infanticide, tacked on a definition of "newly born" as a person under the age of one year,856 and added what is now Section 663 which provides:

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855 [1951] 4 D.L.R. 751, 100 C.C.C. 137 (Ont. H.C.). McRuer J. also pointed to the lack of a definition of "newly born" and found that a four and one-half month old infant did not fit the common-sense meaning of that phrase.

856 Section 2, Criminal Code of Canada.
the death of a human being by means of an "unlawful act" and where the unlawful act is such
"as any reasonable person would inevitably realize must subject another to the risk of at least
some harm"\(^{63}\) and where the unlawful act is also dangerous.\(^{64}\)

With respect to infanticide, de Villiers asked a question that has plagued previous legal analysts:

If it is not necessary for the Crown to prove the two elements mentioned in paragraphs (a) and (b) of S. 663, then why are they contained in the definition of infanticide in S. 233?

De Villiers decided that the elements of mental disturbance set out in Section 233 are relevant only when the accused has been charged with murder and the evidence at trial allows the jury to bring in a verdict of infanticide. He concluded that

[t]o secure a conviction it is therefore sufficient for the Crown to prove that she caused the death of her child by an unlawful act amounting to a wilful act or omission, whether or not she was fully recovered from the effects of giving birth to the child and whether or not the balance of her mind was disturbed. The effects of the child’s birth upon the accused and her mental equilibrium are simply not in issue.

If this reasoning were to stand it would mean that, where a mother kills her new born child, the only difference between the burdens of proof in manslaughter and infanticide would be the need to show objective foreseeability of harm in the first case and wilfulness in the second. It is strange that what is normally considered to be a greater degree on intent attracts the lesser penalty.

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The judge went on to berate the defence for insisting on the introduction of two days of medical evidence that, in his view, were a waste of the Court’s time. I would submit that the heart of the crime of infanticide is the alleged disturbed state of mind of the accused. I include *Lalli* to show the problems that result when Parliament uses a piecemeal approach to law reform. The reasoning in this case may make some abstract sense but if it were followed would render this area of law even more ridiculous.

**Canadian Cases**

Some of these difficulties may be responsible for the small number of infanticides that reach the courts. Although Silverman & Kennedy identified police reports of forty-five infanticides between 1974 and 1983 in Canada, only four cases appear in the Canadian Law Reports for that period. Most of the few reported cases involve neonaticide by young unmarried girls living at home with parents from whom the pregnancy has been concealed. If these cases are typical examples, it is obvious that courts are just as reluctant to convict under the infanticide provisions as they were under murder.

*R. v. Smith* exemplifies judicial attitudes. In this case a 17-year old Newfoundland girl gave birth to a baby in her bedroom while her 5-year old brother continued to sleep in the bed they shared. Afraid that the baby would cry and her father would discover it, Olive Smith put

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865 Silverman & Kennedy, supra note 469.

866 *R. v. Smith* (supra note 859); *R. v. Szola* (1977) 33 C.C.C. (2d) 572 (Ont. C.A.); *R. c. Dupont* [1981] C.S.P. 1055; *R. v. Aoudla* (1979) 21 C.L.Q. 270. It may be that other cases appear before the courts but if the accused pleads guilty and no contentious issues arise, then they are unlikely to appear in the Reports. One case appeared in 1985 but the issue in dispute was a ban on publication of the name of the 17 year-old accused who had pleaded guilty to infanticide and neglect to obtain assistance in childbirth. She, like many others, was given a conditional discharge. (See *Re Regina and Unnamed Person* (1985) 22 C.C.C. (3d) 284.)
her hand over its mouth thereby causing its death. She put the baby and afterbirth into the bed alongside her brother and went to sleep. At trial she, and other members of her family, testified that they knew nothing of the pregnancy until the baby was born. She also stated that she did not intend to kill the baby.

The judge acquitted Smith because he had reasonable doubt about whether her act was "wilful." A psychiatrist testified that denial of pregnancy is a well established hysterical syndrome and that the accused would have been in a state of shock because she was completely unprepared for the birth. By the time she was examined by the psychiatrist she presented as an "immature, inadequate young girl but [with] no evidence of mental illness." The following paragraph illustrates the typical judicial attitude in such cases:

I am satisfied also the accused had not fully recovered from the effect of having given birth to the child and that as a consequence her mind was disturbed. It is almost self evident that a 17-year old girl who gave birth to a child unassisted and in the circumstances shown in the evidence, would immediately after the birth be in a disturbed state of mind.  

The judge in this case is almost at the point of taking judicial notice of the likelihood of mental disturbance in such circumstances. However, his lack of analysis of actual mental capacity is strikingly different from the approach normally taken for gender neutral homicide crimes where mental state is at issue. For example, if mental disorder is raised under Section 16, there is usually a rigorous examination of the nature of the illness, its effect on cognition, whether those effects were in play at the time of the homicide, etc.

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867 Smith, supra note 859 at 280. See also acquittals in R. v. Marchello [1951] 4 D.L.R. 751 (Ont. H.C.); R. v. Jacobs (1952) 105 C.C.C. 291 (Ont. Co. Ct.); and Dupont, supra note 860. The circumstances in Dupont were very similar to those in Smith and Ouellette J. relied heavily on the reasoning in Smith.
Most laypeople would be inclined to agree with the judge. But although such assumptions may work to the advantage of the accused, they may also perpetuate the stereotype of the unstable woman who is the victim of her bodily weaknesses, unless sufficient stress is placed on her home background and social conditioning. This is not to say that the judge's assessment of the girl's state of mind was inaccurate; merely that his assumptions about the causes of her homicidal act may incorporate more in the way of biological determinism than recognition of family power structures. How many of these young girls would be driven to kill their brand new babies if there were support rather than censure from friends and relatives?

Although availability of abortion and the removal of the stigma of illegitimacy has probably reduced the numbers of infanticide among most white, Canadian-born young women, the spectre of disgrace and ostracism still lurks for unmarried women from some immigrant and strict religious cultures. The 1992 case of R. v. A.P.P.\(^{868}\) confirms this. The accused was initially charged with second degree murder but later pleaded guilty to infanticide. She was a 24-year old single woman who lived with her parents and belonged to the Armenian community in Toronto. She "went to great lengths in her own mind to deny the fact she was pregnant" and was afraid that she would be "disowned by her parents and ostracized by the Armenian Community at large."\(^{869}\) Her family knew nothing of her pregnancy. While they were out of the house, A.P.P. gave birth and immediately threw the child out of the window of her second storey bedroom. Despite obvious physical signs of recent childbirth, A.P.P. continued to deny the pregnancy when her mother took her to hospital. She was confined as an involuntary mental patient for two weeks following the birth. At first she had no memory of the event, but her


\(^{869}\) Ibid. at page 3 (Q.L.).
psychiatrist gradually helped her regain her memory. He testified that disclosure of her condition to her family and community would have been "socially and emotionally devastating" and that "she had obliterated the reality of the pregnancy from her mind." 870 As in the Dupont case, the psychiatrist testified that she was suffering from a "dissociative mental state" that protected her from experiencing emotional pain and stress.871

Defence counsel must have had excellent co-operation from the psychiatrist as his report listed all the elements that would be likely to lead to leniency: serious mental disturbance, subsequent feelings of guilt and remorse, and little risk of future similar behaviour. Vaillancourt J. did not go so far as to acquit the accused but he gave her a suspended sentence, and three years probation conditional on continued psychotherapy and community work.

Features that these cases of neonaticide have in common include: immaturity, denial of pregnancy, dependency (economic or otherwise) on parents, authoritarian background. Both Smith and Dupont were afraid that their fathers would hear the baby crying; Ouellette J. described Dupont’s father as "severe." A.P.P.’s father may not have been personally authoritarian but the Armenian culture imposed severe social penalties for extra-marital sex.

Unlike the situation in the United States, the only reported case that refers to postpartum illness is R. v. Szola, in which the Ontario Court of Appeal reduced a 12 month prison sentence for infanticide to a conditional discharge following a guilty plea.872 The judgment makes it obvious that the court would have acquitted the 24-year old accused had she appealed her

870 Ibid. at 8.
871 Ibid. at 10.
872 Supra note 866.
conviction rather than her sentence. In this case the accused had "a most difficult marriage"\(^{873}\) and had immediately become seriously depressed following the birth of twins. (She already had one child.) One baby died after she allowed it to slip from her lap on to the floor. Psychiatrists testified that she was suffering from "extreme post-partum depression"\(^{874}\) which rendered her incapable of realizing the consequences of her act. This means that she would have been able to plead insanity. However, it may be that she was advised to plead guilty instead of risking indefinite hospitalization.

At the appeal her doctor reported that imprisonment without treatment and denial of access to her children could lead to her suicide. His report also mentioned that Mrs. Szola’s depression was aggravated by marital and social factors, thus recognizing that inherent biological factors were not the sole cause of her behaviour. As a result of this medical testimony the court ordered her discharge on the condition that she "continue as long as is necessary to have psychiatric assistance."\(^{875}\)

Cultural and social factors played an important part in the earlier cases of *Aoudla*\(^{876}\) in 1979 and *Sukraj*\(^{877}\) in 1980. However, in some respects the latter had more in common with

\(^{873}\) Ibid. at 573.

\(^{874}\) Ibid. at 575.

\(^{875}\) Ibid. at 576.

\(^{876}\) Supra note 866.

\(^{877}\) (1980) 23 C.L.Q. 162 (Ont. S.C.). Note that the full judgments of *Aoudla* and *Sukraj* remain unreported. The facts set out in *Lalli*, supra note 861, are similar to those of *Sukraj*, in that she apparently had a "callous and indifferent husband," her relatives treated her as a "domestic servant," and she was "lonely and without friends in an alien country." It will be interesting to find out whether she is convicted of either manslaughter or infanticide and, if so, what her sentence will be.
Szola as the victim was eight months old. On the other hand, although married and already the mother of another child, the accused in Sukraj was only twenty years old at the time of the offence. Mrs. Sukraj had emigrated to Canada at the age of fourteen, was married at fifteen to a family friend, and was forced to live in a foreign environment far from accustomed social and cultural support. Inevitably she became depressed. Her son died after she pushed him onto a hardwood floor. Mrs. Sukraj was charged with manslaughter, not infanticide, even though there was psychiatric evidence of depression which, according to the elastic definition of "mental disturbance," could have brought her within the infanticide section of the Criminal Code. Although both Crown and defence counsel argued that incarceration would not be appropriate, the judge sentenced Mrs. Sukraj to ninety days to be served intermittently and one year probation with a provision for psychiatric treatment.

This may be a fairly light sentence for manslaughter and would likely have been much longer had Mrs. Sukraj not shown remorse for her action. The psychiatrist reported that there was no evidence of gross disturbance or "bizarre abnormalities."878 Nor was there evidence that the accused had abused her children. Because the charge was manslaughter, the accused had the burden of showing sufficient degree of mental illness to constitute a defence. I wonder if the result would have been different had the Crown charged her with infanticide.

Indeed the result was different in Aoudla although there were many factors in common with Sukraj. Ms. Aoudla, a nineteen year old Inuit woman from Resolute Bay, moved to Montreal to live with her boyfriend. She thus moved from the family support of a small Northern community to isolation and poverty in a large city. A few days after the birth of her daughter,

878 Ibid. at 162-163.
when Ms. Aoudla’s boyfriend told her he was leaving her, she killed the baby and tried to kill herself. She was charged with and pleaded guilty to infanticide and received a suspended sentence and one year’s probation conditional on living with her brother at Resolute Bay.

The psychiatrist testified that the accused had sought help for emotional problems before the birth of her baby but showed no signs of psychosis; that she had a good understanding of the nature of the offence and was "simply dejected, frightened and withdrawn." The judge concluded that the committed the offence while her mind was disturbed from the effects of childbirth and noted that the disturbance was aggravated by sudden cultural change and abandonment. There is no specific indication that she expressed remorse, but it is likely that the impact of her attempted suicide would have a similar effect on the mind of the judge.

Why was there such a difference in the sentences in Sukraj and Aoudla? Although an intermittent ninety day sentence may not seem to be onerous, any incarceration suggests that the judge believes that some element of punishment is necessary. Why was twenty year old Mrs. Sukraj, isolated from her community just like nineteen year old Ms. Aoudla, treated more severely? Both women were depressed and emotionally disturbed but not to the point of identifiable psychosis; both were trying to cope in completely alien environments. What differences led to these two results? Was it marital status? Mrs. Sukraj had not been abandoned. (But who knows what kind of social punishment was meted out by her family for the death of a son.) Was it the age of the child? Canadian judges seem more ready to accept mental disturbance the closer the killing is to the date of birth. Was it the venue of the trials; are Quebec judges more likely to be lenient than Ontario judges?

879 Supra note 876 at 271. (Note that these are quotations from the journal, not from the actual psychiatric testimony.)
Or was it the charge itself? If so, this might be a ground for retaining infanticide provisions rather than relying on a charge of manslaughter. Had Mrs. Sukraj been charged with infanticide, her case would have fallen somewhere between Szola and Aoudla. It also had a number of elements common to neonaticide cases. Some writers have criticized infanticide provisions on the ground that they hang social issues upon spurious medical theory. I have tried to show in the previous chapter that not all of this theory is entirely spurious. However, it may be that judges are ahead of physicians when they take account of the interrelationship between physical, psychological and social factors - just as Fishbein and Shoham have urged. Maybe it is time that the law specifically recognize this interrelationship instead of trying to stretch biological theory to lengths that are beyond its snapping point.

I referred above to two cases in which English courts seemed to extend the leniency of the infanticide reasoning to women who had recently given birth but who had killed persons other than the newly born child.\footnote{Supra at p. 316, referring to the cases of Mary Lentz and Ann Reynolds who killed their lover and mother respectively.} Like the courts in England, Quebec courts have apparently extended the reasoning in infanticide to cover other cases of maternal child-killing. In Valiquette,\footnote{(1990) 60 C.C.C. (3d) 325 (Que. C.A.)} the Quebec Court of Appeal substituted a suspended sentence, probation and psychiatric evaluation and treatment for a sentence of ten years imprisonment for manslaughter of which the accused had already served twenty months. The accused, herself a victim of child abuse and incest, killed her three year old son and attempted to commit suicide. She was married to a man, not the father of her child, who was extremely violent to her. Because she could not cope, she asked that her son be placed in foster care and that she be granted visitation rights. She
began to suffer from severe depression coupled with psychosis, and came to believe that her child was being abused in the foster home. She wanted to die but felt that she could not leave her son in a threatening world.

The trial court relied on a report from a woman who purported to be a psychologist but on later investigation turned out to have no official qualification. Both Crown and defence counsel suggested a ten year sentence. The Court of Appeal allowed the submission of a psychiatric report that used words like "paranoid," "anhedonia," "psychotic elements"…

The Court also relied on an earlier case, Bessette which is of interest because the accused in that case strangled her six year old son

after being deserted by both a husband and later another man with whom she had lived. She had just given birth to an unwanted fifth child, had had surgery and was suffering mentally and physically.884 (emphasis added)

Mrs. Bessette received a suspended sentence and three years probation with psychiatric treatment.

Rothman J.A. in Valiquette also relied on Szola stating that

[w]hile it is true that the maximum punishment for infanticide is less serious than that for manslaughter, precisely because of the hormonal and emotional condition of mothers immediately following birth, the severely depressed state of appellant in the present case, in my view, brings some relevance to the decision.885

He also referred to Sukraj and Aoudla. The revised sentence, in his opinion, should "be measured not only against the objective gravity of the offence but also in the light of appellant’s

882 Ibid. at 328 - meaning "loss of interest in general, attention and concentration problems, sleep and appetite problems, depressive ideas of a self-deprecating nature, guilt and loss of self-esteem."


884 Valiquette, supra note 876 at 329.

885 Ibid. at 329.
mental state when she committed it and all the circumstances in which she found herself. Rather than impose a reasonable man standard, the judge recognized the particular viewpoint of a woman in Valiquette’s position. It is not clear whether this represented the accused’s actual viewpoint or the judge’s idea of what it must be.

This last case emphasizes what is common to all of the above cases - the importance of the language of medical testimony. It is doubtful that Mrs. Valiquette’s sentence would have been reduced without the new psychiatric testimony, even when other evidence disclosed mental and social disturbance. In both A.P.P. and Dupont the accused were described as suffering from a "dissociative state." In Smith a psychiatrist confirmed the judge’s opinion that the accused had a disturbed mind. Ms. Aoudla had sought professional help for emotional problems. The psychiatrist in Szola testified that the accused "suffered from a severe degree of post-partum depression that was aggravated by … marital and social factors." In contrast, in Sukraj, the psychiatrist was unable to find evidence of "gross disturbance or bizarre abnormalities" - maybe because she did not try to kill herself like Aoudla and Valiquette.

What, then, would be the likely outcome for women if the infanticide provisions were to be repealed and women were left to rely on leniency in manslaughter cases? Valiquette and Sukraj present two different pictures: the first importing the reasoning of infanticide into manslaughter, the second apparently ignoring much of this reasoning. None of the United States recognize infanticide as a separate crime. Defendants either have to rely on a postpartum insanity or, where available, diminished capacity defences; or hope that evidence that falls short of insanity will lead to a lenient sentence.

886 Ibid. at 330.
United States Experience

For those who advocate abandonment of the crime of infanticide, it might be well to investigate what is happening in the U.S. with respect to the post partum psychosis defence. One writer reports that there is little consistency in sentencing. Of those who are unsuccessful with the insanity defence, 50% receive light sentences, usually probation, and 50% receive long sentences, 10 to 20 years.\textsuperscript{887} The swing in attitude towards giving greater value to the life of the child is evident from the concern of one defence attorney that the jury in such a case would be moved to convict because of "passion and sympathy" for the child.\textsuperscript{888} Unlike the Canadian infanticide cases which report baby killings by young single women, the cases discussed in U.S. literature usually involve married women who may already have one or more other children.\textsuperscript{889} The deaths do not take place at the time of birth but several days or even months later. The circumstances normally disclose extremely bizarre behaviour that is consistent with the presence of psychosis. Two cases illustrate typical facts which provoked completely different reactions on the part of judges and juries.\textsuperscript{890} In Commonwealth v. Comitz\textsuperscript{891} the

\textsuperscript{887} Debra Cassens Moss, "Postpartum Psychosis Defence: New Defensive Measure for Mothers Who Kill Infants" (1988) 76 A.B.A.J. 22(1).

\textsuperscript{888} Ibid.

\textsuperscript{889} This does not mean that U.S. courts do not hear cases of neonaticide committed by young girls. Laura Reece in "Mothers Who Kill: Postpartum Disorders and Criminal Infanticide" (1990) 38 U.C.L.A. Law Review 699, cites a variety of U.S. cases involving young unmarried girls in circumstances similar to those described above. Reece distinguishes these cases from postpartum psychosis cases because the young girls have a conscious reason to kill, however warped. On the other hand, psychotic mothers whose reasons are even more warped often also have conscious reasons to kill - no matter how distorted that consciousness may be.

\textsuperscript{890} There are several other recent cases. Anne Brusca in "Postpartum Psychosis: A Way Out For Murdering Moms?" (1990) 18 Hofstra L.R. 1133 at 1159ff describes seven.

defendant drove her one month old baby (her second child) to a stream and dropped him into the water. She had a history of postpartum depression following the birth of her first child. She reported that he had been kidnapped, but after her arrest for murder, and under hypnosis, she recalled for psychiatrists what had actually happened. She pleaded guilty but mentally ill under a Pennsylvania statute that allows the court to hand down the same sentence to someone who is mentally ill as would be imposed on someone completely sane. Two psychiatrists appearing at the sentence hearing disagreed about the extent of the defendant’s mental illness. Comitz’s doctor testified that she "suffered from atypical association which came close to displaying multiple personalities." The state psychiatrist agreed that she was mentally ill but did not believe she was psychotic. The Pennsylvania Superior Court agreed with the court below that mental illness did not excuse her criminal conduct and, instead of granting a light sentence with treatment, affirmed her sentence of eight to twenty years for third degree murder.

In People v. Thompson, the defendant drowned her nine-month old baby in the bathtub after hearing voices telling her that her baby was the devil. Like Sharon Comitz, she had suffered postpartum depression after the birth of her first child, resulting in hospitalization and attempted suicide. She had no problems after the birth of her second child until she stopped breast feeding him at nine months. She also had no history of mental problems apart from those associated with the birth of her children. In Thompson’s case psychiatrists agreed that she had

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892 Marcia Baran, "Postpartum Psychosis: A Psychiatric Illness, A Legal Defense to Murder, or Both?" (1990) 10 Hamline Journal of Public Law & Policy 121 at 130. For further discussion of this and other cases see also Lori A. Button, "Postpartum Psychosis: The Birth of a New Defense?" (1989) 6 Cooley Law Rev. 323 and papers by, Gardner and Lentz, supra notes 447 and 746, respectively.

893 Discussed by Toufexis, "Why Mothers Kill Their Babies" TIME, June 20, 1988 at 81; and in L.A. Times, January 17, 1988, Part IV at 3, col. 5.
suffered a psychotic episode that rendered her insane at the time of the killing. She was found not guilty by reason of insanity and spent several months being treated in a mental hospital. Despite birth control, she became pregnant again but on the birth of this child was treated with hormones and suffered no recurrence of psychosis.

These cases illustrate the importance of psychiatric diagnosis and the weight given to expert testimony. In Comitz's case there was disagreement about her condition which allowed the trier of fact to choose between conflicting opinions. In Thompson's case there was clear identification of insanity which would probably have led to acquittal under existing law whether or not her illness was characterized as postpartum psychosis.

**Critiques of Postpartum Defences and Infanticide Provisions**

A woman who kills her child because of postpartum disorder is less culpable, not more culpable, than a hot-headed man who kills an unfaithful lover. 894

Most recent critiques come from the United States where the uneven legal treatment of women who kill their babies has caused concern and has prompted discussion about the usefulness of legislated infanticide provisions. One writer describes possible extremes as follows:

"Either you get the judge who imposes the maximum, or you get probation," ... said [Peter Goldberg, a Philadelphia attorney]. "Or either the prosecutor says, "I'm going for the death penalty," or the prosecutor reads the psychiatric cases and drops the charges." 895

894 Reece, supra note 889 at 729. Yet, in many jurisdictions, the "rational" man may benefit from the excuse of "crime passionale" - itself based on patriarchal myth. No one seems to consider that elevated testosterone levels may have caused the killing; whereas there is a constant search for biochemical causation for female crime.

895 Moss, supra note 887.
As already discussed, either the woman is "mad" or "bad"; either the victim of aberrant hormones or an unnatural monster. As Laura Reece points out, it is hard not to side either with the unfortunate mother or the dead baby.896 The same polarization does not necessarily occur when a woman kills her mate, perhaps because different myths are at work.897

U.S. writers express the same concerns about postpartum defences as they do about PMS defences but their opinions on this issue are less strident; maybe because postpartum illness is less common than menstrual illness, or maybe because the majority of feminist writers do not feel so personally affected by the former;898 or maybe because infanticide is victim specific whereas "PMS crimes" can run the gamut from mischief to homicide.

Those who oppose the introduction of a gender-specific defence in the U.S. generally cite one of two reasons: (1) such a defence runs the risk of stigmatizing all women, promotes sexism, and reverses recent moves toward gender equality. In other words, it fails to acknowledge that, unless proved otherwise, women are mature adults who should take responsibility for their own actions. Or (2) existing defences have been established over a long period to maintain a balance between the right of an accused to acquittal if she lacks the requisite mens rea and the right of

896 Reece, supra note 889 at 750.

897 Indeed perpetrators seem to subscribe to stereotyping when they categorize their own mental state. One researcher notes that child-murderers feel they should have been placed in mental hospitals rather than prison while mate-killers consider themselves mentally healthy. Diagnoses of mate-killers reveal higher frequency of serious mental illness among them than among child-murderers. (Benedek & Farley, supra note 662 at 40-41, citing Notman.) However, Benedek & Farley warn of "great disparity" in definitions of mental illness and in indices used to operationalize those definitions.

898 This may not be a valid assumption. However, it seems that many feminist writers are professional women who either have no children or who may have experienced few psychological problems after giving birth. On the other hand, it is likely that most have experienced at least some of the symptoms of PMS and have been able to cope with them, thus making them more personally concerned about menstrual than about postpartum stereotyping.
the public to protection against and punishment of dangerous offenders. Proponents of the status quo fear abuse of a postpartum disorder defence, ease of fabrication and lack of clear medical definition.

Christine Ann Gardner believes that postpartum psychosis should be viewed as any other mental illness before the courts since

[i]nequity would result if a mental disturbance related to childbirth is allowed to have legal consequences, as it does in other countries, different from other mental illness.\textsuperscript{899}

She believes that a grave injustice would result if an offender’s mental health were to be predetermined by statute. Gardner writes from a position of concern about child abuse and the possible use of a postpartum disorder defence as a way of covering up or wrongfully excusing such abuse.

Anne Damanta Brusca would disallow the defence because there is not enough conclusive evidence in the medical community to consider postpartum psychosis as an illness in need of special recognition.\textsuperscript{900} Despite the huge disparity in sentences, she believes that the present insanity and diminished capacity defences are sufficient. She also mentions the "guilty but mentally ill" choice enacted by a number of states. However, this choice allows a judge to impose the same sentence on a mentally ill defendant as upon a sane offender - exactly what the judge did in the case of Comitz.

Those who are in favour of a postpartum disorder defence also fall into two camps: (1) adherents of the maternal myth who cannot believe that a sane mother could kill her child; and (2) those who believe that equality and justice require the law to accept different viewpoints,

\textsuperscript{899} Gardner, supra note 447 at 988.

\textsuperscript{900} Brusca, supra note 890 at 1169.
including those of mothers who are suffering from postpartum disorders. The second group are often feminists who have moved beyond the idea that sameness of treatment leads to substantive equality.

Button is a firm believer in the idea that no sane mother could ever kill her child. The following quotation clearly encapsulates the stereotype discussed above:

That a mother could actually kill her own child is so unbelievable, so foreign to our understanding of the mother-child relationship, we instinctively feel it must be an act of insanity.901

Button believes that the postpartum psychosis defense should be recognized as unique. It should not be abused by those who do not suffer from postpartum psychosis. Because of the tragic nature of these cases, treatment should be provided in all situations.902

Writers like Mary Lentz and Christine Gardner both acknowledge the reality of postpartum disorders, but Lentz unlike Gardner believes that as long as steps are taken to control abuse, a specific postpartum psychosis defence should be recognized as coming within the framework of existing insanity defences.

Women who are morally blameless should not be punished merely because their actions took place before they, or anyone else, realized they were in need of help. The courts should not sit by and wait until the medical and psychological fields agree on every aspect of postpartum disorders before establishing guidelines regarding the defense.903

This quotation could equally well apply to PMS defences. Lentz, like others, stresses the difference between psychosis and depression and does not think that a defence based on the latter

901 Ibid. at 323.
902 Button, supra note 892 at 344.
903 Lentz, supra note 746 at 544.
would be acceptable. Neither does she agree with the English trend of expanding the defence to include murders of persons other than the newborn child because she believes there is some evidence to show that one of the characteristics of postpartum psychosis is that it focusses on the newborn child rather than other family members. Lentz does acknowledge an element of sex specificity since the particular combination of biological, psychological and social factors occurs only in women. Men may be stressed out by the arrival of a new baby but they do not have to cope with the additional burden of sudden hormone changes.

Reece points out that, because most crimes are committed by men, criminal law is skewed in favour of the male viewpoint.

The legal system works to strip the female homicide defendant of what her act means to her in the context of her life and forces it into a male-centered homicide structure to be judged in view of male-focused notions of culpability... The criminal law is exclusionary in the sense that a woman must be dealt justice according to established male-centered criminal law doctrines.904

I believe that this reality could provide a justification for female gender-specific defences. The whole existing criminal system remains largely male gender-specific. In an ideal world female and male perspectives would have equal validity and equal, but sometimes different, treatment. It would be better to have such an equitable system but, in the meantime, if this is impossible, it may be necessary in the short term to make specific provision for women’s realities.

Some may argue that there is no need to distinguish between postpartum and any other psychosis because in each case, once insanity is established, the accused will be acquitted. However, it could make an important difference to disposition. Postpartum psychosis happens only after the birth of a baby; other psychoses can occur at any time. Therefore, a postpartum mother with no history of ongoing mental disorders should be considered less dangerous that

904 Reece, supra note 889 at 755.
other sufferers. Also, if the Thompson case is typical, extreme postpartum illness responds to preventative and post-onset treatment. Therefore treatment, not imprisonment, should be the solution of choice.905

While this debate continues in the U.S., what are Canadian and English scholars saying about their infanticide provisions? During the 1970s and 80s three major English groups considered proposals for changing infanticide legislation: the Butler Committee which published the Report of the Committee on Mentally Abnormal Offenders (1975); the Royal College of Psychiatrists' Working Party on Infanticide (1978); the Criminal Law Revision Committee (1980).906

Only the Butler Committee decided in favour of repealing existing infanticide provisions. One of their proposed replacements was the extension of the diminished responsibility defence under the 1957 Homicide Act; diminished responsibility being established by evidence that the accused was suffering from a mental disorder, widely defined by Section 4 of the 1959 Mental Health Act.907 The Committee also proposed the introduction of a new charge - "manslaughter with mental disorder" - a gender-neutral way of continuing to relieve the accused of the burden of proving mental illness.

The Working Party and the C.L.R.C. both voted for continuing, and even extending, specific legal protection for new mothers. They seemed to start from the viewpoint that existing

905 I leave the issue of mandatory versus voluntary treatment to another paper.


907 That is, mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind. This could incorporate the mental state of those suffering from postpartum illness, including depression.
court practice incorporated the correct legal treatment of infanticide mothers, and then attempted to justify this practice by defining mental disturbance in a way that would maintain it - whether or not there was medical justification for the definition. The result would have been to define the emotional imbalance created by social and psychological stress as "mental disorder" - a more overt repetition of the philosophy behind the original Infanticide Act.

The Working Party would have extended infanticide to cover the killing of any of the mother's children aged under five years, not just the lastborn. This is a logical extension, unless, as suggested above, a component of postpartum psychosis is a fixation on the newborn. Under the Butler recommendations, this extension would be unnecessary, as presumably manslaughter with mental disorder would cover such homicides.

Just as Canadian legislators looked to England when formulating the 1948 infanticide provisions in the Criminal Code, the 1984 Law Reform Commission of Canada looked to English studies when considering changes to their law of infanticide. The L.R.C.C. proposed sweeping changes to the laws of homicide, infanticide being a small part. The Commission came down in favour of the repeal recommendations in the Butler Report. However, it concluded that Canadian common law with respect to incapacity to form specific intent was sufficient to incorporate diminished responsibility arguments. So far, Parliament has not yet implemented any of the above recommendations. And in the U.S., no state has enacted an infanticide provision. Therefore, the status quo remains, with all of its inadequacies.

Given the mixed opinion described above, what strategies are appropriate in Canada for reforming the law of infanticide? Reece, in the context of U.S. law, describes two possible approaches: (1) accommodation - special gender-specific exceptions to the general rules that run the risk of paternalistic application; and (2) acceptance - integration of the differences between
women and men into the structure of the law itself. The second approach would avoid paternalism and the unequal treatment that results from imposition of formal sameness. As Reece puts it:

equality should provide for acceptance of the differences between men and women and make the difference costless: equality should acknowledge real differences, without locating the difference in women, and without assuming that a norm is gender neutral because it is facially neutral.\textsuperscript{908}

U.S. writers have come up with a variety of ideas for dealing with postpartum defences. Some are peculiar to their legal system but others are of general interest. Some could be described as "accommodation" and others as "acceptance." For instance, John Dent advocates a reduction of the burden of proof imposed on postpartum defendants, from preponderance of evidence to raising a reasonable doubt, by adding the following to the insanity defence:

... if the accused person is a mother who committed the act within three months of giving birth, when she raises a reasonable doubt as to whether she was capable of knowing or understanding the nature and quality of her act, and that ... she was incapable of distinguishing right from wrong ... \textsuperscript{909}

This incorporates some of the elements of the Canadian infanticide provisions within an otherwise traditional insanity defence. Dent argues that this special burden of proof is necessary for postpartum disorders because of the unusual circumstances of the defendant; (1) Postpartum psychosis is usually fleeting and the defendant is completely rational at the time of trial, making it hard to overcome the presumption of sanity; (2) many juries see the insanity defence as "letting the defendant off" especially if, as in the case of postpartum psychosis, there is no reason for incarceration in a mental hospital; and (3) infanticide statutes are inappropriate because a woman

\textsuperscript{908} Reece, supra note 889 at 755.

who kills a baby under the influence of postpartum psychosis is not criminally responsible at all
and should receive no punishment.

Dent's solution, in effect, creates a gender-specific defence within a general defence. He
has designed it in part to neutralize vengeful juries. However, like existing infanticide provisions,
it leaves the door open for paternalistic application and negative generalizations about women's
weakness. As Susan Edwards argues, a purely medical approach allows society to ignore cultural
and environmental factors that might tip the scales towards infanticide. It excuses those in
power from taking steps to create social support systems for parents such as daycare, home-help,
relief from poverty, etc. Help and concern from a postpartum support worker would help to
reduce the intensity of depression. Also such a worker could be trained to recognize the onset
of psychosis that puts mother and baby at risk. Confidential pregnancy support could prevent
neonaticide by immature, frightened young girls. By siting weakness solely in the woman,
valuable tools for prevention of infanticide go unused. As Benedek & Farley observe, it is ironic
that women are so often labelled mentally ill but those that desperately need help go
unrecognized and untreated. Reece takes this further by pointing out that the failure of
medicine to recognize and account for postpartum disorders is repeated by the legal
profession.

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90 Edwards, supra note 297 at 97.

91 Benedek & Farley, supra note 662 at 43.

912 Reece, supra note 889 at 708. She also asks, "Why is a new mother suffering from a
postpartum disorder invisible in our society until an infanticide makes her a news item?" - at
706. It should be pointed out that many towns and cities do have postpartum support groups that
will help new mothers cope with depression and feelings of inadequacy. However, the existence
of these groups is not widely known among the general public. If a woman is lucky enough to
be correctly diagnosed, her doctor may refer her to such a group. On the other hand, women
who have been misdiagnosed by physicians, may be unaware of the need for or availability of
The creation of special defences for women implies that, in some cases, they are inappropriate subjects for mainstream law. It also perpetuates inequality, as special provisions avoid the need for changing general law to encompass women’s experience.

Legislative implementation of a special statutory exception for postpartum-disordered mothers who kill would only accommodate women - it would signal that women’s experience is beyond the scope of established law.913

But maybe women’s experience is beyond the scope of established law because of its very male-centred nature. Maybe under established law, the only way to recognize women’s experience is through special defences. Maybe the only route to an acceptance ideal is through another legal system.

Can there be any compromise between the paternalistic approach of gender-specific defences and a complete upheaval of the criminal legal system? I agree with Judith Osborne’s argument that removal of the offence of infanticide might not place this category of offenders on the same footing as other offenders.914 But do we want them on the same footing? Would not the law in general benefit from changes that would recognize women’s experience? This more flexible approach would also allow recognition of non-stereotyped experiences of men. Removing infanticide provisions without changing the system to allow greater flexibility would either work to the detriment of women by the application of inappropriate penalties or by returning us to nineteenth century practice in which fact finders refused to convict. One form of compromise might include the individual circumstance element of the Model Code and the help from support groups. Even if they become aware, these women, when they can overcome their depression to search for help, may not find it easy to locate a support group because they are not widely publicized in mainstream media.

913 Ibid. at 756.

914 Supra note 906 at 58.
approach of the Butler Report. However, this compromise should not be confined to the crime of homicide.

Madame Justice Beverley McLachlin points out the danger to substantive equality in developing a female-only defence from which males experiencing similar symptoms are excluded.\(^{915}\) She believes that the key should be the mental state of the woman, not whether she was suffering from a postpartum disorder or PMS. However, the problem with this approach is that evidence would still have to be introduced about the nature and presence of a female "disorder" as precipitating factor. Thus a method of constructing an "acceptance" strategy would be in danger of reverting to "accommodation" if the principal focus were to return to the disorder, rather than the mental state it induces. I will discuss below some of Reece's ideas for creating an acceptance approach.

I have already referred to the "guilty but mentally ill" verdict. This might be more acceptable if the presence of mental illness led automatically to mitigation of sentence. Another solution is mitigation itself but again there would have to be consistency in its application - a factor partially built into infanticide provisions by stipulating a low maximum sentence. However, McLachlin J., in examining both infanticide and PMS defences, has expressed concern about the highly discretionary nature of sentence mitigation. I would think that without education of the predominantly male judiciary about women's realities, sentences are likely to vary according to the judge's awareness or ignorance of this reality, or according to which female myth gains the upper hand in his or her mind.

Some measure of consistency is inherent in the sentencing structure of infanticide provisions. But under the existing Canadian system, a mother who kills her baby must be charged with infanticide to gain the advantage of a low maximum sentence. I have already illustrated the difference in treatment afforded women charged with manslaughter, rather than infanticide. Thus the mere existence of a gender specific "defence" does not necessarily lead to consistency. Outcomes may not be so terribly different in Canada than in the United States, although it seems that women in Canada are charged with baby murder less frequently than in the U.S.

In an effort to graft a postpartum defence onto the California charge of voluntary manslaughter based on passion and provocation, Reece suggests that courts take into account experiences that are unique to women in assessing moral culpability.916 This could be done by defining provocation in a way that would allow for women's response to postpartum circumstances. As she says, women respond to different kinds of provocation in different ways than do men, just as a battered wife responds to physical threat in a different way than a pugilistic male. As an illustration of built-up provocation, she describes Massip's situation from the birth to death of her baby: hallucinations, blackouts, seizures; depression and psychosis; husband's refusal to help. This reasoning could also apply to neonaticide where social and cultural factors play different, but just as potent, roles. I am inclined to argue that this type of provocation defence should be reserved for defendants with severe depression, not psychosis. As Dent points out, women who kill under the influence of postpartum psychosis should bear no criminal responsibility for their actions.

916 Reece, supra note 889 at 728.
Reece goes on to describe mechanisms for reducing murder to manslaughter under the Model Criminal Code, where there is a reasonable explanation or excuse. Reasonableness in the Code is "determined from the viewpoint of a person in the actor’s situation under the circumstances as [s]he believes them to be."917 This would allow recognition of a woman’s postpartum experience and a partial defence for homicide as a result of severe depression falling short of psychosis. The reasonable explanation could be extreme mental or emotional disturbance caused by "hormonal disturbance and psychological stress of new motherhood"918 - and perhaps exacerbated by factors such as poverty, isolation and minority culture.

Butler and the L.R.C.C. both suggest diminished responsibility defences that take into account an inability to form requisite intent. Although diminished capacity defences, as used in the United States are not identical in concept, they have been used to negate intent. Reece points out that confusion caused by lack of consistent definition of "diminished capacity" has brought this defence into disrepute. However, in Molina919, it was held that a woman suffering from postpartum disorders may use evidence of her disorder to show that she did not have the requisite mental state for murder, and may be guilty only of voluntary or involuntary manslaughter.920 Stephnie Molina was found not guilty of second degree murder by reason of insanity after she strangled her eighteen month old son and then stabbed herself and the baby. At trial, evidence showed that the defendant had been depressed, anxious, insomniac and subject to hallucinations for a long time after the birth. The California Court of Appeal held that the jury should have

917 Ibid. at 731.

918 Ibid.


920 Reece, Supra note 889 at 738.
been instructed to consider whether Molina actually formed the requisite intent for murder and, if not, whether the facts might have supported a conviction of voluntary or involuntary manslaughter.

Like many other writers on this and other topics, Reece concludes that the most effective tool for recognition and understanding of women's experience of postpartum disorder is through education of the public and members of the criminal justice system.\textsuperscript{921} Education has been effective in producing a dramatic change in attitude towards drinking and driving. However, drunk driving is not an problem that is suffused with sexual mythology. It is much harder to change entrenched ideas about gender roles. This is not to say that change is impossible. Much has been done in recent years to educate the public and the justice system about the mythology surrounding rape. Although there is still a long way to go, complainants now have procedural and substantive protections that would have been unheard of twenty years ago. Recent Parliamentary debates on changes to the rules on past sexual conduct reflect an an increasing awareness of women's reality.\textsuperscript{922} Education could do the same for women with respect to postpartum disorders, PMS and menopause if only there were a greater consensus among medical professionals.

\textit{Infanticide - A Summary}

The fact that men never suffer postpartum disorders and that not all women or even all mothers suffer from postpartum disorders cannot be allowed to call into question a legitimate and unavoidable aspect of being a woman.\textsuperscript{923}

\textsuperscript{921} See also Marcia Baran, supra note 892.

\textsuperscript{922} See Hansard, April 8 and June 15, 1992: debates on Bill C-49.

\textsuperscript{923} Reece, supra note 889 at 757.
In Chapter 5, I listed a number of questions that Diana Fishbein believes should be answered in relation to violent crimes committed by a small sub-group of women. Postpartum offenders could be just such a group. The first question would be about the contribution of postpartum disorders to violent crime by women.

Postpartum disorders are a reality for many, but certainly not all, women. Mothers who kill their children because of untreated, uncontrolled and undiagnosed postpartum psychosis represent a minute fraction of the total number of women who give birth, as do women who kill while suffering from postpartum depression. Young girls who kill their newborns represent a minute fraction of the total number of young girls who give birth. Neonaticide and infanticide represent a minute fraction of the total number of homicides. In global terms these homicides are not a serious problem for the legal system. However, they are a serious problem for women perpetrators caught up in the legal system; and, if these women are portrayed as representative of women as a whole, they are a serious problem for all women. (As I will show below, a parallel situation exists with respect to PMS.)

Fishbein would next ask how biological factors interact with social factors to produce postpartum crime. Canadian and English infanticide provisions avoid, probably for paternalistic reasons or as a way of ignoring social and environmental stresses, the need for detailed medical diagnosis of the type of disturbance thought to have caused homicidal behaviour. Inclusion in or exclusion from the DSM has little importance in Canadian and English courts. However, this might change if these gender specific provisions were to be repealed without some kind of replacement. As I noted in Chapter 4, careful analysis of the different reactions in the psychiatric community towards classification of PMS and postpartum disorders should be carried out before repeal of these provisions and before introduction of a PMS defence.
The DSM is a psychiatric, not an interdisciplinary source. It recognizes social and environmental factors but does not attempt to evaluate or quantify them. At present there does not seem to be any one source that would be acceptable in court as an aid to determining how biology and environment interact. It is much easier to find a biologist who would deny the importance of environment and vice versa. Even if it is not always possible to assess the relative effects of biology and environment, can a subgroup of potential postpartum offenders be identified before they commit a crime? I have already discussed those factors that heighten the danger of serious postpartum depression. Psychosis is harder to predict unless a woman has experienced mental disturbance after a previous pregnancy.

Medical writers argue that the removal of postpartum disorders as specific categories (rather than sub-categories) in the DSM has hindered their diagnosis and treatment. If the DSM were used solely for medical purposes, as it is intended, I would not hesitate in arguing for their reintroduction along with some recognition of possible biological causes. Unfortunately, however, the DSM is looked upon by lawyers, journalists and the general public as a source of accurate information for solving legal, social and personal problems. It is all too easy to extrapolate this information to cover inapplicable situations and to make sweeping generalizations about women as a whole. It seems ridiculous to me that one single authority from one single medical discipline should have such power to shape people’s lives. It helps to create an unjustified hierarchy of evidential weight for fact finders in the legal process. But to give psychiatrists their due, it is not their fault that the legal profession has latched on to this one source as a convenient tool for winning trials. North American courts’ reliance on the DSM leads to parochialism and reliance on local fashion. For better or worse, a long off-shore tradition of medicine and psychiatry is largely ignored by our courts.
Although postpartum disorders are only partially recognised in the DSM, there appears to be a general medical consensus that they should be divided into three categories - baby blues, depression and psychosis. Only the last two are of significant relevance to the law. There is less recognition that postpartum homicide should be divided into two categories - neonaticide and infanticide. Logically speaking there should be an additional category to cover the killing of victims other than the newborn if there is a causal connection between the death and a postpartum disorder.

Another important issue is availability of effective therapy. What role, if any, should such availability play in the formulation of legal defences? It may not play a theoretical role but it must make a practical difference to disposition, especially if there is a perceived danger of recurrence. In addition, effective therapy tends to validate the very existence of a disorder, even when etiology and exact cure or control mechanisms are unknown. If, as Dalton did with Sandi Craddock, a therapist can mount a "before and after" demonstration, a judge is bound to be more comfortable in ordering conditional probation instead of incarceration.

We thus come down to a number of choices that depend on medical knowledge, legal philosophy, practical necessity or a combination of all three. Although medical professionals have come closer to subdividing and defining different types of postpartum disorders than premenstrual problems there is still a lack of consensus about etiology, classification and treatment. Must the legal system wait until medical research comes up with more concrete answers, or are legal actors capable of assessing existing medical knowledge and combining it with specific facts of a case to come to a just conclusion? A common concern in judgments involving expert witnesses is a refusal to allow a medical witness to give opinions about an ultimate issue. If the legal system waits for medicine to reach a consensus, it is admitting that it cannot reach decisions.
without incorporating official medical doctrine. I believe that this is an indirect delegation of power to decide on ultimate issues.

For example, X commits a crime (mischief) and then argues that he was acting under the influence of delusions caused by a medical condition. Witnesses show that X has been acting in an erratic fashion and has complained about his mental confusion. There has been recent research reports about a "Mischievous Confusion Syndrome" but there are arguments about its existence. No one is claiming that X was not experiencing the symptoms of MCS at the time of the offence. Medical evidence for and against MCS is introduced, plus lay testimony to substantiate symptoms. There are two possibilities: (1) the finder of fact is allowed to weigh all the evidence, including facts about social stress, and reach a conclusion; or (2) the evidence is inadmissible or given little weight because MCS is not to be found as an established category in medical texts.

Do we have to wait for a medical consensus before deciding the question of whether or not there should be a gender-specific defence for postpartum offenders? I would answer "no." We should be looking at reality as seen by women, not just by the medical profession. Having answered "no," and having balanced the arguments both pro and con, should there be a gender-specific defence that would excuse women offenders because of a mental state involuntarily brought about, for a number of reasons, after childbirth?

**Conclusion**

After a great deal of consideration, and after acknowledging the arguments put forward by Judith Osborne, I have to answer "no." But like Osborne, I would not want the law to leave a void where the infanticide provisions used to be. If Parliament repeals them, there must be concurrent reform of other aspects of general, not just homicide law. Reformers must find a way
of creating an "acceptance" model that creates and preserves substantive equality. I believe that the ideas put forward by the Butler Report come closest to this ideal. However, I would not confine them to the crime of culpable homicide.

Recognition of the Battered Women’s Syndrome, although it was described by a psychiatrist and could be construed as medicalization of women’s social reality, went part way towards validating women’s experiences in abusive spousal relationships. It redefined self-defence to encompass at least part of some women’s reality. McLachlin indicates that she would prefer to graft women’s experience onto traditional defences. This, in theory, is what happened with what has erroneously come to be known as the BWS defence. But the public has hailed it as a "new" women’s defence. It seems that, even when attempts are made to to remain within the system, what is intended as inclusionary is viewed as exceptional.

This could also happen with the creation of a new offence like "manslaughter with mental disorder" as advocated by Butler. However, I believe that Butler’s approach would come closer to recognizing real sex differences without necessarily singling women out for patronizing legal concessions. It would also avoid constitutional challenges under Section 15 of the Charter because such an approach would give equal recognition to male-specific mental disorders.

Of course, a great deal would depend on a definition of "mental disorder" and whether prosecutors would use such a section in preference to simple manslaughter or murder. We would also be back to the dilemma of having to rely on medical testimony and having women’s experience validated from out of the mouths of others rather than themselves.

We would also have to avoid the problems of onus of proof that are inherent in present infanticide provisions. The prosecution would, in fact, be conceding the existence of mental

924 McLachlin, supra note 915 at 19.
disorder by pressing such a charge. If she had to go further and actively prove mental disorder as an essential element of the crime, we would be back to the anomalous position of a possible acquittal if the prosecution does not prove mental disorder beyond a reasonable doubt. A better alternative might be to preserve the presumption of sanity but recognize a partial defence of mental disorder that would be wide enough to recognize postpartum illness.

A disadvantage of the above approach is the continuation of the stigma attached to anyone found to be suffering from "mental disorder." "Insanity" replaced "lunacy" in part to remove stigma. Instead of fulfilling this purpose, the stigma merely moved to the new term. The same could happen with "mental disorder." This latest term still connotes illness within an individual due to physical or mental weakness. It says nothing about the impact of cultural and environmental factors. I believe that a way must be found to incorporate ideas of writers like Shoham et al.925 who recognize the synergistic effects of multiple causation. Maybe a woman's hormone imbalance will not always be enough to excuse her conduct, but that imbalance coupled with poor accommodation, social isolation and an uncaring husband may well tip her into "mental disorder." (Maybe the word "disturbance" would be marginally better.)

Although conclusions might be better left until the end of this study, I have found it helpful to discuss these issues here in the context of infanticide in order to create a focus for analysis of PMS defences which exhibit a number of similarities but also a number of differences.

925 Shoham et al., supra note 775.
(ii) PMS DEFENCES; THE REAL AND IMAGINARY

Most important legal decisions [on women’s issues] seem to have been decided on motions for summary judgment, with a record virtually bare of facts. Thus, even the victories have been hollow victories in that they have not necessarily contributed to greater consciousness among women or in the broader society of women’s existence.\[926\]

I have become forcefully aware of the truth of this statement while researching for this paper. Even the trials for serious crimes such as infanticide and culpable homicide are rarely recorded in law reports. The reason for this is not necessarily gender bias. Jury trials do not yield written judgments. Therefore, for a serious charge like murder, unless an accused elects to be tried by judge alone or the case goes to appeal, there will be no easily accessible record of legal analysis. In-depth research would require scrutiny of charges to the jury, something that is beyond the scope of this study. But it is something that should be done in order to determine what, if any, emphasis the judge may have placed on conditions such as PMS. Without first-hand sources, researchers are forced to rely on anecdotal reports in the media - an unreliable source, as I have shown in an earlier chapter.

Less serious cases that are heard in provincial courts are also unlikely to be reported unless they deal with constitutional or other complicated legal issues that lead to a written judgment. For the most part, I have gleaned the facts of cases from secondary sources, which are not always consistent. The authors of these sources often have a political or philosophical axe to grind which may influence how they present extracts from cases and how they interpret them.\[927\] Dalton reports that most crimes committed by PMS sufferers are summary offences

\[926\] Ruth Colker, *Consciousness and Love: Towards a Feminist-Theological Dialogue*, Legal Theory Workshop Series, Faculty of Law, University of Toronto (1988) at 64.

\[927\] See infra, page 405ff.
such as petty larceny and fraud. These, of course, are completely unreported unless there is a sensational element that appeals to the media; in which case, all the old stereotypes are trotted out yet again.

**Violent Offences that have been attributed to PMS**

I will begin this section by describing a number of English cases that began the most recent round of legal controversy about menstrual defences. The case that started it all was *R. v. Craddock* in which the 28-year old accused had stabbed a fellow barmaid to death. The Crown reduced the charge from murder to manslaughter because of Craddock's "diminished responsibility" and a jury convicted her. Sandie Craddock already had 30 prior convictions and a history of mental problems including 25 attempted suicides. However, psychiatrists had consistently testified that she did not have a mental disorder. While in custody awaiting trial she attempted to escape, assaulted a warden, slashed her wrists, tried to hang herself and attempted to strangle another prisoner.

It appears that at this point Craddock’s father mentioned that his daughter’s acts of violence all occurred on a regular monthly basis. The defence called in Katharina Dalton who diagnosed severe PMS after studying official records and Craddock’s diaries. Sentencing was delayed for three months to test whether Dalton’s progesterone treatment would be successful. After hearing evidence that treatment with large doses removed the symptoms, the trial judge released Craddock on probation on condition that she continue treatment under medical supervision.

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928 Dalton, supra note 411.

This was a good result for Craddock and for other women in the same position who, as I have already discussed, are a minute fraction of the total number of menstruating women. However, the Criminal Law Yearbook records that "[t]he chronic disorder of pre-menstrual syndrome from which D and an estimated four million women suffer was explained to the court." (emphasis added) It does not say who explained this to the court. Nor does it say whether this figure represents the incidence in England, Europe or worldwide. Because of its source in a mainstream reporting service, such a phrase becomes cloaked with reliability in the eyes of legal practitioners seeking new defences. This is also the phrase that the media will inflate when they attempt to project Sandie Craddock's biological condition on to all women.

After her release Craddock changed her name to Sandie Smith. Over the next year she behaved normally except for one occasion on which she threw a rock through a window following an administrative error which resulted in her missing four progesterone injections. She reported the incident to the police and was released on condition that she continue treatment. Over the next eight months Dalton gradually reduced the dose. Sandie again began to exhibit bizarre behaviour. She began by sending an anonymous letter to a policeman whom she claimed had insulted her in 1978. She followed this up with a phone call to the police station giving her name as Sandie and stating that she was going to kill the officer in question. The next day she appeared at the station carrying a knife and was eventually convicted on two counts of threatening a police officer and one count of carrying a weapon. The court again put her on probation under Dalton's supervision, taking into account that her actions were caused by deliberate reduction in dose by her doctor not by irresponsible behaviour by the accused.

930 Ibid.
Smith appealed her conviction on the ground, among others, that the trial judge should have declared the existence of a PMS defence of "irresistible impulse due to a specific, innocent, and remediable medical condition."931 The Court of Appeal declared that there was "no authority for a defence of irresistible impulse due to a temporary medical condition"932 and that the facts did not merit a defence of automatism. It also refused to recognize PMS disorders as a substantive defence, in part because this would allow release without treatment or supervision and thus defeat one of the objectives of criminal law - protection of society. However, the court approved the use of PMS to mitigate sentence and to reduce the charges in Craddock because of diminished responsibility. Sandie was set free on three years probation conditional upon continuation of progesterone treatment.933

One day after the Smith trial, 37-year old Christine English received a conditional discharge after killing her lover by smashing him against a lamp post with her car.934 Unlike Sandie Craddock/Smith, English had no prior history of violence or criminal acts. However, she had suffered severe postpartum depression after the birth of her second son and had attempted suicide at that time. She also had a long record of suffering from PMS. The facts disclose that, in Canada, she might well have raised the presence of the Battered Woman Syndrome as going towards self defence or mitigation, as there was a history of alcoholic violence in the relationship and a great deal of provocation.

931 Christopher Boorse, "Premenstrual Syndrome and Criminal Responsibility" in Ginsberg, supra note 48 at 84.


As in Craddock the Crown reduced the charge to manslaughter due to diminished responsibility. Dalton and a Broadmoor psychiatrist supported the diagnosis of severe PMS and testified that English’s failure to eat for nine hours prior to the incident had aggravated her condition by causing hypoglycemia.

McArthur, in discussing this case notes that

the trial and press focused on the premenstrual syndrome itself, not on the particular symptoms English experienced... The press picked up on the illogic of women’s bodies as abnormal and sensationalized the English case. They reported in panicky tones the concern that all women could potentially use PMS as an "excuse" for their antisocial behaviour... In turn, the court and press alike embraced a theory with the potential to denunciate women as a group.

Thus this case fulfils the worst expectations of feminists and sets the scene for an attempt to use the defence in the U.S.

In People v. Santos the defendant was charged with second-degree assault and endangering the life of a child after beating her 4-year old daughter so badly that she required two weeks’ hospitalization. Santos told police that "I don’t remember what happened ... I would never hurt my baby ... I just got my period." Stephanie Benson, her lawyer used this evidence to construct a defence of PMS induced automatism despite the fact that Santos apparently said in an interview that "PMS [is] not my defense ... but it’s my lawyer’s ... My nerves are not that bad that I’m just going to beat up on my kids because my period comes."


936 McArthur, supra note 71 at 858-859.

937 Unreported decision of New York Criminal Court No. 1K046229, Nov. 3, 1982.

938 Quoted in Pahl-Smith, supra note 840 at 257.
At a pretrial hearing Benson argued for dismissal of charges on the ground that PMS had caused Santos to act irrationally. The pre-trial judge, although not making a definitive statement about the viability of a complete PMS defence, did leave the door open by stating

\[(\text{inasmuch as disruptions of the mind are admissible evidence in a criminal case, why should physical eruptions of the body likewise not be admitted.})\]

The issue of the PMS defence was not settled as the case was disposed of by plea bargaining. Santos pleaded guilty to a non-criminal harassment charge and received no sentence, fine, or probation. However, in a separate family proceeding she did lose the custody of her child. It is interesting to note that Dalton, who never examined the defendant, stated that Santos was not a sufferer of PMS. Both Benson and Elizabeth Holtzman, prosecutor, claimed victory in Santos; Benson stating that the defence was responsible for mitigation of the charges, and Holtzman claiming that the withdrawal of the defence was a "signal that PMS is a defense without merit."[40]

Although it was not a criminal case, \textit{In re Lovato v. Irvin}\footnote{Ibid. at 26. Irvin also had a history of violence with other women, depression and possible abandonment.} should be mentioned here as it involves physical violence that a clinical psychologist stated may have been partly due to her "menstrual periods."[42] Jamie Lynn Irvin stabbed her roommate and lover Betty M. Lovato, the last of a long lasting series of violent incidents that characterized their relationship. Irvin
pleaded guilty to aggravated assault. In a later civil action Lovato obtained a judgment that included medical expenses for treatment of her wounds. Irvin tried to have the judgment debt discharged under bankruptcy, claiming that she had acted violently under the influence of PMS and that because of this her actions were not wilful. The Colorado court refused to accept this argument, holding that PMS fails to meet the Frye test; that is, PMS has not been established either medically or legally as an explanation for improper conduct. [and] expert testimony [has] demonstrated a lack of any general acceptance in the psychiatric community as an explanation of inappropriate behavior. Thus it appears that, although one U.S. court was willing to entertain the idea that PMS might be introduced as evidence of an excuse for criminal behaviour, those jurisdictions that are bound by the Frye test are not yet ready to accept its validity.

It is interesting to note Benedek’s report that, after the assault, Irvin went to a gynecologist who treated her with progesterone and finally performed a hysterectomy. (Earlier treatment with valium was unsuccessful.) Apparently Irvin ceased to suffer emotional difficulties after this treatment. Irvin’s suicidal and violent history has much in common with that of Sandie Craddock, including the effectiveness of gynecological treatment. With properly documented medical evidence, it is likely that Irvin could have successfully pleaded PMS as a mitigating factor in the criminal case had it been held in Britain. This could well be an example of an extremely rare form of severe PMS. Irvin had sought medical help for years in controlling her violent impulses. Had she killed Lovato she would probably have been convicted of murder, since the evidence did not fit an insanity defence and PMS is not accepted as an excuse in the U.S. Writers like Elizabeth Holzman would deny the use of PMS in the courts on philosophical grounds.

944 Holzman, supra note 200 at 714.
grounds. But, assuming that Irvin suffered uncontrollable violent impulses related to her menstrual cycle, is it fair that she should be prohibited from raising the cyclical nature of her illness as an explanation and ground for mitigation?

The first Canadian murder case to raise the defence was R. v. MacDonald in which a psychiatrist called by the defence testified that PMS had rendered the accused insane within the meaning of S. 16 of the Criminal Code. A twelve woman jury rejected an insanity defence based on PMS but convicted the accused of manslaughter, not murder, apparently on the basis of lack of required intent. Unlike the English Courts, the Nova Scotia Supreme Court did not order probation and treatment, but sentenced Lisa MacDonald to five years in a Federal Penitentiary.

A different judicial attitude prevailed in the case of R. v. Edwards, a case of serious assault with a weapon, decided in Ontario a year earlier. Marsali Edwards, like Christine English, had been living with an abusive partner - "a wife beating drunk." An argument developed about his refusal to pay child support and she lost her temper and attacked him. According to Kendall, the judge sentenced Edwards to three years probation because he thought that she would not receive the medical treatment she needed for PMS if she were in jail. This conclusion was probably fair to the accused but, as Kendall points out, the entire focus of the sentence was on "an immediate physiological pathology within the individual woman" rather than on the unbearable social circumstances that surrounded the crime.


946 For more discussion of this case, see Kendall, supra, note 62; Osborne, supra note 839; and Elizabeth A. Sheehy, "Personal Autonomy and the Criminal Law: Emerging Issues for Women" Ottawa: CACSW, 1987.

947 The words of the trial judge as quoted by Kendall, ibid. at 80.

948 Ibid.
This (and *In re Irvin v. Lovato*) would have been a good case in which to apply Fishbein's and Shoham's models of multiple causation. Judging from the available facts, it differs from the extreme symptoms described in *Craddock*. Would the signs and symptoms experienced by Edwards have led her to assault a non-abusive partner? Would a woman, unaffected by PMS, have assaulted her partner in similar circumstances?

In my personal experience as a legal counsellor, I have encountered more than one case in which an abused wife reacted violently against her partner. One husband, like Edward's, was withholding vitally needed child support; the other had been taunting his wife with evidence of a sexual relationship with another woman. The first woman was charged with and pleaded guilty to causing a disturbance; the second ended up with a black eye. Although unwise, their reactions were so understandable from a female viewpoint that it did not enter any woman's head to ask whether they were premenstrual at the time. The first woman may have qualified for the Battered Women defence; the second would not. If I had had to appear as defence counsel for the latter and there had been reliable evidence that she had lashed out during her premenstruum, it would have been difficult, if not impossible, to refuse to press a PMS defence in the absence of reliable judicial recognition of the cumulative effect of multiple causation. It is easy to theorize about the political incorrectness of a PMS defence but, if confronted by a human being who has been pushed past her limit by a partner whose actions are not perceived as grounds for provocation, it would be hard not to grasp at any straw that would protect her from years in jail and the loss of her children.
PMS "Defences" for Lesser Crimes

Although sensational violent crimes obviously grab the headlines, most offences that may be attributed to PMS are less serious. Dalton gives examples of such crimes as hoax telephone calls, shoplifting, arson, damage to property. A recent Scottish case illustrates the apparent ease with which some British judges and legal commentators are accepting PMS as a mitigating factor in criminal cases.

In December, 1990, Carol Thomas had a "domestic argument" and took off in her car in a state of anger. She rear-ended another driver at an intersection, spoke briefly to him and drove off without leaving particulars. She was traced through her licence plate number. Thomas pleaded guilty to careless driving and leaving the scene and was acquitted on the impaired charge. At trial, evidence was introduced to establish that she had been suffering from premenstrual tension at the time of the accident and that she had consumed alcohol. The sheriff fined her £50 for careless driving and £100 for failing to stop. The latter conviction also carried a disqualification from driving for six months. On appeal from the disqualification, the High Court of Justiciary removed the disqualification. Lord Ross, for the court, noted that

[w]hile suffering from the premenstrual syndrome she acts like a completely different person; she can become almost aggressive and act irrationally. It is also

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949 Dalton, supra note 411 at 293-295. She also illustrates characteristics that differentiate a PMS crime from a non-PMS crime. For instance she states that PMS offenders always act alone and never attempt to escape detection.

950 R.S. Shiels, "Premenstrual Tension as Mitigation in a Criminal Case" (1992) 32(3) J. Forensic Sci. Soc. 245 at 246, describing the trial of Carol Thomas for driving (1) without due care and attention, (2) while over the prescribed blood alcohol limit, and (3) for leaving the scene of an accident without giving her name and address. There is no information to indicate the nature of this domestic dispute. It could have been a violent physical fight with her husband or a tiff with her mother-in-law. She could have been a victim of abuse like English and Edwards or a "nagging bitch." As usual, there was no focus on her social circumstances, only her biological condition.
confirmed in the report from her medical case notes it appears she was suffering from bad premenstrual tension at the time of the driving offence.\footnote{Ibid. at 247, quoting from the judgment.}

The court concluded that disqualification was neither "necessary nor appropriate"\footnote{Ibid.} and that the sheriff should have taken her condition into account when imposing sentence. The judges did not seem to think it necessary to impose any conditions, such as medical treatment, for the protection of society. Assuming that Thomas' condition is as bad as described, she could easily present a monthly danger on the road. In theory, this is similar to allowing an untreated epileptic to continue driving after the same kind of behaviour.

In his commentary on the case, R.S. Shiels observes that the court could have disposed of the appeal without mentioning premenstrual tension because disqualification was excessive in the circumstances even in the absence of a medical excuse. However, Shiels goes on to claim that "[t]he judicial recognition of premenstrual tension as a mitigation is a notable and humane advance."\footnote{Ibid. at 248.} On the other hand, he does point out that the recognition of PMS as a mitigating factor may lead to difficulties later in regard to the proper holding of a licence or to the driving of a vehicle in the knowledge of the likelihood of irrational behaviour such as might well affect the nature and quality of the driving.\footnote{Ibid.}

Thus, what Mrs. Thomas, and others like her, may have gained on the swings of the court she may have lost on the roundabout of the vehicle licence department. If PMS is recognized as a disorder affecting rationality, women do well to be afraid of the label, as it could curtail
activities that are essential to normal functioning in today’s society. All the more reason to push for subdivision and new nomenclature that will separate severe PMS from other less serious symptom combinations.

With respect to lesser crimes in Canada, the British Columbia court recently (1988) rejected PMS as a full defence in a "refusal to blow" case. In addition, McArthur and Kendall both report that Alberta provincial court judges have considered PMS in two 1984 shoplifting cases. In the first, the accused received three years probation and a direction to seek psychiatric help. In the second, the judge rejected the argument that PMS was a disease and therefore a complete defence by itself. McArthur, interpreting the original report by Fennel, states that the judge held that PMS coupled with other factors was enough to negate specific intent because these factors rendered the woman irrational at the time of the offence. Kendall, interpreting the same Fennel article states that "the judge did note that the woman’s state of mind may or may not have been caused by PMS." (emphasis added) The difference in these reports may appear to be a minor discrepancy but it shows how a "may or may not" situation can escalate to a definite "PMS defence" when researchers accept secondary sources as accurate reflections of what was said in a courtroom. The danger of inaccuracy is even greater when the writer approaches the topic with a firm preconceived bias.

As with more serious crimes, the court, maybe because of the way the defence conducted the cases, zeroed in on PMS rather than external factors. I do not have enough facts to suggest

955 Referred to in Kendall, supra note 62 at 13. In a personal communication with a psychiatrist involved in this case, I was told that the judge did consider PMS when sentencing.


957 Kendall, supra note 62 at 78.
alternative defences but it is possible that these women were suffering from the effects of childhood abuse, ongoing spousal abuse, isolation, depression, or a host of other factors that are commonly found in the Elizabeth Fry Society shoplifters counselling program.958

Canadian courts may not be so ready as British courts to accept PMS as an established entity that might entitle an accused to mitigation or partial defence but they have gone further along the acceptance route than U.S. courts. There is no reported U.S. case in which the court has accepted PMS as a legitimate defence. Despite this, writers in that country have gone out of their way to identify PMS as an issue, where it would probably have passed into legal limbo were it not for what, on analysis, I would call untoward attention. An exception to this is the case of In re Lovato v. Irvin described above.

The mere mention of PMS in a judgment is enough for some writers to characterize it as a "PMS case." James Lewis cites seven cases, including Santos, that he connects with a PMS defence although he does concede that the "only near test of a PMS defense in a criminal cases in the United States was People v. Santos."959 One is Reid v. Florida Real Estate Commission960, a 1966 case that he wrongly cites as 1986 and that was concerned with menopausal symptoms not PMS. The only criminal case that he cites is State v. Lashwood961

958 See discussion in Chapter 4.
"For people who feel something has been stolen from them - their independence, dignity, virginity - shoplifting is one way of reaching out and taking it back. And for those who aren’t getting their needs met out of life, it can be a way of expressing anger or a cry for help." - Joanne Sutton, counsellor and program supervisor, Elizabeth Fry Society, Vancouver.


960 188 So. 2d 846 (Fla., 1966).

961 384 N.W. 2d 319 (S.D. 1986).
in which the defendant, was convicted of three counts of forgery after a plea of *nolo contendere* (pursuant to plea bargaining negotiations). Lashwood appealed on the ground (among others) "that her pleas were not knowingly, voluntarily and intelligently made because of her prior history of mental problems." Morgan J., dismissing her appeal, went on to observe that

> [w]hile psychiatric examination [pursuant to an initial plea of insanity] confirms that Lashwood suffers from premenstrual syndrome and she has significant memory loss, the report also shows that Lashwood knew right from wrong and had the ability to help in her own defense.

This is the only reference to PMS in the judgment. The other cases cited by Lewis involve civil matters concerning employment and child custody issues.

One recent U.S. case, however, is significant because of its similarity to cases like *Thomas* (above). In a detailed note, Christina Hosp describes the Virginia case of *Commonwealth v. Richter*[^964], tried in a jurisdiction that does not follow the *Frye* test. Dr. Geraldine Richter was pulled over by police who noticed that the car she was driving was weaving back and forth across both lanes of a two lane highway. Richter's three young children were in the car. When an officer questioned her about how much she had had to drink, she swore at him and refused to take a sobriety test. She continued to curse and swear when she was taken before a magistrate and kicked the breathalyser when asked to give a breath sample. She finally decided to blow about an hour after being pulled over. The breathalyser recorded a level of 0.13 percent. Richter later testified that she had consumed four glasses of wine over a six hour period. The judge

[^962]: Ibid. at 321.

[^963]: Ibid.

found Richter not guilty of Driving While Intoxicated (DWI) because he had a "reasonable
doubt" about the cause of her behaviour.

The defence argued that (1) the breathalyser results were unreliable because Richter had
been told to hold her breath before taking the test; and (2) she had become abusive only after
she was told that her children would be placed in protective custody for the night. A physician,
Dr. Cay, testified that "moderate" PMS had exacerbated the situation and could explain her
abnormally abusive reaction. Dr. Cay met the defendant for the first time one day before the trial
and was allowed to present hearsay evidence that Richter was in the premenstrual phase of her
cycle when she was arrested. There was nothing in the trial record to show whether Richter knew
she suffered from PMS prior to her arrest.

In making his decision, Smith J. seemed to feel he had to determine whether Richter’s
behaviour was due to intoxication or PMS. Although evidence was led to show that women
absorb alcohol more quickly during their premenstruum than at other times of the month, the
judge did not consider the significance of the combined effect of alcohol intake and PMS; that
is, that the presence of PMS might make intoxication more, rather than less, likely. Hosp
also points out that that the defence did not use PMS to explain Richter’s erratic driving but to
explain why she became so excessively abusive on being pulled over.

This case seems to be a product of an expensive defence rather than deep legal reasoning.
Richter was able to marshall three scientific experts to attack the accuracy of the breathalyser
result and to provide an alternative explanation for what, on the face of it, was drunken abuse.
I also wonder how much influence motherhood mythology played in the judge’s conscious and
unconscious reasoning. Had Richter been alone her ranting and raving may have placed her in

965 Ibid. at 437.
the raging virago category. By testifying that she was afraid for the safety of her children, she became the lioness defending her cubs.

Whatever the motivation for the decision, this is the only case in which a court has acquitted an accused arguing PMS as a defence. It therefore goes a lot further than those cases in which PMS has provided grounds for mitigation. It remains to be seen whether Richter is the start of a new trend in the U.S. or whether it remains an anomaly.

**PMS as a Sword and a Shield**

If PMS gains legal acceptance as a defence, it is inevitable that it will be used as a sword to wrest rights from women, unless PMS is very narrowly defined for criminal purposes. Women writers, with justification, constantly point to the danger that men will use women's "disorders" to take away rights from women. The areas most often identified are employment, child custody, and defences to wife battering. Reported civil cases in which PMS has been raised are as hard to find as criminal cases and researchers are often scraping the barrel when they attempt to show that the decision was influenced by the presence of PMS.

Chait\(^{966}\), Kendall\(^{967}\) and Holzman\(^{968}\) express concern that the use of so-called female disorders as defences will contribute to the denial of political power and responsible employment to women. Two U.S. employment cases have been cited as illustrations of PMS/menstrual issues in the courts. In the 1969 case of *Crockett v. Cohen*\(^{969}\), Rosa Mae Crockett was appealing the

\(^{966}\) Supra note 44.

\(^{967}\) Supra note 62.

\(^{968}\) Supra note 200.

refusal of a government agency to award her disability insurance benefits under the Social Insurance Act because in its opinion her medical impairment was not "disabling" as defined by the Act and that she had "residual work capabilities." She was an inspector of electric condensers, a job that required her to carry heavy loads. She was 49 at the time of the appeal. The District Court reviewed her long history of ill health which included arthritis, premenstrual tension, vulvovaginitis, spastic bowel syndrome, intestinal obstruction, secondary cystitis mild myositis, hypertension, mild anxiety, depression and various other symptoms. As the court puts it: "The report recites that the claimant has suffered from "female troubles" for years, but at the time she is doing well except for nerves and arthritis." Mae Crockett testified that she suffered constant pain and that her hands were so sore she could hardly use them. There is no record that she complained that "female troubles" were preventing her from working. The Court sent the case back for reconsideration because the examiner had failed to apply the correct test and had merely recited the evidence without giving reasons for his decision. The examiner should have considered: (1) objective medical facts; (2) medical diagnosis and opinions; (3) subjective evidence of pain and disability; (4) claimant's educational background and work history. Crockett's subjective evidence did not include PMS - or else the judgment, which was very detailed in other ways, just failed to mention it. Crockett v. Cohen is cited as a "PMS" case, but PMS was an insignificant factor in the reasoning.

Almost twenty years later, Linda Swanson resigned from her job as a secretary and receptionist after eight years with her employer. She tried to withdraw her resignation two hours

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970 Ibid. at 741.

971 Ibid at 742.
later but her boss refused to reinstate her. The Court described Swanson's circumstances as follows:

On June 19, 1985, Swanson was grieving the deaths of her grandmother and a close friend. She was also suffering from a yeast infection, food allergies, and premenstrual syndrome, which caused depression, irritability, and irrational upsets.972

This is the only mention in a five page judgment of PMS. However, it does link PMS with "irrational" upsets. An appeals examiner from the Department of Health & Welfare concluded that Swanson had voluntarily quit her job without good cause and could not collect unemployment benefits. The Idaho Supreme Court in a majority decision held that the examiner should have taken into account whether or not Swanson genuinely intended to quit or whether she was merely expressing displeasure with management. They also held that the Employment and Security Act should be interpreted liberally so as to effectuate the purpose of the statute. Bistline J. remarked that her boss was "extraordinarily precipitate" in following Swanson to her home to deliver his acceptance of her resignation and that "[s]uch actions seemingly belong more appropriately in a children’s or young lover’s quarrel."973 If there was an irrationality contest going on here, I believe that the boss should have won, yet there is no mention of his hormonal balance or lack of it.974 If cases such as this are cited as "PMS cases" it is possible that a defence may grow incrementally out of irrelevant data and insignificant references.

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973 Ibid. at 901.

974 This reasoning in this case might become important in Canada now that Bill C-113 has been passed and people who quit work "without just cause" will receive no unemployment benefits.
Had a man acted like Swanson in similar circumstances, it is unlikely that a court would have looked beyond his state of bereavement to find an explanation for his actions. This is not to deny that the cumulative effect of Swanson's loss and her physical condition might not have precipitated her into action that she might not have taken had she been healthy and ovulating. I just want to point out that lawyers and judges seem to attach much more relevance to women's physical and emotional symptoms as they affect intent than they do to men's. Except for the studies that try to tie testosterone levels to aggression, no one appears to ask whether a man's T levels might have caused an irrational reaction. These two cases go to show how few appear before the courts when writers have to resort to such equivocal judgments in support of assertions of the dangers of PMS defences.

An area that justifiably causes concern is the possible use of PMS by fathers who are trying to gain custody of their children. Kendall cites Babcock v. Babcock975 as a case in which "a British Columbia Supreme Court judge considered a woman's PMS condition to be an important factor in denying her custody."976 Mrs. Babcock, while she had custody of her daughters, tried to commit suicide by taking an overdose of Fiorinal. The father then gained custody via a consent order, with supervised access to the mother. Hyde J., considering whether Mrs. Babcock should regain custody, stated that this suicide attempt might "well turn out to be related to a condition which was subsequently diagnosed by Dr. Monks" as premenstrual syndrome. Dr. Monks testified that he was successfully treating Mrs. Babcock for PMS and migraine and that he had no present concern with her drug use or mental health. However, the doctor also stated that her symptoms would return if she stopped her medication and special diet.

976 Kendall, supra note 62 at 79.
Hyde J. refused Mrs. Babcock’s request for custody and maintained supervised access with the right to apply in six months for unsupervised access if she had stayed on her diet and medication.

In this case, Hyde J., before the suicide attempt, had found that both parents were equally capable of raising the children. It was probably the suicidal behaviour, rather than its cause, that led him to change his mind. It is interesting to note that no explanation other than PMS was put forward for Mrs. Babcock’s behaviour. There is no evidence about her economic situation, whether she had to work to support the children, how Mr. Babcock treated her, or any other external factors. The judgment discloses that Mr. Babcock was playing games with respect to access, so it is likely that he was causing Mrs. Babcock extra stress by being obstructive. The expectation of recurrence because of an implied lack of faith in her ability to stick with treatment is central to Hyde J.’s decision. I wonder how much of this decision rests on the belief in the myth that women are the hapless victims of their raging hormones and that, once these hormones gain the upper hand, there is no hope for rationality. In this case, an attempted suicide lost the mother custody but PMS was instrumental in perpetuating that loss.

Two U.S. custody cases refer to menstrual problems. The first, *Tingen v. Tingen*977, was an appeal from a divorce decree that granted custody of three of four children to the father, despite the fact that the "father did not, other than his cross complaint, express an interest in having the custody of the children"978 and the children had expressed a wish to stay with their mother. There was evidence that Mr. Tingen had physically abused his wife. He also attended cockfights and operated a gambling establishment. I would have thought that these latter, if not the former, activities would have been enough for a court to award custody to the mother.

977 446 P. 2d 185 (Oregon, 1968)

978 Ibid. at 186.
However, this is reckoning without the impact of a medical report that diagnosed the mother as suffering from

anxiety reaction, premenstrual tension syndrome, and tension headache, and that these symptoms have been brought on by emotional stress, anxiety, hostility and frustration, and that they would be greatly, if not entirely alleviated by settling her marital problems.979

The Appeal Court reversed the judge below, finding that he had unduly "isolated factors pertaining to the mother's illness"980 to the exclusion of other factors. It would be interesting to know how many similar trial decisions have not gone to appeal because of a lack of financial and emotional resources. In this case, the court clearly rejected the idea that fitness could be based solely on a medical condition. This does not mean that a more determined father will not succeed with such an argument. For instance, the only evidence about Mrs. Babcock's unfitness was her medical condition.

In the Matter of Parshall, the parents tried to prevent the termination of parental rights over their daughter after their son died due to head injuries inflicted by a beating by the mother. The evidence showed that the mother was "impulsive, unable to handle frustration, suffering emotional impairment from her own history as an abused child...."981 A psychologist diagnosed personality disorders which are difficult to cure. He also stated that she tried to project blame onto others for her son's death "and most recently onto her alleged premenstrual syndrome."

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979 Ibid. at 186.
980 Ibid. at 187.
981 405 N.W. 2d 913 at 914 (Mich. App., 1987).
This is the only mention of PMS in the judgment - hardly a justification for classifying it as a "PMS case." 982

Another use for PMS in a legal context is as evidence of provocation in a murder case - as in "she ranted and raved at me for so long that something just snapped." Holtzman and McArthur both observe that PMS could be used as an excuse for violent behaviour against women. For example, "the husband/batterer could assert that his wife was in the throes of her illness, became violent with him, causing him to attack and seriously injure her." 983 She could contend that he had beaten her for years whenever she had become emotional or irritable. This could lead to a contest between a the Battered Woman Syndrome and the PMS myth. 984 I have heard of only one case in which this occurred and have been unable to track it down. 985 However, if PMS becomes a successful defence and is recognized as causing violent irrational behaviour in a few cases, it is almost inevitable that men will cite such behaviour as an excuse for violent retaliation. It would be ironic indeed if PMS were to become the vehicle for a male form of the Battered Woman Syndrome.

982 James Lewis, supra note 959, lists it with Lashwood, Swanson, and Tingen as possible examples of acceptance of PMS by the courts.

983 Holzman, supra note 200 at 715.

984 Now that the Battered Woman Syndrome has been recognized as a medical entity by Canadian courts, it could be used as a factor in situations other than self defence; for example, certain types of provocation. Indeed, it could be used to substantiate a PMS defence if the accused can show that her level of fear, her ability to control herself, or her perceptions are consistently altered during the paramenstruum.

985 Personal communication with a Crown pathologist who described a case in which she did an autopsy on a woman with multiple stab wounds and in which the husband claimed she drove him to it by her violent irrational behaviour.
McArthur refers to a case in which a dentist was acquitted of rape after claiming that his girlfriend had filed charges while premenstrually irrational. If the complainant's credibility was destroyed because of allegations of PMS, then this represents a real danger to women. However, just as there is no doubt that some lawyers will continue to use women's illnesses in order to defend women, there is no doubt that other lawyers will use them to defend men. Rather than running away from reality by pretending that PMS does not exist, feminists should already be formulating strategies to deal with this danger.

Critiques of PMS "defences" - Opinions of Women

When the Craddock and English cases sprang to public attention there was also an explosion of literature on the pros and cons of PMS as a complete or partial defence. Some of these articles came from medical professionals; others from concerned feminists. Although some medical professionals tended to approve the defence, others recognized its deficiencies. Similarly, some feminists completely condemned such a defence while others recognized some merit. Landers notes a progression of feminist responses to medical attempts to identify women's menstrual cycle as a justification for keeping them in their place. She argues that the early Women's Movement evaded the issue by concentrating solely on women's suffrage; and that the second wave of feminists attempted to either minimize the differences between men and women in an effort to gain men's rights for women, or to glorify the differences by raising the public's

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987 Lander, supra note 154 at 103ff.
consciousness about menstruation. By minimizing the effects of menstruation, women could make
themselves more like men. By glorifying them, women could claim superiority.

Similarly, modern writers seek to evade legal analysis by denying a PMS defence to some
women out of fear of the consequences to all women. Others seek to fit PMS defences into an
existing legal system that has little place for women's reality - a form of minimization. Yet
others want to recognize that reality by either (1) creating gender-specific defences - a form of
glorification (?) or (2) or adapting and gradually changing existing legal concepts by
acknowledging and accepting the realities of a diversity of people, including a diversity of
women. The following are examples of some of these different approaches.

Women writers tend to be more polarized in their reaction to the idea of PMS as a
defence than to postpartum illness as a defence. I have been interested to observe, among the
papers I have read, that the authors who are adamantly against the PMS defence have conducted
little analysis of the U.K. cases. Elizabeth Holtzman, who has written a number of articles since
the Santos case, vehemently denies the viability of such a defence. She states that

the defense rests on the baseless notion that some women may be driven to violent
behaviour in connection with the menstrual cycle.988 (emphasis added)

She acknowledges that some women exhibit cyclical symptoms but believes that these are "an
important medical concern, but not a legal issue."989 Holtzman does what she fears and accuses
society of doing; that is, she lumps all women together as if they were a homogeneous group.
In retaliation to the stereotype "women go crazy once a month" she generalizes that "women do
not commit crimes on a monthly basis and women do not become insane and violent with cyclic


989 Holtzman, "Premenstrual Syndrome as a Legal Defense" in Gise, supra note 396 at 138.
regularity once a month." She states that she has been unable to find any scientific evidence suggesting that there is a connection between the menstrual cycle and psychosis, insanity, or crime. Holtzman dismisses Smith and English in eleven lines and does not mention Craddock (in this particular paper). She overlooks or dismisses by silence all of Dalton’s work including reports of successful therapy which, although attacked for their conclusions and methodology, do not appear to have been contradicted with respect to extreme cases of PMS.

Holtzman is driven by a legitimate fear that the "PMS legal defense is the old hocus-pocus about women in a new guise." She rightly says that "we must be very careful about the language we use" but her own language lacks the balance necessary to give it serious credibility.

Kay Heggestad, a physician specializing in family medicine, agrees with Holtzman. She believes that PMS is as common as menstrual periods themselves, thus adopting a very wide definition for the syndrome. She accurately states that the vast majority of women do not seek or need treatment but this is because the vast majority of women do not suffer from debilitating symptoms. She exaggerates that "the only absolute prerequisite for having PMS is to be female." Even at the present stage of medical knowledge, it is possible to create a narrower definition of PMS. She erroneously says that for thirty years Dalton has proposed progesterone

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990 Ibid. at 139.
991 Ibid. at 142.
992 Ibid. at 142.
993 See also Holzman, supra note 200.
therapy for "all menstrual complaints" whereas Dalton is very specific about the range of patients who will benefit from this form of treatment.

Heggestad raises legitimate concerns but does so in an almost hysterical fashion (which in itself could contribute to irrational stereotyping). She fails to mention any of the criminal cases involving extreme PMS. Nor does she suggest subdivision of the symptoms so that extreme cases might receive the help they deserve without stigmatizing all women. Like Holtzman, Heggestad, by describing all women as PMS sufferers, contributes to the myth rather than deterring from it. These authors create an either/or situation; either all women have criminal tendencies because they suffer PMS (the stereotype that women must fight against) or no women have such tendencies (a questionable assertion in the face of Dalton's findings). Kendall995 has identified several other feminist writers who are afraid that recognition of a PMS defence will reinforce notions of female inferiority.996

I do not believe that such one-sided arguments serve the feminist cause. McArthur997, Chait998 and Osborne999 recognize real problems and therefore take a more realistic and contextual approach. I believe that there must be more solutions in addition to discourse and education. These tools are essential but they must be supplemented by concrete action. Just

995 Supra note 62.


997 Supra note 71.

998 Supra note 44.

999 Supra note 839.
saying that the PMS defence is bad will not make it go away, as lawyers will continue grasp it as a tool to use "in the best interest of the client." The establishment of PMS clinics is one form of concrete action. Unfortunately advocates of this type of help, usually PMS sufferers themselves, have had such an uphill battle to receive recognition of the reality of their circumstances that they tend to see this recognition as a panacea and discount the dangers of stereotyping.100

As Judy Fudge points out in a similar context1001, the danger of men using a tool like PMS as a sword may be more dangerous than women using it as a defence. However, the two go hand in hand. If we are going to use discourse, we should make one of the focuses of our discourse, communication of facts within the courtroom. Women’s subjective signs and experiences must be presented along with the totality of external social conditions of women - as was done in a different context in Lavallee. These external conditions must be stressed and given great weight so that the door is opened to improvement in women’s lives. These illnesses are real, but I wonder how strong the symptoms would be if women were no longer chained to a system of subordination. Maybe some women who commit violent crimes would continue to do so because in their case biological factors are the principal cause of their behaviour. Other women, when they no longer need an excuse for venting their frustration and despair, may

1000 See for instance Cassara, supra note 406 at 207-212. Cassara recognizes that PMS myths may temporarily set the women’s movement back by buoying pre-existing prejudices but she seems to assume fatalistically that if it is not PMS it will be another myth. As an example she cites the fact that spasmodic dysmenorrhea was recently blamed on the myth that women do not accept their sexuality, are immature, and lack coping skills - an etiology now disproved.

hardly notice adverse symptoms. Indeed many may take advantage of the positive symptoms already reported by a significant number of women.

Judy Fudge and others have alerted women to the dangers of asserting "rights" that men may turn around and use against them. Just how real is this danger in the context of women’s "disorders?" I have discussed this issue above in the context of a number of court cases concerning child custody. Other valid concerns about the use of such defences include the following: liberal application of such defences will thwart the goal of substantive equality by reinforcing stereotypes of female weakness and irrationality; women’s illnesses are a vehicle for exerting social control over them; the defence will become universal and abused; women will be conned into believing in an artificially constructed "disease"; a focus on legal defences will distract attention from social and economic problems of women. In the past feminists were so engaged in the fight to achieve equality that they were unaware of such dangers until they became self-evident. As the above list discloses, they are now more aware in advance of possible adverse consequences of apparent steps forward and should be more prepared to deal with them.

I have found two different reactions to the possible consequences for men of the use of these defences. McArthur believes that gender-specific defences might be contrary to equality provisions in the Canadian Charter since men who experience symptoms similar to those of PMS

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1002 McArthur, supra note 71 at 864.
1003 Kendall, supra note 44 at 15.
1004 Pahl-Smith, supra note 840 at 266.
1005 Holtzman, supra note 989 at 142.
1006 Kendall, supra note 44 at 25.
would not have access to this "easy" defence.\textsuperscript{1007} Perhaps the existence of this easy defence would induce the medical community to carry out more research into male cycles to determine whether men might also be entitled, in proper circumstances, to a similar defence. If they were, women could no longer be considered abnormal.

Heggestad worries that men might concoct a similar defence for themselves. I should imagine such a "concoction" would have an even more uphill battle than the PMS defence because cyclical mood swings that affect male rationality would run directly counter to the male myth of rationality and emotional stability. A worst case scenario might be a situation in which a man is acquitted upon proof that his abuse of his wife occurs on a regular cyclical basis due to uncontrollable hormone swings. I find that a difficult concept to accept even though he would in logic be entitled to such a defence.

A number of writers mention the problem of abuse by women of these defences. Because diagnosis relies so heavily on self-reporting there might be opportunities to fake evidence in the absence of external corroboration. Hosp argues that self-reporting techniques "are vulnerable to manipulation by a woman who carefully plans her crime."\textsuperscript{1008} She suggests that "[o]ne can easily imagine the wife who plots her husband's death over a multi-year period, being careful to build a pattern of "symptoms" timed to her menstrual cycle."\textsuperscript{1009} (emphasis added.) Heggestad illustrates the same point by inventing a hypothetical murder, set up to look as if it were committed under the influence of PMS. In their eagerness to deny the defence, these writers may succeed in doing what they seeks to avoid; that is, characterize women as a group -

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{1007} McArthur, supra note 71 at 864.
\item \textsuperscript{1008} Hosp, supra note 964 at 442.
\item \textsuperscript{1009} Ibid.
\end{enumerate}
\end{footnotesize}
not as irrational victims of their hormones, but as cold blooded cheaters and fakers. The fact that they see the PMS defence as a danger "easily imagined" rather than an extremely remote possibility, shows a lack of faith in honesty and integrity of women as a whole. As already pointed out, such extreme arguments do not advance feminist objectives.

Dalton, in the last chapter ("Jumping on the Bandwagon") of her most recent book, asserts that the "very purpose of [her] rigid definition ... is to prevent the malingerer and her legal advisers from jumping on the bandwagon and falsely claiming premenstrual syndrome where it does not exist."

She counters claims that PMS may be easily faked by stating that, in Britain at least, it is difficult to produce false evidence of medical events that must, under the British (and Canadian) medical system, be recorded in medical notes held by the general practitioner.

Heggestad, supra note 994 at 161.

"She could play the part of the loving wife and an excellent worker three weeks each month and turn into an angry, irrational person during the premenstrual week. She could see her doctor and obtain charts to "document" her outbursts of anger. She might even join a PMS group. If she were very clever, she would get her husband to call the doctor for assistance in treating these symptoms. After three or four "documented cycles", she could commit a crime such as murdering her husband for his insurance money, making sure she does it within a week of her next period. She could also make sure that she shows her jailer some evidence of the start of her period. The doctor, her co-workers, and the other members of the PMS group all can testify truthfully that she has severe PMS. She can then walk into court clutching her symptom charts and claim the "The Devil," her hormones, made her commit the crime. Consequently, she may receive probation, her doctor’s favorite treatment - which results in a full recovery - and her husband’s insurance money."

I should also stress again that most murders are committed by men, and that those men who commit first degree (planned and deliberate) murder must manipulate circumstances if they want to avoid detection.

Premenstrual Syndrome Goes to Court, supra note 411 at 144ff.

Ibid. at 144.
To summarize, all of the above concerns have substance but the degree of danger cannot be evaluated unless some form of PMS defence is more widely accepted and applied. Women who seek to deny these defences do so out of fear of slowing progress towards equality and of losing those gains that women have struggled so hard to achieve. Some, in their fear, reject truth because they believe that our patriarchal system will use it against them. Rejection of truth is a kind of self-inflicted silencing. It is impossible to explain or rectify a condition that you deny, be it biological, psychological or social. Denial also allows the opposition to take charge and dictate definitions and treatments. Women must participate in researching, defining, and applying these defences. Otherwise men will do it for them - to their detriment.

If women claim public protection by means of the right to a gender-specific defence, will this entail the surrender of their private right to control their own bodies? Is it consistent for feminists to argue for the exclusion of criminal law from the issue of abortion yet invite it in to protect women who suffer from sex-related disorders? Is it consistent to ask for special benefits such as maternity leave for pregnancy and special crimes relating to sexual intercourse with girls under fourteen and, at the same time, attempt to deny to men, because of their gender, the benefit of equality rights designed to better the condition of women? If a right is based on traditional ideas of "equality" women must be prepared to meet inevitable disadvantages that may accompany its advantages. However, if we could frame "equality" in a way that respects difference and recognizes the viewpoints of people other than financially secure, conformist white males, the spectre of continued female subordination might evaporate.
PMS "Defences" - A Summary

I entitled this section "PMS Defences: The Real and Imaginary." They are imaginary because, so far, no court has accepted PMS as a complete defence. They are real because a number of courts have acknowledged that PMS may affect cognition to the point that an accused deserves mitigation of sentence after conviction, or conviction on a lesser charge when she lacks the requisite mens rea. They are imaginary to the extent that a number of writers have inflated mere references to the possible existence of PMS in a defendant to the status of "defences." Researchers who pick up those secondary sources without referring to the original cases run the risk of further distorting the significance of the court decisions. They are real to the extent that the court saw fit to mention PMS at all in cases that could have been decided without such a reference. This shows that PMS had at least some relevance for the judge.

It is impossible to tell how widespread is the use of PMS as a tool for mitigation as most of the trials in which the subject is raised are not reported unless they are sensational - and then the reporting is done in the popular media.

The danger of PMS being used against women is real. It has already happened and doubtless has been happening for decades under other guises. Instead of ignoring PMS defences out of fear of misuse, women should pre-empt this misuse by education both inside and outside the court system. Just as women have gradually taught society about the reality of their experiences as rape victims, they can give lessons on the reality of PMS. They can develop strategies, other than running away, to deal proactively with inevitable male attacks.
Conclusion

In my conclusion under "Infanticide" I opted against a gender-specific postpartum defence but argued against creating a void in place of existing infanticide provisions. There is already a void where PMS is concerned. How can we fill it? It is likely that the courts, in the near future at least, will demand validation of women’s experiences via medical corroboration. The acceptance of PMS as a reason for mitigation varies in direct proportion to its acceptance by the medical establishment in each court’s jurisdiction. English medicine recognizes PMS; therefore, English judges finds the existence of PMS a credible reason for mitigation. U.S. medicine is still making up its collective mind about whether PMS is a psychiatric disorder, an organic disorder or whether it even exists; therefore, U.S. judges are reluctant to grant any validity to PMS defences in criminal cases.

As demonstrated so many times in this study, the only certainty that flows from my research to date is that this whole area of disorders defined specifically as "female" is fraught with uncertainty and obscured by disagreements: disagreements among doctors about definition, cause and treatment; disagreement among lawyers about the characterization and viability of defences based on women’s illnesses; disagreement among feminists about the need for such defences; disagreement among women at large about the existence of these disorders and the need for support groups and special clinics. Add to that, interdisciplinary disagreement among physicians, psychiatrists, sociologists, and lawyers, and what is supposed to be scholarly discourse ends up as an unintelligible Tower of Babel. How can this situation be rectified so as to protect women as a group from harmful stereotyping and individual women from wrongful conviction?
Women must work on all levels to counteract false myths and to present their own perceptions to the public, whether or not these perceptions confirm or deny medical findings - in the doctor’s office, in the courtroom, in schools and, especially, in the media. In the context of crime, as far as it is possible, no article should be published that does not emphasize that men commit 90% of violent crimes, and less than 0.1% of women commit crimes which can be characterized as occurring under the influence of women’s illness.

Women should publicize the fact that "[n]o studies confirm women’s complaints that they cannot think clearly before and during menstruation."1014 (Emphasis added) Then women who perceive themselves to be confused can either challenge such findings or ask if there are reasons other than biological that make them feel as they do. They should stress the following quotation from McArthur:

At all times of the month men commit far more crimes than do women ...[and] the hormonal make-up of men is more like that of premenstrual women than women at any other time! 1015

Medicalization of women’s bodies preserves harmful stereotypes. The legal system reinforces medical opinion by insisting on relying upon it in the courtroom, sometimes to the exclusion of other evidence. Thus these two great bastions of male domination work hand in hand to maintain a hierarchical society which ignores or discredits the world views of women. Medical and legal attitudes are paternalistic when they urge these defences without considering adverse consequences, and blind when they would disallow them completely. "Law, like

1014 Gise, supra note 396 at p. xviii.
1015 McArthur, supra note 71 at 868-869.
Andrea Dworkin has said that feminists must listen to the very real concerns of right wing women and should attempt to communicate with them. Feminists must not ignore or scoff at the opinions of other women; neither those who blame all their woes on their hormones, nor those who refuse to recognize that their symptoms might be due to illness. Just as women of colour feel alienated when white middle-class women purport to speak for them, women who have experienced the misery of illnesses such as PMS feel alienated when feminist non-sufferers seek to invalidate their experiences "for the greater good" of the group. To be effective, feminists must make practical provision for strategies which take into account differences as well as sameness.

Although most non-biological studies agree that social and cultural factors may help cause, or at least affect, these illnesses, I have not yet found a study that has examined age, cultural background, socioeconomic grouping, marital status, etc. to determine whether there are any measurable relationships between symptoms and environment in the case of PMS. Such

1016 Ibid. at 841.

1017 Unfortunately, many women's expectations of themselves are conditioned by the role they have been taught to play within a patriarchal society. Although their expectations may be based on false premises, they are no less real to these women. Therefore, not only do women have to search for an outlet for their voices, but they must also ensure that their voices are authentic; that is, they must learn to distinguish between a conditioned and a thoroughly analysed response.

1018 Dworkin, A. [From video of speech given by her in Canada, cite unknown.]

1019 This does not necessarily mean that such studies do not exist, but that they are not easily accessible to scholars seeking information. Fishbein, supra note 233, suggests such an approach for female crime, and Shoham, supra note 775, has taken such an approach in studies of male crime.
studies are urgently required so that society can focus on the social needs of women sufferers as well as problems pertaining to individual women. This may mean exploding further myths - those connected with the idea of family since "[w]e now know that the family is all too often a perilous and damaging unit for its weaker members, who are usually women or children"\textsuperscript{1020} - made weak by subordination.

With respect to legal strategies, McArthur advocates that lawyers not rely on a "syndrome" at large but on actual symptoms of a particular accused. She believes that this would assist in reducing stigmatization of women as a group. She envisions that a defense should be available to women whose symptoms are so incapacitating that they lack the necessary criminal intent. Their symptoms should be focused upon, and not the supposed syndrome, in the same way that men citing similar symptoms do not hinge their defense on a disease, disorder or illness with a single label.\textsuperscript{1021}

Although I sympathize with her objective I do not think that she is accurate when she says that men can rely on mere description of symptoms. The cases on diabetes and epilepsy (discussed below), for example, indicate that courts pay attention to the label that medicine gives these symptoms if only because medical expert witnesses use such labels in their testimony.

Chait suggests incorporation of women's actual experience into legal analysis. As with the battered-woman/self-defence cases this would help identify and remove stereotypes from legal consideration and would educate judges and juries about women's reality. The law can no longer afford to ignore social and cultural factors that contribute to gender inequality. As Bates points out:

\textsuperscript{1020} Frank Bates, supra note 740 at 271.

\textsuperscript{1021} McArthur, supra note 71 at 870.
Law and legal responses to social phenomena are all part of culture, so inextricably connected that any systematic attempt to disentangle them is futile.\textsuperscript{1022}

Osborne, one of the few writers who is in favour of gender-specific defences, believes that one solution would be

the reconstruction of criminal law along integrative feminist lines to produce new legal categories, responses and sanctions in the criminal law which affirm women's specificity without attribution of inferiority to the special treatment.\textsuperscript{1023}

This may be easier to say than to do.

While the courts rely on medical diagnoses to reach decisions, none of these legal solutions will be effective until there are clear medical or legal definitions for these illnesses. As Dalton says:

[those few women who lose control of themselves for a day or two, month after month, need help and help is available. However, they must not be confused with the other 99.9 percent of women who are well able to control their actions. PMS is not a universal defense, nor should it be allowed to become one. Medical evidence is required by the court and the doctor must become fully conversant with the recognition, diagnosis and treatment of the syndrome.]\textsuperscript{1024} (emphasis added)

Unfortunately, confusion about recognition, diagnosis and treatment of the syndrome is the heart of the problem.

In an earlier (unpublished) paper on PMS defences I argued that interdisciplinary cooperation and longitudinal studies are necessary before any credible legal strategy can be

\footnotesize{1022} Bates, supra note 740 at 275.

\footnotesize{1023} Osborne, supra note 839 at 184.

\footnotesize{1024} Dalton, K. cited in Apodaca & Fink, supra note 842 at 77.
formulated and implemented. However, I have come to believe that women should not have to wait for the medical communities to make up their minds before striving to change the law in order to gain recognition of their reality. Prior to the medical monopoly of mental disorders, the law trusted lay juries to reach conclusions about whether a person was a "lunatic" or not. They used their own experiences and observations of "normal" people as a gauge for measuring abnormality. Medical evidence, if available, was merely an additional assessment tool. I have a feeling that these juries' assessment of dangerousness and non compos mentis may have been just as accurate as those who rely solely on medical definitions such as bi-polar affective disorder and schizophrenia.

Similarly, if women are able to gain recognition of their reality (not their myths) by the public, medical recognition and definitions may follow. I believe that women's demands for rape crisis centres and treatment for post rape distress were instrumental in the recognition of Rape Trauma Syndrome. It was not the recognition of a syndrome that opened the centre doors but political pressure from women in the community who exposed the extent of rape in our society and demanded resources from government in order to help each other. A similar process occurred in the evolution of the Battered Woman Syndrome. Maybe women who attend PMS clinics and support groups, and who are aware of the legal issues involved, can push medical researchers into coming up with sub-categories of PMS that will be accepted in court, with or without the testimony of a doctor. Hopefully, in this way women will have more control of the proper use of PMS as a defence by identifying their own reality, forcing medicine to label it in accordance with that reality, and then using that label in court.

Meanwhile, a combination of diminished responsibility defences plus mitigation of sentence appear to be the best routes to follow. Criminal law reform, as suggested above under
infanticide, could take the mental state induced in some women by PMS into account along with postpartum disorders. PMS like postpartum conditions appear on a continuum. Some varieties are so severe that an accused could plead insanity; others are so mild that they should offer no excuse. Dalton’s approach prevents malingering but it denies any defence to women who do not fall into her strict category. However, Dalton’s PMS is a verifiable, narrow, treatable category whose sufferers deserve mitigation because of diminished mental capacity.

If, as in Craddock, there is a likelihood of further violence, the court should make provision for release plus treatment, assuming that there exists a treatment that has been proven effective (as in Craddock and English). Since many sufferers from women’s disorders experience a sense of isolation and depression, courts should direct convicted accused to associations that can provide group therapy. This appears to have been a successful tactic with women shoplifters and with some male batterers. Further work should be done with the separate groups within Canadian cities that provide support for victims of postpartum, premenstrual and menopausal illnesses to determine whether they might be able to assist in the criminal law context.

(iii) MENOPAUSAL DEFENCES

Although I have come across a number of anecdotal references to judicial reactions to women of menopausal age, I have found only one reported case in which a woman used menopause as a substantive defence.¹⁰²⁵ In Reid v. Florida Real Estate Commission¹⁰²⁶, the

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¹⁰²⁵ I have a personal recollection of an Alberta case in the 1970s in which a judge called a witness’s credibility into question because she was 46 years of age. However, I have not tracked it down.

¹⁰²⁶ Supra note 960.
49-year old petitioner, a "prominent real estate broker,"\textsuperscript{1027} sought reinstatement of her licence which had been suspended following charges of shoplifting a $3 steak. At her hearing she alleged she had been going through a period of untold mental anguish and nervous discomfort, with emotional problems that brought on persistent headaches, all caused by what is commonly called the "change of life."\textsuperscript{1028} She also stated she had suffered from "premenstrual tension." The Court held that the petitioner, at the particular time of the incident, was unable to form any rational intent to steal.

This case certainly supports the stereotypical picture of the anxious and confused menopausal woman. However, I have already described studies that show that this picture is the exception rather than the rule.\textsuperscript{1029} It is almost thirty years since this case was heard. I doubt whether a menopausal defence would have such an easy passage now that greater numbers of older women are assuming positions of power and responsibility outside the home.

Medical evidence for a causal connection between premenstrual signs and diminished mental capacity is equivocal; evidence for a causal connection between menopause and diminished capacity is practically non-existent. However, if such evidence were to surface, the reasoning I have already presented both for and against gender-specific defences should apply equally to defences that rely on menopausal illness.

\textsuperscript{1027} Ibid. at 850.

\textsuperscript{1028} Ibid at 849.

\textsuperscript{1029} For example, Morse & Dennerstein, supra note 56, citing, at 187, a study by Ballinger (1976) who chose at random 760 women of ages between 40 and 55 and found no specifically menopausal emotional disturbance distinct from pre-menopausal problems.
B. MALE "DISORDERS" IN THE COURTS

(i) IMPOTENCE

People respond to the idea of a PMS defence in a number of ways ranging from acceptance to disapproval. When I have introduced the idea of a defence based upon sexual impotence, I have met with a variety of responses including incredulity and laughter of a type not met with in discussions of female defences. Why should there be such a difference? Both conditions involve sexual function; both may be related to hormone balance; both may cause mood changes; both may be connected in some way with criminal offences. Theoretically, if a man can show that there is a causal connection between his impotence and a reduced capacity to form criminal intent, why should he not raise it as a defence? In this section, I will examine existing law - scant though it is - and then discuss the applicability, in the male context, of various defence models put forward for "female" defences.

When we think of impotence in connection with the law, it is natural to consider it as grounds for annulling a marriage, not as a criminal defence. However, it is in the latter context that impotence is of relevance to this study. Not unexpectedly, I was able to find only one reported criminal case that deals with this topic even indirectly. However, that case, Bedder v. D.P.P.1030, went all the way to the House of Lords, and created a precedent for the law of provocation that was followed by Canadian courts for thirty-two years until the Supreme Court of Canada adopted a different approach in 1986.

Bedder was an eighteen year old youth who had "the misfortune to be sexually impotent, a fact which he naturally well knew and, according to his own evidence, had allowed to prey on

his mind." When he attempted and failed to have intercourse with Doreen Redding, a prostitute, she jeered at him. When she tried to get away, Bedder grabbed her. In the ensuing struggle, she kicked him "in the privates." Bedder retaliated by stabbing her to death.

At trial, Bedder argued that there had been enough provocation to reduce the crime from murder to manslaughter. However, his argument failed and the jury found him guilty of murder, probably on account of Sellers J.'s charge on the objective branch of the test for provocation which demands that an ordinary person would have been provoked under the same circumstances. Sellers J. instructed them that

an unusually excitable or pugnacious individual, or a drunken one or a man who is sexually impotent is not entitled to rely on provocation which would not have led an ordinary person to have acted in the way which was in fact carried out.  

The Court of Appeal and the House of Lords approved these instructions. Simonds L.C. expressly rejected the idea that "the reasonable man should be invested with the peculiar physical qualities of the accused."

It is interesting that both the English and Canadian cases that extended the scope of the objective test involved issues of male sexuality. In R. v. Camplin the fifteen year old killed his victim by hitting him over the head with a chapati pan. He claimed that the male deceased had provoked him by a assaulting him sexually. The trial judge specifically directed the jury to take Camplin's age and sex into account when applying the objective arm of the provocation test. In upholding these directions, the House of Lords expanded the definition of an ordinary person

\footnote{1031}{Ibid., per Lord Simonds, L.C. at 802.}
\footnote{1032}{Ibid., quoting Sellers J. at 802.}
to take into account "the entire factual situation, which includes the characteristics of the accused." Lord Diplock stated that age was a relevant factor in deciding the gravity of provocation against, and the degree of self-control that should be expected from, the accused.

The Canadian Supreme Court went part way towards applying *Camplin* in *R. v. Hill*. This case also involved an alleged homosexual assault which the sixteen year old accused used to argue (1) self defence and (2) provocation. The trial judge directed the jury that, in deciding whether an ordinary person would have lost control, they should not consider the particular mental make-up of the accused; however, for the second arm of the provocation test they could take into account "the mental, the emotional, the physical characteristics and age of the accused."

Dickson, C.J.C. for the majority pointed out that the objective arm of the test reflects "society's concern that reasonable and non-violent behaviour be encouraged." Thus, an ill-tempered or exceptionally excitable person cannot rely on his short fuse to claim mitigation by provocation. Or as Wilson J. put it:

The objective standard ... may be said to exist in order to ensure that in the evaluation of the provocation defence there is no fluctuating standard of self-control against which accused are measured. The governing principles are those

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1035 It should be noted that the House of Lords were able to fall back on changes to English homicide law as partial justification in overruling *Bedder*, by relying on wording in the 1957 Homicide Act.


1037 C.R. at 106 (Dickson C.J.C. quoting trial judge).

1038 Ibid. at 108-109.
of equality and individual responsibility, so that all persons are held to the same standard notwithstanding their distinctive personality traits and varying capacities to achieve the standard. 1039

However, Dickson J. held that "features such as sex, age, or race do not detract from a person’s characterization as ordinary." 1040 On the other hand, he found that the trial judge had not erred by failing to expressly state that, for the purposes of the objective test, the ordinary person was someone of the same age and sex as the accused. He felt that the jury were able to deduce the relevance of these factors without specific instruction.

The dissenting judges agreed with the majority’s expansion of the scope of the objective test but found that the trial judge’s instructions would have misled the jury into believing that sex and age could not be considered when applying it. Wilson J. identified the fault inherent in the reasoning behind cases like Bedder as the assumption that provocative insults occur in a vacuum with no reference to reality. However, inclusion of too much subjective data would undermine the objective nature of the first arm of the test for provocation and would merge it with the second, subjective arm. Wilson J. gave the following example of the wider test:

[I]mpotent men are not excused for having a lower provocation threshold than that expected of "ordinary" people, but rather are measured against the standard of an ordinary person similarly situated and similarly insulted. The objective standard applies to mental states rather than to attributes which simply go to placing the insult in its proper context. 1041

The judges in Hill were therefore unanimous in adopting the substantive test in Camplin, but disagreed about the role of the judge in interpreting it for the jury. After Hill and until the

1039 Ibid. at 124.
1040 Ibid. at 114.
1041 Ibid. at 127.
Supreme Court revisited objective tests in *R. v. Creighton*\(^{1042}\), it seemed likely that, in cases like Bedder’s, juries would have been allowed to take impotence into account when assessing the gravity of provocation. However, the reasoning of the majority (5:4) of the Supreme Court in *Creighton* casts some doubt on this interpretation of *Hill*.

In *Creighton*, the accused had, with her consent, intravenously injected the victim with cocaine. When she went into convulsions, he refused to call for emergency assistance but left her alone in her apartment where she soon died. He was charged with manslaughter. Unlike *Hill*, the issue in this case was the objective test for unlawful act manslaughter (unintentional homicide) not the objective test for provocation in a case of murder (intentional homicide). However, McLachlin J. for the majority quoted from the judgments of both Dickson and Wilson JJ. in reaching her conclusion that

> personal characteristics not directly relevant to an element of the offence serve as excuses only at the point where they establish *incapacity*, whether the incapacity be the ability to appreciate the nature and quality of one’s conduct in the context of intentional crimes, or the incapacity to appreciate the risk involved in one’s conduct in the context of crimes of manslaughter or penal negligence.\(^ {1043}\)

She went on to point out that people could properly be held at fault for deciding to undertake activities without having accounted for their deficiencies.\(^ {1044}\) In such a case, Bedder could not have argued provocation if he had been aware in advance that failure to perform was likely to make him angry and lose control.

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\(^{1043}\) Ibid. at 213.

\(^{1044}\) Ibid. at 216.
Don Stuart, in his critique of Creighton, notes that exclusion of consideration of factors such as inexperience and lack of education in cases of unlawful act manslaughter runs directly counter to the unanimous decision in Hill that held that factors such as age (inexperience) could be taken into account in the objective arm of the test for provocation. I am inclined to agree with his conclusion that

[t]his reversal to a rigid objective standard cuts across a well-recognized need to ensure that the criminal justice system is sufficiently sensitive to issues of gender, race and disadvantage.

Isabel Grant and Christine Boyle discuss possible discrepancies between Creighton and Lavallee and conclude that the latter case, like Creighton, applies the same standard to all - not, like Hill, a flexible standard that may rise or fall depending on qualities of the accused. However, the fixed standard "require[s] the decision-maker to inform himself of the overall context in applying the standard." This makes sense as a matter of principle and maintains an appearance of philosophical consistency. But it is not always easy to divide personal characteristics and background of the accused from surrounding circumstances or overall context. Sometimes these personal characteristics create, or at least affect, the context.

Grant and Boyle are understandably concerned about possible erosion to the effectiveness of the statutory duty to take "reasonable steps" to ascertain consent when seeking sexual contact.

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1046 Ibid. at 250.

1047 Isabel Grant & Christine Boyle, "Equality, Harm and Vulnerability: Homicide and Sexual Assault Post-Creighton," ibid. at 252.

1048 Ibid. at 253.
with another person.\textsuperscript{1049} I share these concerns but wonder whether there should not be a different approach to an objective test that is part of a partial defence that reduces murder to manslaughter, than to an objective test that indirectly forms part of the definition of the crime of manslaughter itself. The two types of situation seem to be qualitatively different. The first deals more with cognition; the second with control and irresistible impulse. In the case of sexual assault, there is a positive duty to seek consent; in unlawful act manslaughter there is a positive duty to avoid certain acts. Where provocation is concerned there is a mitigating response to what could be construed as a reflex action.

I believe it might be possible to maintain the broadness of the test in \textit{Hill} without infringing on the reasoning in \textit{Creighton}. Since age, race and sex are factors that the court can take into account in \textit{Hill}, would it not be logical to extend this concept to cover, for instance, disabilities and sexual orientation? And could "disabilites" include severe PMS and impotence? This, of course, does not mean that the mere existence of a disability should be an excusing factor, merely that it is a something that can be taken into consideration when applying an objective test.\textsuperscript{1050}

\textit{Camplin} and \textit{Hill} reflect courts' increasing willingness to look at the circumstances of real people when applying an "ordinary person" standard - a more contextual approach. This may detract from the "objectivity" of the provocation test but it is more in keeping with the idea that courts should not impose full criminal responsibility for an intentional killing on a person who,

\textsuperscript{1049} Section 273.2(b) of the Criminal Code.

\textsuperscript{1050} A thorough discussion of the concepts outlined in \textit{Hill} and \textit{Creighton} is beyond the scope of this study. I must admit I have found myself entangled in contradictory reasoning when trying to reconcile the two cases, perhaps because neither approach is completely appropriate for dealing with the huge diversity of human experience.
because of age, sex or other personal characteristics lacks the capacity to act according to the standard of an ordinary, healthy white male. It is interesting to compare the reasoning of Canadian and English courts with that of Reece in relation to an expanded definition of provocation in cases of infanticide.\footnote{Reece, supra note 889. Reece has proposed that courts take into account experiences that are unique to women in assessing moral culpability. Since sexual impotence, as defined in this study, is unique to men, her reasoning would dictate that courts define provocation in a way that would allow for men’s response to circumstances surrounding impotence.}

Reece, of course, did not confine provocation to actions on the sudden but included factors such as long-term depression; exhaustion and hormone changes occurring in the period between birth and death of the infant victim. However, to fit Canadian law as it now stands, it might be possible to separate the final act from circumstances leading up to it while maintaining the legal relevance of both sets of evidence. The former could be triggered "on the sudden" while the latter could be characterized as part of Lord Diplock’s "entire factual situation" or be used to compare the accused with Wilson J.’s "ordinary person similarly situated."

Reece’s model would allow the introduction of a variety of information such as: the fact that the accused had undergone medical tests, had been depressed about the results, had unsuccessfully tried various remedies, had been laughed at or scorned on previous occasions, had been brought up in a macho society … All of this, however, goes only towards a provocation defence. Could an accused suffering from impotence ever fit a defence model analogous to those suggested for PMS offenders?

Although Bedder, Camplin and Hill all involved issues of male sexuality and loss of control because of perceived sexual insult, no one suggested that there might be a biological reason for the the actions of the accused. No one thought to ask whether they were at a low point
in their bio-rhythms or were suffering from an excess or deficiency of testosterone or prolactin. Had there been scientific data to support a biological defence, could it or would it have been used by defence counsel? How could such a defence be compared with proposed PMS defences?

Although biological evidence may play a part in establishing provocation, the above scenario does not fit the "classical" model advocated by Dalton for the PMS defence. Just as we run into contradictory myths in infanticide defences, we crash head on with conflicting images of the sexually impotent man. On the one hand, he is supposed to be a limp-willed weakling incapable of action; on the other, if openly scorned by others - especially women - few are surprised if he retaliates with physical violence against his tormentor. On the surface it would appear to be illogical to argue that impotence is akin to nineteenth century abulia or neurasthenia - disorders characterized by an inability to act - and at the same time blame impotence for violent actions by men who suffer from it. It also seems inconsistent to blame high testosterone levels for general male violence and then blame the low levels experienced by some sexually dysfunctional men for their particular brand of violence. However, it might be appropriate to compare those dysfunctional men with the class bully. Most suffer from low self-esteem,

1052 The same point could be made about women who are said to suffer from the Battered Woman Syndrome. On the one hand, they are cowed by abuse into a chronic condition of low self esteem, fear and inability to take positive steps to leave an intolerable situation; on the other, when they reach a stage where they believe they are in danger of death, they take violent steps to protect themselves.

1053 Note that in most men impotence is not associated with low T levels. However, diminished libido may be. Malcolm Carrothers, a chemical pathologist who runs a Hormonal Health Care Centre in Harley Street, London, claims that symptoms of middle aged lethargy, loss of vitality and virility, and depression may be due to the "viropause." He treats this "disorder" with testosterone tablets, since he theorizes that these symptoms are caused by abnormally high levels of Sex Hormone Binding Globulin which lower the levels of free testosterone. He believes that testosterone replacement will put the "tiger in the tank" of debilitated males. (C.B.C. broadcast, November, 1993) This appears to be the male equivalent of the menopausal hormone deficiency disease discussed earlier.
insecurity and fear of comparison with "normal" peers. A bully lashes out physically only at those weaker than himself. In cases like Bedder, this means women.

How might a chemical "impotence" defence work? To be comparable to PMS, an accused would have to establish a hormonal or other physiological imbalance that impairs cognitive function and impulse control to such an extent that it excuses him from full criminal responsibility. Assuming Dalton to be correct about PMS, there is a direct link between progesterone deficiency and brain function. Even if there is a similar link between testosterone deficiency and impotence, there is no established direct link between testosterone deficiency (or impotence) and altered cognitive function. The violence that is connected with impotence results from an insult to the ego, not from uncontrollable hormone changes in the brain.\footnote{1054}

In part I(A)(ii) of this chapter, I postulated a more holistic approach to "female" defences. If such an approach were accepted for women, would it work for male accused who claim impotence as a defence? Just as a tiny percentage of women would qualify for a PMS defence, only a small number of men with impotence - and therefore an even smaller fraction of men as a whole - would qualify for an impotence defence.\footnote{1055}

\footnote{1054} Maybe researchers could find a chemical link between a sexually aroused man unable to achieve satisfactory performance and altered brain function. However, no one seems to have thought of conducting such research - maybe because this theoretical picture runs counter to male myths.

\footnote{1055} Since there is at present no such thing as an "impotence" defence or even any suggestion of such a defence, it is impossible to determine how much violence may be attributed directly or indirectly to this disorder. In one recent month of legal counselling, I encountered two older women who traced either the onset of, or a dramatic increase in, violence to their husband's inability to achieve an erection. It may well be that impotence is at the root of a significant amount of wife assault - not necessarily for chemical reasons but because of failure to meet cultural expectations about the real man.
It may be that impotence, like PMS, can be viewed on a continuum. At one end, temporary impotence may cause depression, insecurity and irritability; at the other, permanent or chronic impotence may cause senseless violence against the perceived cause of, or contributor to, the "disease," his sexual partner. At one end there is a man who is temporarily ill; at the other a violent sociopath.

Using Fishbein's approach, a court could consider the synergistic effects of social and biological factors to create a profile of the man who would be most likely to qualify for an impotence defence. Such a man would have to demonstrate (1) the physical disorder and (2) a cultural background that contributes to an inability to control a violent reaction to imputations of sexual incompetence. For example, a man, from a macho society with a strong work ethic, suffering from impotence exacerbated by unemployment.

I feel that Fishbein's approach would be unlikely to succeed in practice even if there were to be a major shift toward general acceptance of more flexible defences. Public policy would likely prevent its implementation, as it could be extended, one way or another, to defend virtually all violent male offenders. For example, testosterone excess plus a "rotten social background" might excuse the majority of men charged. Thus a floodgates argument would be raised plus the general policy that refuses to excuse inherently excitable or pugnacious individuals. However, if impotence can be separated from other defences, the floodgates argument would not hold. In the case of a violent retaliation to a sexual insult by a woman, the power of the myth of woman the emasculator might unconsciously contribute to acceptance of such a defence, provided it could be cloaked in a veneer of scientific data. This, of course, would merely be another version of "blame the victim."
As with PMS, a major concern would be likelihood of recurrence and effectiveness of preventative treatment. The mechanical approach to impotence, outlined in Chapter 4, suggests that injections and prostheses would be acceptable treatments that (as with English PMS offenders) could allow release on conditional probation.

An "impotence" defence may sound far fetched. Indeed, what man would be happy about publicizing such a sensitive problem? Some might prefer incarceration to exposure as "less than a man." Indeed, this very situation surfaced in a fictional account in the 1987 movie From the Hip. The defendant had killed a prostitute who had threatened to reveal that he was impotent. The defence lawyer tried to argue that a sexually impotent man would be too inadequate to be able to carry out a brutal murder. However, the defendant was so incensed at these courtroom imputations of impotence that he "leaps from his chair, brandishing the murder weapon."

Present barriers to an impotence defence include, therefore, male mythology that is likely to lead to denial by men of such a defence; lack of scientific knowledge of male cycles, hormone fluctuations and sexual functioning; lack of any known biological connection between impotence and decreased cognitive capacity. In addition, this type of defence would be open to all of the criticisms levelled at biological defences for women. In the case of women, there is a built-in mythology that still accepts some form of connection between female reproductive functions and cognitive disorder. Apart from Victorian notions of a causal connection between masturbation and insanity, there is little to support the idea that underfunctioning male sexuality, by itself, leads to physical violence.

1056 Described in Berger, supra note 98, at 1.
1057 Ibid.
However, if society accepts gender-specific defences based, in whole or in part, on female biology, then women can hardly be heard to complain if similar reasoning is applied in the creation of male-specific defences. As discussed in Chapter 5, a number of researchers were willing, if not eager, to attribute criminal behaviour to an extra Y chromosome. In the next section I will very briefly mention the reception given in the courts to an XYY defence.

(ii) **XYY SYNDROME**

Of all the medical conditions considered in this study, the XYY syndrome is the only gender-specific disorder that demonstrates a clearly definable biological anomaly - the extra Y chromosome. Other disorders point to the likelihood of hormonal abnormalities but these have yet to be pinned down. In XYY syndrome, we have a situation in which, at first glance at least, we may attribute internal causation to some male offenders. The estimated incidence of the extra Y chromosome is one in one thousand\(^{1058}\) and only a small percentage of these become criminals. Therefore, the floodgates argument would not apply to an XYY defence. Yet, fewer men have tried to rely on such a defence than women who have raised a PMS defence. Why is this? Is there an inherent reluctance to attribute internal causation to men; or is there merely a lack of adequate scientific data to support an XYY defence?

A glance at the literature would suggest the latter answer. I could not find any recent case in which the XYY issue has been raised. Those cases that achieved notoriety in the press occurred in the 1960s and early 70s at the time when research in prison populations seemed to support the theory that all XYY males might have violent or criminal tendencies. The first of

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\(^{1058}\) Note that no firm consensus has been reached about the specific incidence of the extra Y chromosome. See discussion in Chapter 4.
these occurred in France, a jurisdiction that appears to be less reluctant than North America to accept biological causation theories. Daniel Hugon's lawyers failed in their attempt to show that the accused was unfit to stand trial because of XYY syndrome. They also failed to secure an acquittal at trial. However, when he was sentenced for murder in October 1968, he received only a seven year term\textsuperscript{1059}. This suggests that the judges were influenced enough by the evidence to mitigate sentence.

In the same month, Lawrence Hannel was acquitted by reason of insanity of the murder of a 77 year old widow in Australia. A psychiatrist testified that every cell in his body and brain was abnormal because of his extra Y chromosome. The newspapers presented this case as an example of a successful XYY insanity defence. However, those who later reviewed the trial transcripts discovered that Hannel's chromosomal abnormality was mentioned only once and did not form the basis for acquittal\textsuperscript{1060}. This is yet one more instance where the media have distorted the truth and helped perpetuate gender-based mythology.

The same rush to turn unsubstantiated theory into unreliable fact appeared in newspaper speculation as to whether serial killer, Richard Speck, had an extra Y chromosome - speculation declared to be false after failure of his appeal. The above cases indicate that, even when evidence of XYY is admitted in court, it has never constituted a full defence. It is possible that, in the right case, it could contribute to mitigation of sentence in the same way as PMS.

\textsuperscript{1059} This case is discussed in Judith DiGennaro, "Sex-Specific Characteristics as Defenses to Criminal Behavior" (1983) 6 Crim. Justice J. 187 at 197; and in Susan Horan, "The XYY Supermale and the Criminal Justice System: A Square Peg in a Round Hole" (1992) 25 Loyola of L.A. Law Rev. 1343 at 1348.

\textsuperscript{1060} Ibid. DiGennaro, fn. 50 and Horan, fn. 67.
Like the PMS defence, an XYY defence in various jurisdictions must pass some form of the *Frye* test before it can be admitted. So far, those jurisdictions have rejected admission of XYY evidence because it has lacked the degree of medical certainty to make it probative. In *Millard v. State*¹⁰⁶¹, a geneticist testified that the extra Y chromosome caused marked physical and mental problems. However, he would not give an opinion about the defendant’s sanity or insanity. The defence failed to call a psychiatrist to support the genetic evidence and to contradict a prosecution expert who declared that the extra Y chromosome had little or no effect on the defendant’s mental state. The judge refused to submit the issue of the defendant’s sanity to the jury.¹⁰⁶² However, it is possible that this trial judge may have admitted the evidence had the defence been more skillful at the battle of the experts.

Courts in both New York State and California have refused to admit evidence of XYY Syndrome because the theory, that an extra Y chromosome is a factor that causes crime, has yet to be properly substantiated.¹⁰⁶³ The Court in *Tanner* summarized many of the criticisms previously discussed in this study:

1. aggressive behavior may be one manifestation of the XYY Syndrome, but the experts cannot confirm that all XYY individuals are involuntarily aggressive;
2. experts could not determine that the defendant’s aggressive behavior resulted from the chromosomal imbalance;
3. experts were unable to state that the possession of XYY results in a mental disease that would constitute legal insanity under California law.¹⁰⁶⁴

¹⁰⁶² See DiGennaro, supra note 1059 at 198.
¹⁰⁶⁴ Quoted in DiGennaro, supra note 1059 at 199.
As DiGennaro points out, XYY Syndrome does not appear in the DSM. Therefore, psychiatrists do not officially recognize it as a mental disorder. Any lawyer who seeks to rely solely on the presence of this syndrome to show insanity or diminished capacity would have a well nigh impossible task in the United States and, probably, in Canada.

This shows the danger and the fallacy of relying on a purely biological defence that appears to exclude consideration of the cumulative effect of internal and external causal factors. Why should there be a requirement to show that all XYY individuals are involuntarily aggressive? Surely it would be more just and reasonable to require evidence that shows that the presence of XYY makes an individual more prone to aggression when it is coupled with other factors such as low intelligence, poverty, severe personal stress and absence of family support. Courts in cases like Tanner abdicate their legal responsibility when they refuse to entertain a defence solely on the ground that the perception and cognitive abilities of a defendant must be validated by the medical profession.

It could be argued that admission of social and psychological factors in conjunction with a biological disorder might open the floodgates to all kinds of similar defences and, therefore, almost all criminals would have to be acquitted on the ground that "my body/psyche/social background made me do it." If negative environment alone were to be the criterion, I would tend to agree, but the kind of defence I am suggesting would require careful proof of the existence of specific biological factors coupled with particular types of environment - plus proof that such a combination of factors are likely to lead to a mental state that provides grounds for mitigation.

If scientists were finally able to demonstrate a causal connection between XYY and crime, would an accused be any better off than he is now in the disposition of his case? Unless he could be genetically engineered in some way, the answer is probably "no." Since the main thrust of
an XYY defence is the offender's lack of free will, if he proves such a causal connection he will also be demonstrating the likelihood of his own continuing dangerousness. Women who raise a PMS can point to evidence of successful treatment. XYY offenders have no equivalent recourse. Susan Horan suggests strategies like "protective confinement, home monitoring, mandatory periodic supervisory examinations and required enrollment in schools with controlled environments." Those researchers who believe that the criminal behaviour of an XYY offender is a product of his environment as well as his genetic makeup could also devise social conditioning that might overcome the environmental component.

As with female gender-based defences, proponents of an XYY defence must always take care to avoid the trap of stereotypically categorizing all XYY men as potential criminals while at the same time opening the door to those who, because of additional biological or social factors, are entitled to be treated less harshly than so-called "normal" male criminals.

(iii) BIOLOGICAL DEFENCES FOR PEDOPHILE OFFENDERS

Although some legal judgments have referred to pedophilia as a disorder, I have not come across any judicial analysis or expert testimony that has explored possible chemical etiology or causal connection between specific biological factors and the crime of child molesting, violent or otherwise. In Chapter 4, I pointed out that sexual assault by pedophiles resembles infanticide because the offender restricts himself to one type of crime and suffers from some form of impulse control disorder. A major reaction to infanticide is the assumption that there

1065 Because of space constraints I have not conducted a comprehensive examination of Canadian or foreign caselaw. Instead, I have selected a small number of Canadian cases over a twenty-five year span to determine the type of expert evidence admitted and the sentences handed down.
must be something chemically wrong with a mother who kills; there is no equivalent assumption
about a man who seeks sexual contact with children. He is assumed to have a disease of the will
which should respond to behaviour modification, not a disease of the brain or endocrine system
which might be amenable to medication.1066

The DSM, so often quoted in court, defines pedophilia by its symptoms and related
behaviour, making no mention of causation. Unlike XYY syndrome it is considered a mental
disorder. Despite this, courts appear to have been reluctant to allow the presence of pedophilia
to negate mens rea. I say "appear," because, like PMS offenders, pedophiles who commit
indictable offences may have in the past elected trial by jury, rather than trial by judge
alone.1067 This may be the explanation for the lack of reported judgments unless the case goes
to appeal. Again like PMS offenders, pedophiles who commit summary conviction crimes, are
heard in lower level courts whose judgments are seldom reported in law journals. This leaves
the field free for sensational journalism, rather than legal scholars, to present to the public the
picture of the pedophile offender.1068

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1066 I should note here that many pedophiles are treated with a testosterone inhibitor
to suppress sex drive. However, this drug is not specifically designed to correct chemical
imbalance in pedophiles; it suppresses T levels in all men who take it.

1067 Now that public consciousness has been raised about the issue of child molesting
and sexual abuse and tolerance of pedophiliac offenders is at a low ebb, it is likely that present
and future offenders will choose trial by judge alone to avoid a biased jury decision.

1068 It would be interesting to compare similarities and differences between media
presentation of pedophiles and PMS offenders, and then to compare media "facts" with the
reality of what happened at trial - a task beyond the scope of this study. While working as a law
clerk in the mid-80s, I observed a range of cases - from incest to assault by an acquaintance
-involving sexual offences against children, both pubescent and pre-pubescent. Those dealing with
indictable offences against pre-pubescent children were all jury trials. None presented medical
evidence of "disease."
The few cases available disclose a changing attitude towards the possibility of curing the "disease" of pedophilia. In the 1971 case of *R. v. D.* 1069, a 28 year old married schoolteacher appealed his sentence after conviction for sexually molesting one young girl in 1970 and another in 1971. The offences occurred after the accused had voluntarily commenced treatment at the Clarke Institute of Psychiatry in Toronto. A psychiatrist testified that there was a favourable chance of "cure" if D continued with treatment. The Ontario Court of Appeal supported a disease model for pedophilia and substituted probation with medical treatment for twelve months definite and eighteen months indeterminate imprisonment. They did not refer to any principles of general deterrence but stated that

[d]eterrence in this case is of small moment because the Court is of the view the appellant suffers from an illness, *as do all pedophiles*; they are not deterred by punishment to others. 1070

The judges make no distinction between fixated and occasional pedophiles. Neither do they mention that the possibility of imprisonment might have been one factor that led this offender to seek treatment - unfortunately too late.

D. had no previous record and the Court was sympathetic towards his attempts to obtain treatment. The Alberta Court of Appeal in *R. v. Dwyer* 1071 said nothing about the value of treatment in the case of homosexual pedophile who was appealing his classification as a dangerous sexual offender 1072. Dwyer (35) had a string of convictions for approaching teenage

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1069 (1971) 5 C.C.C. (2d) 366 (Ont. C.A.)

1070 Ibid. at 368 (emphasis added).

1071 (1977) 34 C.C.C. (2d) 293.

1072 This category has been replaced by a general "dangerous offender" provisions (see Sections 753 ff. of the Criminal Code). These sections were passed in the 1976-77 session of Parliament.
boys and persuading them to engage in sexual activities with him. For the first offence in 1965 he received a one year sentence with a recommendation for psychiatric treatment. For the fifth and last offence, involving three 13 year olds, he received four years concurrent. At the dangerous sexual offender hearing the judge noted that Dwyer had never been violent, cruel or aggressive. It seems that this offender was the type of man who might be a member of the Man Boy Love Association, not a violent pedophile interested in obtaining sexual gratification from physically immature children.

A psychiatrist from a government mental institution recommended "a programme of behaviour modification" stating that the accused was presently "motivated by something which outweighed the fear of apprehension and conviction...." He downplayed possible harm to the teenage victims, being of the opinion that "a lot of the psychological trauma evolves from the Court proceedings and the questioning of children..." Despite testimony from two psychiatrists about lack of harm, the Alberta Court of Appeal upheld the finding of the court below that Dwyer was "likely to cause injury, pain or other evil ....through his failure to control his sexual impulses." In doing so they relied on common sense rather than expert opinion and had the following to say about psychiatry:

In weighing the evidence of psychiatrists it must be kept in mind that behavioural psychiatry is still an uncertain field influenced at times by theories which are not necessarily demonstrated when put into practice in the realities of life.

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1073 Ibid. at 297.
1074 Ibid.
1075 Ibid. at 298.
1076 Ibid at 299, quoting Legg, D.C.J.
1077 Ibid. at 303.
I wonder if the result would have been the same had the psychiatrist been able to offer effective
treatment in the form of a pill or an injection.

The accused in R. v. Nye\textsuperscript{1078} exhibited a number of characteristics described as typical
of certain types of pedophile in Chapter 4. He had a "sad and impoverished childhood\textsuperscript{1079}, was
an alcoholic, suffered job-related stress. Previous offences had occurred when he was drunk. He
had sought treatment for alcoholism and pedophilia prior to his first conviction. Despite having
a heart condition, Nye consented to take Provera and Temposil, drugs that reduce sex drive but
are also dangerous to people who suffer from cardiac problems.

The Crown appealed Nye’s suspended sentenced plus three years probation. As in its 1971
judgment, the Ontario Court of Appeal "recognized paedophilia as a disease... a "lifelong
illness."	extsuperscript{1080} However, seventeen years after R.v. D., psychiatrists from the Clarke Institute
were now admitting that pedophilia is not curable, merely controllable. This time the Court did
look at principles of general deterrence and emphasized that Nye had used some degree of force
in his sexual contact with his victims who were young pre-pubescent girls.

In imposing a six-months sentence, the Court noted that psychiatrists had reported that
continuation of therapy was "imperative,\textsuperscript{1081} and therefore recommended that, if therapy were

\textsuperscript{1078} (1988) 43 C.C.C. (3d) 180 (Ont. C.A.).

\textsuperscript{1079} Ibid. at 182.

\textsuperscript{1080} Ibid. at 183.

\textsuperscript{1081} Ibid. at 186.
not available in jail, he should be granted temporary passes to attend treatment sessions at the Clarke Institute. \(^{1082}\)

Three B.C. cases from the 1990s demonstrate offenders who already are, or are in the process of becoming, modern stereotypes: the "drunken Indian," "the dirty old man," and the "priest pedophile." \(^{1083}\) In *R. v. L. (D.),* the accused, who had lived on the same reserve as the victim's mother, was convicted of touching a three year old girl for sexual purposes. He had a long history of alcoholism but a psychologist could find no indication of pedophilia. The Court unanimously dismissed the Crown's appeal from a suspended sentence plus probation, mentioning that "both the trial judge and the experts concluded that this was a case for treatment, rather than incarceration." \(^{1084}\) Locke J.A. specifically distinguished the circumstances of this case from those where there has been "active assault or molestation by the accused" and a "continuous pattern of conduct, on occasion coupled with real violence." \(^{1085}\) Taylor J.A. noted that the circumstances of this case were unlikely to recur and that the accused was likely to respond

\(^{1082}\) It appears that courts may only recommend, not order treatment during incarceration. Thus it is quite possible that an offender, if left untreated, could emerge from jail in a much more dangerous state than when he entered.

\(^{1083}\) The first case, *R. v. L. (D.),* (1990) 53 C.C.C. (3d) 365 (B.C.C.A.), was a *cause celebre* in the newspapers when the trial judge described a three year old girl as being "sexually aggressive." The girl's mother testified that her daughter had a habit of rubbing her genitals against people and generally acting in a sexually precocious manner, a matter that the trial judge considered worthy of investigation - presumably to determine whether the little girl had been sexually abused earlier in her life. McEachern, C.J.B.C., commented on the unique facts of this case and "how relatively easy [it is] to reach simplistic conclusions when one is not burdened by the factual details where legal truth is usually to be found."

\(^{1084}\) Ibid. McEachern, C.J.B.C. at 379.

\(^{1085}\) Ibid. at 381.
affirmatively to probationary treatment.\textsuperscript{1086} I describe this unusual case in order to highlight the danger in assuming that all men who have sexual contact with children are pedophiles and that there must be room to look at the accused as an individual, not just as a representation of a "disease."

The "dirty old man" category may be illustrated by \textit{R. v. Heywood}\textsuperscript{1087} an appeal of a summary conviction for loitering in a playground after previous convictions for sexually assaulting two nine year old girls in 1987. Prior to his arrest, the accused had been taking "crotch shots" of little girls while they were playing on swings, etc. A psychiatrist/witness described Section 179(1)(b) of the Canadian Criminal Code as "a legal embodiment of a component ... of sexual offender treatment programs and relapse prevention."\textsuperscript{1088} Melvin J., in a detailed judgment, described the history of the legal use of the word "loiter" as incorporating elements of malevolent intent. He highlighted the evidence of a psychologist and psychiatrist who testified at length in the court below about pedophilia in general, and about factors that would likely facilitate re-offending - in particular the effect of continued contact with children. Melvin J. concluded that the objective of the provision, namely, "the controlling of the impulses of potential reoffenders and the protection of the public" is of greater importance than the constitutionally protected rights found in sections 7 and 11(d) of the Charter of Rights and Freedoms.

\textsuperscript{1086} Ibid. at 383.

\textsuperscript{1087} (1991) 65 C.C.C. (3d) 46 (B.C.S.C.)

\textsuperscript{1088} Ibid. at 62. Section 179(1)(b) reads:
Everyone commits vagrancy who ...(b) having at any time been convicted of an offence under ... section 271 [sexual assault] ... is found loitering in or near a school ground, playground, public park or bathing area.
Such a provision seems sensible for the protection of children but what if the same type of reasoning were applied to PMS? Could laws be passed to prohibit PMS offenders from working during the premenstruum (if their offences occurred in the workplace); or from contacting spouses or certain relatives for a number of days out of each month - a kind of PMS restraining order? This may appear to be far fetched, probably because of the range of PMS offences. However, it is not long since sterilization laws in Canada could have been used to prevent an infanticide mother from having further children. Society’s priorities change with the rise of new theories and abandonment of old. At the moment child sexual abuse is a "hot topic" and strong preventive measures are becoming increasingly acceptable to the public, even when individual liberties suffer in the process.

The last case I will discuss is R. v. Blancard, a recent decision of the British Columbia Court of Appeal. Blancard, a former priest pleaded guilty to five counts of indecent assault that he had committed between 1967 and 1980 on girls between the ages of six and eleven. He was sentenced to three years imprisonment and appealed on the ground that the trial judge had placed too much emphasis on general deterrence and not enough on his rehabilitation prior to the laying of charges. The judgment paints a picture of a person trapped in a role to which he was not suited and trapped by a disease for which he constantly sought treatment. He was also the victim of childhood physical and mental cruelty in the home. In 1988 he was officially diagnosed as a pedophile and entered a residential treatment program that lasted

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1089 For example, the Sexual Sterilization Act, R.S.A. 1942, c. 194, s.4 was not repealed until 1972 upon proclamation of R.S.A. 1970, c.341. This law also allowed sterilization of people with epilepsy and psychoses.


1091 Ibid. at 4.
approximately a year. Again psychiatrists acknowledged that they knew of no permanent solution for this problem\textsuperscript{1092} and recommended Blancard continue to attend twelve step programs for people with addictive personalities. He finally left the priesthood and was married by the time charges were laid in late 1991.

Rowles J.A. noted that Blancard had "pursued, with considerable success, his own rehabilitation"\textsuperscript{1093} and that the trial judge had been satisfied that specific deterrence was not an issue. However, she went on to state that "[i]n the case of sexual offences against children, general deterrence must be a primary consideration."\textsuperscript{1094} On the other hand,

"[t]o fail to recognize the value to society of successful efforts made by pedophilic offenders to rehabilitate themselves, and thus to cease to offend, is... not in accord with the ultimate goal of sentencing."\textsuperscript{1095}

Rowles J.A. reduced the sentence to one year imprisonment and two years probation on condition that he continue therapy approved by his probation officer.

None of the above judgments deal with specific causation of pedophilia or with evidence of organic factors such as abnormal brain chemistry. However, if these cases continue to come to court in ever increasing numbers, I should not think it will be too long before lawyers seek out evidence from scientists like Berlin\textsuperscript{1096} who claim to have found indications of chemical differences between fixated pedophiles and the rest of the male population.

\textsuperscript{1092} Ibid. at 3.

\textsuperscript{1093} Ibid at 6.

\textsuperscript{1094} Ibid. at 10.

\textsuperscript{1095} Ibid. at 12.

\textsuperscript{1096} Supra note 585.
In summary, court judgments recognize that pedophilia is a disease with no known cure. They do not refer to etiology but do describe a number of factors, such as alcoholism and an abusive childhood, that researchers have found associated with pedophiles. Since this is a disorder affecting volition rather than cognition, it is not surprising that none of these accused tried to use an insanity defence. However, none of them used extreme violence to or caused the death of a young victim.

(iv) CONCLUSION

Judgments that deal with crimes connected directly or indirectly with male sexuality tend to reinforce the idea that Western societies are still caught up in the old gender role myths described in previous chapters. They are more interesting for what they fail to say than what they actually discuss. Except for the XYY defence, which has such obvious male-specific connotations, there is practically no mention of internal chemical causation as there is with female-specific defences. It all comes back to the old idea of male will versus female instinct. There also seems to be an aversion to excusing a man from the consequences of acts that may be beyond his control, even in the small percentage of cases where biological abnormality is clearly demonstrated. Firm proof of biological causation appears to be a prerequisite to the acceptance of male-specific defences. In contrast, lack of definite proof of a biological connection between chemical abnormalities in women and the crimes some of them commit does not always bar judicial consideration of female gender-specific defences.

Of course, judges cannot consider biological defences unless the accused raises some medical or scientific evidence to back them. This is impossible while biological researchers fail to look for such evidence. I am not arguing that there are biological causal connections between
impotence, XYY syndrome, pedophilia and crime; merely that scientists have not been as ready to assume them in men's behavioural disorders as they have in women's.

I have looked at possible ways of applying PMS-types defences to male "disorders" and have commented that this idea may seem far fetched. In deconstructing the notion of male-specific defences, I have wondered what the response might be to violent actions by women in situations where they might want to bring in the relevance of their procreative abilities, their abnormal genes or their abnormal sexual urges.

The man suffering from impotence is thought to be incapable of perpetuating the species - hence the power of mythology surrounding this subject. The female equivalent is not the frigid woman because, unless she has some physical barrier to intercourse, she is still capable of conceiving. The female equivalent is therefore the barren woman, a person to be dreaded in cultures that subscribe to hierarchical philosophies such as primogeniture. What if such a woman believed that her femininity were dependent upon her ability to conceive; what if she were seeking desperately for a cure for her infertility; and what if an insensitive partner or male relative were taunting her each month about her "failure." Imagine that this woman found she was menstruating yet again and her partner began to deride and insult her. Could she raise a defence of provocation as Bedder did when he killed Doreen Redding? Theoretically, if men like Bedder can raise such a defence, then this woman should be entitled to a similar one. However, it is unlikely that a judge or jury would believe that an "ordinary woman in the shoes of the accused" would react with violence to such insults. This woman would perhaps be better to rely on the slightly less shaky ground of a PMS defence.

I can think of no equivalent to the XYY defence. The presence of a Y chromosome immediately identifies a person as male. There must be women with three X chromosomes, but
it is extremely unlikely that anyone has researched them for violent tendencies. Just as an extra
Y chromosome has led to the idea of a "supermale," an extra X chromosome in a woman is
likely to lead to an assumption of the "ultrafemale" - a woman who is even more passive than
the stereotype of her XX sister. Even though researchers have shown that XXY males show up
more often in prison populations than in the community at large, there has been no rush to
identify them as violent. I wonder whether anyone has even considered looking for XXX women
in prison populations.

In the area of pedophilia, I did not come across any papers that even mentioned the
possibility of fixated pedophilia in women. There have been some reported incidences of women
sexually fondling young boys, but no one appears to have suggested that they have been driven
by some uncontrollable impulse to do so. A lot of research has gone into establishing links
between childhood abuse in men and their later sexual deviance. These papers that I have read
are deliberately setting out to look for causes of male pedophilia and contain a latent assumption
that women do not suffer from this "disease" - (just as there is a latent assumption (erroneous)
that men do not experience cyclicity of mood.) This assumption may well be correct, but a male-
specific defence based on organic causation of pedophilia cannot be justified unless the possibility
of its occurrence in women is excluded.

So far, these speculations are just that - speculations. There is no indication that courts
will accept, in the near future, a biological defence for sexual assault of children by men. There
is even less likelihood that they would accept an equivalent defence for women. Such a defence
would have to overcome mythology about women’s sexuality and lack of scientific information
about what causes people (overwhelmingly men) to molest children.
Analysis of the above defences brings us close to the realm of fantasy. It is now time to come back to legal reality by examining what is happening in court to defences based on epilepsy and diabetes.

II. DEFENCES BASED ON EPILEPSY AND DIABETES

In this section, I will examine judicial reaction to two defences based on physical disorders that may periodically affect volition and cognition. Theoretically, these defences are similar but the courts have linked one to insane and the other to non-insane automatism. One carries centuries of mythological baggage; the other is a phenomenon of the twentieth century. In the first - epilepsy - the sufferer may have lost consciousness despite medication; in the second - diabetes - the sufferer may have lost consciousness because of medication. In the first, the law has decided that the disease is a proximate cause of automatism (internal causation); in the second, it has elected to decide that the treatment is the proximate cause (external causation). Yet, in the second there would be no treatment were it not for the existence of the disease. The treatment, defined as an external cause, becomes the legal equivalent of a blow to the head. It is ironic that a blow to the head, unfortunately placed, may cause certain types of epilepsy. It seems that criminal law has adopted a form of the doctrine of remoteness, used with some bizarre results in tort law.

A. EPILEPSY

Legal commentators have observed that there is a
judicial tendency to characterize instances in which the condition of unconsciousness is likely to recur as insanity rather than automatism so that the defendant may be committed.\textsuperscript{1097}

Although judicial opinion has varied over the years, there is now a consensus in English and Canadian courts that lack of voluntariness due to epilepsy should be classified as insane, rather than non-insane, automatism.\textsuperscript{1098} This brings in the burdens of proof and medical treatment issues that always accompany a defence of mental disorder. It is ironic that, at a time when the law is consolidating its view that epilepsy must be defined as a disease of the mind for the purposes of the mental disorder defence, lay groups and medical therapists are at long last convincing the public that the epilepsies are organic disorders, not diseases of the mind.

It is symptomatic of our system of law that, until recently, legal scholars have clung to the idea that those who do harm while unconscious \textit{must either} be acquitted and freed unconditionally because of non-insane automatism or be acquitted and incarcerated because of insane-automatism. Recent changes to the Canadian Criminal Code are designed to grant more leeway to judges during disposition of cases in which the finder of fact has found the accused not criminally responsible on account of mental disorder. It remains to be seen whether those sections will make practical differences in the case of people with epilepsy who commit crimes of violence during seizures. It is to be hoped that these sections will be used to ensure maximum freedom for the perpetrator compatible with reasonable safety for the public. As one author has expressed it:


\textsuperscript{1098} However, with the change of terminology from insanity to mental disorder in Section 16 of the Criminal Code, this might be described more accurately as automatism with (or without) mental disorder.
The law here is concerned with a continuum of forms of conduct and situations, and any division [into insane and non-insane automatism] will cause a sense of arbitrariness in the borderland.  

To highlight the problems with previous legislation, I will briefly discuss relevant caselaw.

Not surprisingly, U.K. law has led the way yet again through judicial consideration of sensational trials for murder and other high-profile crimes. Before the leading case of *Bratty v. Attorney General of Northern Ireland* in 1961, courts in the U.K. and North America were undecided about how to treat an epilepsy defence. Instead of defining epilepsy as legal insanity, they were more inclined to consider unconscious behaviour stemming from an epileptic seizure as a form of non-insane automatism. For example, a New York court in 1915 reversed the conviction of one, Julius Magnus, for disorderly conduct committed according to "undisputed medical evidence, while he was suffering from a attack of epilepsy" that caused "epileptoid automatism." Similarly, in *R. v. Charlson*, the English Court of Appeal defined unconscious behaviour caused by both cerebral tumours (thought to have been suffered by the accused) and epilepsy as sane automatisms. Charlson a previously loving father, suddenly and for no apparent reason hit his 10 year old son repeatedly on the head with a hammer and then threw him out of a window. Barry J. stated that

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1101 *People v. Magnus* 155 N.Y. Supp. 1013 at 1014 (1915).

[i]f he did not know what he was doing, if his actions were purely automatic, and his mind had no control over the movements of his limbs, if he was in the same position as an epileptic fit, then no responsibility rests on him at all. 1003

The judges in Magnus and Charison were more willing to follow medical criteria in distinguishing sane from insane automatisms and did not equate disease of the brain with disease of the mind. However, all of this changed with the case of R.v. Kemp1004, in which Devlin J. held that violent behaviour caused by a disease of the brain (in that case, arteriosclerosis), was insane automatism. In Bratty, the House of Lords confirmed that Devlin J.'s reasoning applied to epileptic automatisms, though their job was made easier in this case because expert testimony indicated that medical opinion in 1961 had veered round to the idea that epilepsy can be a "disease of the mind."

Bratty had picked up a young girl and taken her for a ride in his car. As a defence to a charge of murder, he argued that he had committed the crime in a state of "blackness" although he was able to describe to police what he had done. His lawyer called medical experts in an effort to show that Bratty might have been suffering from psychomotor epilepsy.1005 Lord Denning noted that "[a]ll the doctors agreed that psychomotor epilepsy, if it exists, is a defect

1003 Ibid., at 325, Crim. App. C.


1005 Peter Fenwick claims that the medical history of the accused could not possibly support such a diagnosis, but the case went to the House of Lords on the issue of whether automatism caused by psychomotor epilepsy is should be classified as sane or insane. (See Peter Fenwick, Psychological Medicine: Automatism, Medicine and the Law (Monograph Supplement 17, Cambridge University Press, 1990) at 7.
of the reason due to disease of the mind." He disagreed with Barry J.'s conclusion in *Charlson* and made the following, often quoted, remark:

> It seems to me that any mental disorder which manifested itself in violence and is prone to recur, is a disease of the mind.\(^{1107}\)

It was fairly easy in this case to make theoretical statements about an epilepsy defence as there was little evidence to support the idea that Bratty was in an automatic state or that he suffered from epilepsy. It is unlikely that many people suffering from epilepsy would identify with this accused. However, in the more recent case of *R. v. Sullivan*\(^{1108}\), the House of Lords was confronted by an accused who had a long history of epilepsy and who had violently attacked a neighbour during a seizure. In May, 1981, Patrick Sullivan was sitting and chatting in a neighbour's apartment with the neighbour and an 80 year old friend, Mr. Payne. All he could remember was that one minute he was talking to his friends and the next he was standing at a window looking down at Mr. Payne who was lying on the floor. Sullivan was told by the neighbour that he had kicked Mr. Payne. At his trial for causing grievous bodily harm, medical witnesses testified that this behaviour was likely due to discharge of electrical impulses into the brain that would affect memory and ability to control bodily movements. Lymbery J., the trial judge, held that the decision in *Bratty* prevented Sullivan from arguing non-insane automatism and that his only choices were either an insanity or a guilty plea. Not surprisingly, considering the inevitable consequences at that time of an insanity plea, Sullivan decided to plead

\(^{1106}\) Supra note 1100 at 536 (All E.R.). In 1961, medical knowledge about TLE (or psychomotor epilepsy) was limited due to lack of sensitive diagnostic equipment. Now that physical lesions have been associated with TLE, it is more likely that today's physicians would define this disorder as an organic disease of the brain.

\(^{1107}\) Ibid. at 534.

\(^{1108}\) [1983] 2 All E.R. 673 (H.L.)
guilty. Both the Court of Appeal and the House of Lords agreed with Lymbery J. Lord Diplock reflected the reluctance of most people to label someone with epilepsy "insane" but felt forced to do so because an unconditional acquittal of such an offender could be dangerous to the public.

It is natural to feel reluctant to attach the label of insanity to a sufferer of psychomotor epilepsy of the kind to which the appellant was subject, even though the expression in the context of the special verdict of not guilty by reason of insanity is a technical one which includes purely temporary and intermittent suspension of the mental faculties of reason, memory and understanding resulting from the occurrence of an epileptic fit. But the label is contained in the current statute... It does not lie within the power of the courts to alter it. Only parliament can do that... Sympathise though I do with the appellant, I see no other course... than to dismiss this appeal.1109

This reluctance to attach a label of insanity may explain why neither the Court of Appeal nor the House of Lords objected to the trial judge’s allowance of a change of plea after his ruling against a non-insane automatism defence. They likely agreed that a probation order with medical supervision was more appropriate and more merciful than an indefinite stay in a psychiatric hospital.1110

The decision in Sullivan likely explains why Miss A, a 19 year old nanny who killed a 20 month old baby, pleaded guilty to manslaughter with diminished responsibility. Although she had no history of epileptic seizures, A had a sister who suffered from focal epilepsy and A’s

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1110 Two writers interestingly question whether medical supervision in Sullivan’s case could lead to any improvement in his condition as he had been under medical care for years and there was no evidence to suggest that he had not followed his doctors’ directions. Hence, possible danger to the community was not reduced by this type of sentence. (See Mervyn E. Bennun & Christopher Gardner-Thorpe, "McNaghten Rule Epilepsy - OK?" (1984) 47 Mod. Law Rev. 92 at 97) The same reasoning could apply to PMS sufferers where, unlike the Craddock/Smith case, consistent medical therapy is in force at the time of the crime. For other articles that discuss Sullivan, see L.M. Clements, "Epilepsy, Insanity and Automatism (1983) 133 New Law J. 949; Diana Brahams, "R. v. Sullivan: Epilepsy, Insanity and the Common Law" (1983) 133 New Law J. 137; and case comment in [1983] Crim. L. R. 257.
EEG recorded "numerous bursts of eliptogemc activity." A came from a normal family, was successful in school and did not abuse drugs or alcohol. Unlike Sullivan, A was able to remember what she had done but had a sense of acting like a puppet. A was sentenced to probation with in-patient psychiatric treatment. After treatment with carbamazepine, A had no further abnormal experiences.

Courts in Canada have followed the same type of reasoning as in Bratty and Sullivan. For example in R. v. O'Brien, the accused was convicted of attempted murder when, without warning or provocation, she attacked a Mrs. Flannigan and threatened to kill her. A psychiatrist testified that the accused was suffering from an organic disease of the brain and could have committed the assault during an "epileptic fugue." This diagnosis did not stop the New Brunswick Court of Appeal from unanimously agreeing that psychomotor epilepsy was a disease of the mind within the meaning of Section 16 of the Criminal Code. Richie J.A. stated:

For the purpose of interpreting the phrase "disease of the mind" as used in s. 16, diseases which affect the mind should not, as is done in medicine, be divided into those that are physical in origin and those that are mental in origin... The primary thing to look for is a lack of, or abnormality in, the reasoning capacity of the mind.

The same court in 1975 applied the same reasoning in R. v. Johnson in which the accused was charged with stealing a car. Brett Johnson had been drinking on the day of the crime and overturned his car near the home of a Mr. Mosher, who took him into his house, provided first

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1113 Ibid. at 305.

1114 11 N.B.R. (2d) 638.
aid and gave him cheese and coffee. Shortly after entering the home, Johnson put his hand to his head, slid to the floor and his limbs became taut. After repeating this behaviour a couple of times, Johnson became aggressive and threatened to kill Mosher if he would not give him his car keys. During a struggle, Johnson grabbed the keys and drove off in Mosher’s car. A psychiatrist and a neurosurgeon testified that Johnson’s EEG results indicated sub-clinical epilepsy and that alcohol could precipitate an epileptic attack. The trial judge found Johnson guilty and sentenced him to eighteen months in jail plus a fine. The Court of Appeal sent the case back for a second trial after holding that the trial judge should have made a finding as to whether Johnson was insane within the definition of the Code. I do not know whether Johnson pleaded guilty at the second trial.

In R. v. Gillis1115, the accused went round to a neighbour’s house and declared that he had cut his friend’s throat. When police arrived, Gillis pulled out a knife and threatened them. There was no evidence of the crime Gillis had mentioned. The Crown called a police witness who testified that about twenty minutes before the above incident, Gillis had suffered what seemed to be an epileptic seizure. When he was tested at the police station, Gillis registered a count of 0.19 on the breathalyser machine. Gillis had a history of seizures plus a lengthy criminal record that included offences of a similar nature. A neurologist for the defence testified that the accused suffered from general and psychomotor epilepsy and that his behaviour was consistent with these disorders. A psychiatrist for the Crown described Gillis’ condition as a disease of the mind that would render him unable to appreciate the nature and quality of his acts during epileptic attacks. He also testified that alcohol could precipitate seizures. The defence then called a psychiatrist in rebuttal who stated he cold find no evidence of severe mental illness and

1115 (1973) 13 C.C.C. (2d) 362 (B.C. Co. Ct.)
that epilepsy was an "organic illness of central nervous system affecting the mind."\textsuperscript{1116} Both psychiatrists believed that Gillis' condition was treatable. The trial judge followed \textit{Bratty} and found the accused not guilty by reason of insanity. Similar reasoning was endorsed by the Supreme Court of Canada in \textit{Revelle v. R.}\textsuperscript{1117}, which involved an accused who had a history of brain damage, depression and alcoholism.

United States law has not followed such a clear path, maybe because a number of states have a greater range of choice in disposition in cases of epileptic automatism. Defendants do not necessarily have to be committed indefinitely to psychiatric institutions if they are acquitted because of their medical condition (as was done in the past in both the U.K. and Canada). For example, in \textit{People v. Grant}\textsuperscript{1118} the defendant had consumed four whiskeys over a two and a half hour period prior to striking a police officer who had come to investigate a complaint at a tavern. While in the police car on his way to the station, Grant was excited and upset. On arrival at the station, he suffered a grand mal seizure. At trial it was found that Grant had a complicated history of psychomotor epilepsy and violence. He had previous convictions for aggravated assault and involuntary manslaughter. A psychiatrist testified that Grant suffered from psychomotor epilepsy that "prevented his conscious mind from controlling his actions."\textsuperscript{1119} Despite this evidence he was convicted of aggravated battery and of obstructing a police officer. The Appellate Court noted that no Illinois court had previously determined whether actions during psychomotor seizures were sane or insane automatisms. They also noted that "[t]he entire record

\textsuperscript{1116} Ibid. at 366.
\textsuperscript{1118} 360 N.E. 2d 809 (1977) - Illinois Appellate Court.
\textsuperscript{1119} Ibid. at 813.
on appeal... reflects that the defendant suffers from psychomotor epilepsy which is not insanity"\textsuperscript{1120} and went on to state that

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\text{[w]e are not troubled by the decision of the British House of Lords affirming a murder conviction in which the trial judge refused to instruct on the defense of automatism despite the presence of evidence tending to establish that the defendant was suffering from psychomotor epileptic seizure at the time the offense was committed.}\textsuperscript{1121}
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The majority reversed the defendant’s conviction. Green J. in dissent, agreed with the majority that a person committing an involuntary act due to psychomotor epilepsy could not be found guilty. However, he believed that the "mental disease or defect that results in the epileptic’s lack of substantial capacity to conform his conduct to the requirements of law at that time"\textsuperscript{1122} should bring him within the definition of insanity. He went on to say:

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\text{I share with Lord Denning and the majority of commentators on the subject … a belief in the need for protective custody for persons who repeatedly attack others while in a state of automatism. The situation merits an attempt by the legislature to devise a procedure balancing the rights of the public to be protected against the rights of the person subject to automatism to be at liberty and basing any deprivation of liberty upon the degree of danger presented by that individual.}\textsuperscript{1123}
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The court in \textit{Grant} had clear evidence of the presence of psychomotor epilepsy. In cases where the diagnosis is equivocal, courts are more wary of spurious epilepsy defences. In \textit{State v. Caddell}\textsuperscript{1124}, the defendant was appealing his conviction for kidnapping and sexually assaulting a girl that he dragged into his car. The defendant had a history of commitments to

\begin{itemize}
\item \textsuperscript{1120} Ibid. at 815.
\item \textsuperscript{1121} Ibid.
\item \textsuperscript{1122} Ibid. at 817
\item \textsuperscript{1123} Ibid.
\item \textsuperscript{1124} 215 S.E. 2d 348 (1975) - S.C. North Carolina.
\end{itemize}
mental hospital. He testified that he remembered nothing of the kidnapping and raised the defence of unconsciousness. Lake J. for the majority, denied the appeal. With respect to the defence of unconsciousness (non-insane automatism) he listed causes that included somnambulism, diabetic shock and epileptic black-outs. The Court referred to Bratty but did not go so far as to agree that epilepsy, in law, should be equated with a disease of the mind.\textsuperscript{1125}

In summary, although U.S. law is not clear on this topic, it seems certain that courts in Canada and in England will force the use of a mental disorder defence if an accused pleads not guilty because of automatisms caused by epilepsy. As I have noted before, this is one area where the language of medicine and law disagree. Although each discipline uses the words "insanity" and "disease of the mind" they have separate, though overlapping meanings.

B. DIABETES

Because of centuries of association between the ideas of epilepsy and insanity, the possibility that someone with epilepsy might be forced into a psychiatric facility, as a result of actions carried out during a seizure, may not seem absurd to the layperson. However, when similar reasoning is applied to symptoms associated with diabetes, there is an obvious change in

\textsuperscript{1125} In a later case, \textit{Matter of Torsney} (1979), described by Richard Beresford in "Legal Implications of Epilepsy" (1988) 29 (Supp. 2) Epilepsia S114 at S117, a jury acquitted a policeman of the motiveless murder of a 15 year old boy after pleading psychomotor epilepsy. He had no history of epilepsy and neurologists testified that he did not have the disease. The court committed him to mental hospital but he was later released because hospital staff could find no evidence of mental illness or epilepsy.
attitude. Yet the social issues that led to the decisions in cases like *Bratty* are equally present in
certain people with diabetes.\footnote{1136}

Sixteen years after Lord Devlin stated in *Kemp* that the law is not concerned with the
origins of a disease, but simply with the mental condition that brings about the criminal act,
English courts had to face the issue of automatism caused by high levels of insulin injected to
control diabetes. Quick, a nurse in a mental hospital, had been an insulin dependent diabetic
since the age of seven. He was charged with assaulting a patient but said he could remember
nothing about the incident because he had been suffering from a hypoglycemic reaction at the
time of the assault. On the morning in question, Quick had injected his usual amount of insulin,
had eaten breakfast but had failed to eat lunch. During the day he drank some whisky and a
quarter bottle of rum. The assault occurred in the middle of the afternoon. Quick had a history
of admissions to hospital because of insulin reaction and had previously behaved violently while
his blood sugar was low. The trial judge held that the defence of non-insane automatism was
not available to the accused because of the ruling in *Bratty*. Quick, like Sullivan before him,
decided to plead guilty as the lesser of two evils.

The Court of Appeal felt obliged to reconcile the legal reasoning of *Bratty* with the
medical absurdity of declaring a diabetic insane and committing him to a mental institution for

\footnote{1136 I have confined the following discussion to English cases in order as they offer
excellent illustrations of the issues. Canadian Courts since *Rabey* have followed the same
reasoning. Therefore, whatever I say should also be applicable in Canada. However, I should
once again draw attention to *Parks*, supra note 837, in which the Supreme Court steadfastly
adhered to the idea that sleepwalking was not a disease of the mind even when the condition of
the brain that caused Park's sleepwalking allowed, or directed, him to drive a car and commit
homicide.}
an indefinite stay. The latter idea was obviously unpalatable to both the court and the community. As the Court put it:

No mental hospital would admit a diabetic merely because he had a low blood sugar reaction; and common sense is affronted by the prospect of a diabetic being sent to such a hospital, when in most cases the disordered mental condition can be rectified quickly by pushing a lump of sugar or a teaspoon of glucose, into the patient's mouth.

This is certainly true, but it might be appropriate for a mental hospital or other treatment centre to admit a patient who is unable or unwilling to take simple steps to avoid mental incapacity or who deliberately ingests alcohol that he ought to know will increase his likelihood of violence. This is another example of an undifferentiated picture of a community of people; those known as "diabetics." The thought of sending all people with diabetes to mental hospital is just as absurd as the sought of sending all PMS sufferers there. But, just as the general population includes a small number of people who may need help in order to protect themselves and the public, it is not too far fetched to imagine that a small number of people with diabetes may need similar help - not necessarily at a mental hospital. Once again, I think that the absurdity highlighted here is not the notion of incarceration of diabetics but the narrowness of legal choices.

The Court of Appeal reasoned its way out of an untenable situation by falling back on another dichotomy; that is, the distinction between external and internal causation. They

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1127 R. v. Quick [1973] Q.B. 910, [1973] 3 All E.R. 347, [1973] 3 W.L.R. 26. It is curious that the Court did not take the easier way out and declare that the low blood sugar had been induced by Quick's own recklessness. His hypoglycemia could then have been equated with voluntary intoxication. If Quick was a nurse and had a long history of violent insulin reactions, he must have had a more than average knowledge of the effect of alcohol coupled with lack of food.

1128 Ibid. at 931.
determined that Quick's violent behaviour was caused by insulin (external cause) rather than the
disease of diabetes itself (internal cause), thus extending the scope of non-insane automatism. In
this way they skirted the issue of whether diabetes itself could be equated with insanity in other
circumstances. This left the door open to characterize diabetes as a disease of the mind in
a later case.

Fenwick describes this differentiation into internal and external causes as "medically
nonsensical." He notes that a violent act committed while the mind is disordered due to an
excess of injected insulin would be classified as non-insane automatism, while the same act
committed due to the same excess of insulin secreted because of an insulinoma of the pancreas
would be insane automatism.

The next case of interest is R. v. Bailey, in which the accused was charged with
assaulting a rival for his girlfriend's attentions. Bailey had lived with his girlfriend for over two
years but she had left him for this other man. Bailey, like Quick, had suffered from diabetes
since childhood. On the night of the assault, he went round to his rival's home for a discussion.
Shortly before he left, he reported he felt unwell and asked for and drank some sugar in water.
When he got up to leave he hit the rival over the head with an iron bar he had brought with him.
Despite the fact that he was able to recount the events to the police, he raised the defence of
hypoglycemic automatism. He told the court that he had eaten nothing after his evening injection.
The trial court refused to allow this defence to go to the jury on the ground that his condition,
like intoxication, was self induced. The jury convicted Bailey.

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1129 Compare with the reasoning in Parks, supra note 837.
1130 Supra, note 1105 at 9.
The Court of Appeal did not agree that failure to take food after an insulin injection could amount to self-induced automatism. They added that it was not likely to be common knowledge, even among people with diabetes, that such failure to eat would lead to violent and uncontrollable behaviour. Thus there could be no presumption, as in the case of deliberate ingestion of drugs or alcohol, that Bailey’s actions were reckless. This was an issue that should be left for the jury to decide on the facts of the case. However, the Court also found that there had been no miscarriage of justice since a properly instructed jury would have rejected Bailey’s defence.

I noted that Quick left the implication that diabetes could, in certain circumstances, be characterized as a disease of the mind. This is exactly what happened in the case of *R. v. Hennessy*. Hennessy had had diabetes for ten years and required two injections a day to control his blood sugar. Because of personal stress, anxiety and depression, he failed to take his insulin for several days. He was charged with stealing a car and driving while disqualified. After he arrived at the police station, he became dazed and confused and was taken to hospital where his blood sugar levels were found to be almost three times normal. At trial, Hennessy pleaded automatism as a result of hyperglycemia. However, he changed his plea to guilty when the judge held that his only defence was insane automatism. The Court of Appeal confirmed that in cases of this kind, insanity was a legal, not a medical, concept and that hyperglycemia, being caused by an inherent defect, should be dealt with under the McNaghten Rules.

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A number of commentators have pointed out the anomaly of labelling a diabetic offender insane if he neglects to take insulin, but blameless if he takes too much or neglects to eat.\textsuperscript{133} The distinction might be valid in law if dangerousness and likelihood of recurrence were the real criteria, as the policy makers seem to desire. However, in this day and age, violence due to untreated diabetes is very rare and, once identified, unlikely to recur. In contrast, violence due to an excess of ingested insulin is not nearly so rare and may recur for all kinds of reasons. In \textit{Quick}, the Court of Appeal focused on the unacceptability of equating diabetes with insanity; however, in \textit{Hennessy}, they were caught by their own logic. But is not just as absurd to take Mr. Hennessy to a mental hospital when the medical solution would be an injection of insulin - a remedy that is almost as fast acting as a sugar cube in Mr. Quick's case?

C. \textbf{CONCLUSION}

It is interesting to compare articles about epilepsy and diabetes defences with those that deal with PMS and postpartum disorders. The former concentrate on traditional arguments and issues; for example, policy reasons for and against widening non-insane automatism defences, whether epilepsy and diabetes fit within established legal insanity (mental disorder) definitions, the Hobson's choice between a guilty plea and a defence of mental disorder\textsuperscript{134}. Judges state


\textsuperscript{134} It remains to be seen whether the change in terminology from insanity to mental disorder, coupled with more liberal rules for disposition, will make such a defence more attractive to those suffering from epilepsy. It may depend largely on whether the stigma of "insanity" will attach itself to "mental disorder" just as attached itself to "insanity" after it
that causes of epilepsy are irrelevant and that the effect of this disorder on the reasoning powers of the accused is the most important factor. Articles on PMS and infanticide question the reality of these disorders, dwell on etiology and causation, and question the very need for these defences. This is not to say that authors have ignored the application of traditional legal concepts with respect to "female" defences but one writer has argued that "traditional medical-legal concepts are not neatly applicable to the PMS defense." 1135

From the above, it seems obvious that traditional concepts are not neatly applicable to epilepsy or diabetes either. However, this deficiency in the law may be due to its inability to adapt general rules to meet the real needs and recognize the real experiences of those who commit criminal acts because of and during an altered state of consciousness. This deficiency covers both PMS and epilepsy defences but legal writers generally agree that the concept of an epilepsy defence is sound, while a large number deny the validity of a PMS defence.

Factors that surface again and again in relation to epilepsy and similar defences are: (1) blameworthiness of the accused - was his condition self-induced by ingestion of alcohol, drugs, an overdose of medication or a failure to take medication? 1136 (2) likelihood of recurrence of similar danger to the perpetrator or to the public; (3) seriousness of the crime; (4) availability

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1135 Karen McArthur, supra note 71 at 856. She includes an analysis of the applicability of various defences to crimes supposedly committed under the influence of PMS.

1136 Again I use the male pronoun deliberately. Apart from the case of Miss A, described above, all of the cases that I readily found involved incidents of violence committed by men. I am sure that women, as well as men, have committed violent acts during epileptic seizures but, either violence by women is underreported or it is much less prevalent. It would be interesting to compare the female:male violence ratio for epileptic offenders with the same ratio in the general population.
of therapy; (4) type of disease; (5) ease of fabrication. These factors are not driven by medical necessity but by the law's role as an agent of social control.

When medical doctrine reinforces social control, lawmakers invite medical practitioners to share the power of law; but when medical doctrine interferes with or opposes legal policies, lawmakers either manipulate or ignore it. When convenient, medical theories may be used to buttress legal philosophy even when their scientific bases are obscure or obsolete.1137 Maybe legal policy makers are right to be cautious about blindly accepting medical criteria in formulating defences for those who commit crimes in an apparent state of automatism. There is such a multitude of views about the causes, nature and effects of disorders like PMS and epilepsy that

[t]he medical criterion therefore gives scope for widely differing results. The decision often depends not only on the school of thought and on the basic attitude of the expert, but also on the manner in which the case is argued, and even on terminological emphases.1138

On the other hand, as writers like Lederman point out,

to label as mentally ill everyone whose consciousness may malfunction at times and result in violence, only because of social danger, is an acknowledged lie in our accepted terms.1139

There must be a closer compromise between medical and sociolegal realities. This could be done, in part, by a change in semantics to remove, as far as possible, the stigma of insanity or mental disorder. I noted above that a New York court in 1915 talked about "eliptoid automatism" in relation to a complete defence. Rather than retain the terminology of mental

1137 For example, see my earlier discussion about the medical underpinnings of the crime of infanticide.

1138 Lederman, supra note 1099 at 832.

1139 Ibid. at 833.
disorder, would it not be more accurate and more merciful to create classes of automatism that
could lead to conditional acquittal without the stigma of a criminal record or the erroneous
assumption of mental disorder? These organic disorders could then be viewed on a continuum
of dangerousness. For example, a person claiming "epileptic automatism" could be acquitted if
able to prove that his actions occurred in a state of unconsciousness or altered consciousness; but,
instead of setting him completely free or committing him to a psychiatric institution, he could
be freed under medical and legal supervision that would hopefully minimize the chance of
recurrence. Similar provisions could be made for diabetic, hypoglycemic or postpartum
automatisms. Categories of automatisms could be kept open so that other conditions could be
added if justified by the individual's reality and medical evidence.

It would be necessary to have criteria that would make it difficult for accused to fabricate
such a defence. However, I do not think this danger is as acute as some might suggest. Courts
in *Bratty* and *Bailey*, for example, had no difficulty in seeing through the defences of these
accused. One medical author has suggested the following guidelines for epilepsy. It is interesting
to compare them with Dalton's guidelines for PMS. In order to assess the probability of a
crime having been committed during an episode of epileptic automatism, the accused should be
able to show:

(a) a past history of unequivocal epileptic attacks;
(b) the crime is out of character with the accused's previous personality;
(c) the crime is motiveless and unpremeditated;
(d) EEG studies are compatible;
(e) an altered consciousness during the event;
(f) total or partial amnesia for the crime.\(^{1141}\)

\(^{1140}\) Supra, at page 172.

\(^{1141}\) Hindler, supra note 1090 at 249.
Other authors have urged a more flexible range of dispositions. The English and Canadian Parliaments have recently proclaimed laws that go part way to meet this requirement.\textsuperscript{1142} Judges are no longer bound to order detention in psychiatric facilities.\textsuperscript{1143} They may now order admission to hospital with or without restrictions; guardianship; supervision and treatment; and absolute discharge. The court must still hear evidence from medical practitioners. These changes allow more appropriate treatment of those acquitted by reason of mental disorder but they do not necessarily remove the stigma of such a verdict. These changes create no resolution of the conflict between sane and non-insane automatisms. They merely create more flexible dispositions.

I do not have enough space to consider defences of mental disorder in depth but I believe that the above discussion makes it obvious that, even if such defences are a proper vehicle for delusional states, it is not an effective method of dealing with automatisms. Neither is it theoretically sound. An insanity defence may be valid for a person who knows she is acting but does not appreciate the nature and quality of her acts (lack of \textit{mens rea}). It is not appropriate for a person who does not appreciate she is acting at all; that is, a person who is unconscious despite physical movement (lack of \textit{actus reus}).

Critics of solutions via change in semantics will argue that mere changing of words will just move the stigma from the old term to the new. I believe that this is true when changes are


\textsuperscript{1143} In England there is a requirement that judges must order detention in cases of murder. There seems to be no logical reason why murder should be an exception. Perhaps the legislators thought that the British public were not ready for more lenient treatment for those who kill - no matter the reason.
merely cosmetic; for instance changing the Lunacy Act to the Mental Health Act. But if the semantic change is accompanied by change in kind that more accurately reflects medical and legal truth, then it may be possible to neutralize or destroy the stigma.

Such removal of stigma, of course, depends on destruction of false myths - as I have discussed at length in earlier chapters. In summary, unless women are able to present their reality and have it accepted by the population at large, gender-based defences will be ineffective, distorted or rendered impossible by the power of myth. PMS defences, wrongly used, contain all the seeds of gender prejudice and also import some of the mythology that attaches to the idea of insanity. This mythology coupled with medical endorsement in the DSM would make it easy to characterize certain PMS symptoms as disease of the mind. I have shown that courts are much more ready to characterize epileptic automatisms as insane than hypoglycemic automatisms, and have speculated that the residue of centuries of myth has facilitated this label.

In the final chapter I will return to the fictional accused that I introduced in Chapter 1 and attempted to diagnose in Chapter 4. I will speculate about the type of treatment they would encounter in today’s courts under today’s law in Canada. I will conclude by suggesting alternative ways in which courts might achieve justice and gender equity, relying on various theoretical models presented in earlier chapters.1144

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1144 For the purpose of this study, I assume that the legal system and the courts are appropriate vehicles for dispensing justice. I could question whether our adversarial system is an effective or appropriate method of attaining justice or arriving at the truth, but that is a topic for another study.
CHAPTER 7 - BIOLOGICAL DEFENCES
FROM THE THEORETICAL TO THE CONCRETE

For the last time I will return to the hypothetical fact patterns described in Chapters 1 and 4. How would they fare under existing Canadian law? What would be the effect of proposed changes to the law described in Chapter 6?

1. Maxine - PMS and Murder

Maxine has killed an abusive male partner who has continually assaulted both her and her daughter from a previous relationship. Various specialists have tentatively diagnosed PMS, manic depression, schizophrenia, catamenial epilepsy and BWS. On further testing, it is found that Maxine responds positively to progesterone injection therapy. Although she remains somewhat anxious and depressed, there is no longer an obvious escalation in symptoms during the perimenstruum. Her EEG discloses the presence of a minute limbic lesion but her neurologist is reluctant to treat her with anticonvulsants while she is receiving progesterone. Maxine is reluctant to allow her lawyer to raise the insanity defence because she doesn’t want Stephanie to grow up thinking she has a "lunatic" mother.

Possible full defences under existing law include self-defence (including self-defence which includes a BWS component), and mental disorder (either psychosis or insane automatism). Partial defences include lack of mens rea for murder, and provocation. The facts as they stand do not support an argument for self-defence. If her client would allow, Maxine’s lawyer could probably successfully use a straightforward Section 16 mental disorder defence if Maxine’s psychiatrists are willing to testify that she was in a psychotic state at the time of the stabbing. Even though it is the state of mind that is relevant, not the label put upon it, the Crown might successfully fight the mental disorder defence because of conflicting psychiatric diagnoses - schizophrenia versus manic depression. It is doubtful whether PMS per se would be sufficient to secure an acquittal on the ground of mental disorder. Since Maxine does not wish to use this defence, a greater danger lies in the possibility that the Crown, itself, might raise the issue of mental disorder despite the refusal of the defence to do so. Should Maxine be found to have
been mentally disordered within the Section 16 definition at the time of the killing, her lawyer could argue for conditional release because progesterone therapy has controlled her symptoms. A paternalistic judge might grant this request if he or she is influenced consciously or unconsciously by myths of "madness" similar to those that have led to the release of infanticide mothers.

An alternative approach for Maxine (but still governed by Section 16) would be insane (or "mentally disordered") automatism caused by epilepsy. However, this disorder has not been fully investigated and is merely speculative at this stage. Unless public attitudes change with the introduction of the new "mentally disordered" terminology, such a verdict would leave her with the stigma of the "insane" label. If there were firm evidence of epilepsy, Maxine might want to consider pleading guilty to manslaughter, relying on a conditional discharge based on cases like *Sullivan*.

There is not room here to discuss the application of self-defence incorporating evidence of BSW. Maxine knew Rick for only two years prior to the stabbing. It is doubtful whether this is long enough to establish the pattern of abuse and deterioration of mental state that is required for a successful defence. Much would depend on Maxine’s social and mental history before she met Rick.

Because she has responded positively to progesterone, Maxine has a therapeutic track record to back up a PMS defence. Assuming the facts as described are sufficient to raise a reasonable doubt, she should be able to show a lack of *mens rea* for murder. Maxine’s friend Cathy would, on the Dalton model, be useful in establishing a lengthy track record of menstrually related behavioral disturbance. Maxine’s history of post partum depression would also help to corroborate a diagnosis of severe PMS. Maxine’s lawyer could use English case law
as precedent, agree to plead guilty to manslaughter, and again ask for a release conditional upon continuation and monitoring of progesterone therapy.

If Maxine can show that Rick was threatening or insulting her at the time of the stabbing, she could argue provocation. Despite Creighton, it could be argued that Hill has opened the door in Canada to a more subjective defence that would allow the introduction of evidence about Maxine’s particular circumstances during application of the first arm of the provocation test. To paraphrase Dickson J. in Hill, features such as a history of abuse and a hormonal imbalance should not necessarily detract from a person’s characterization as ordinary. The definition of provocation seems to have widened in the context of cases involving male sexuality and male gender roles. I wonder if the courts would be willing to apply similar reasoning to female sexuality and female gender roles. It is more likely that they would be more comfortable clinging to disease models like PMS and epilepsy as they fit more closely with established stereotypes.

The above discussion highlights how compartmentalized these defences must be under the present system. Strategically, Maxine’s lawyer must pick one plan at the expense of other possible defences. The law becomes a gambling strategy. If her chosen tactics fail, the lawyer will find it difficult if not impossible to come back to court and mount an alternative defence. The court looks at Maxine as a "disease" or as a "victim" or as a "criminal." Would the approach of the Butler Commission be any better? Under that model, Maxine could plead guilty to "manslaughter with mental disorder" relying on a wide definition of mental disorder that would incorporate temporary disability of mind.

A more realistic (but presently unavailable) defence would take a holistic approach, taking into account all the circumstances of Maxine’s environment (abusive), biology (propensity for hormonal disorders and/or epilepsy) and psychology (stress related problems). Medical evidence
could then be cumulative instead of contradictory. Labels created by medical professionals, while important, would be less determinative of final outcome than Maxine’s lifestyle reality as seen by Maxine herself and by witnesses (including experts). Under present law, self-defence relying solely on BSW would likely fail, not because Maxine was not a victim of battering but because it probably did not go on long enough to create a "psychological disorder" verifiable by expert testimony. A PMS defence, standing alone, might fail because there is no pattern of extreme disorder and medical evidence might be equivocal. A defence of Section 16 mental disorder might fail because of disagreement among expert witnesses. Epilepsy might fail because no connection has been established between Maxine’s limbic lesion and her behaviour. However, if a court could apply all of this evidence as a whole instead of in discrete "bits," it would surely not be difficult to establish grounds for a conditional release. There would be no need for a gender-specific defence in Maxine’s case.

2. **Gina - Postpartum disorder and Murder**

Gina’s infant daughter, her toddler son and her husband have died after Gina has deliberately driven her car over a cliff. Psychiatrists disagree about whether she was suffering from postpartum psychosis at the time of the incident. The prosecutor refuses to charge Gina with infanticide with respect to the baby’s death. He says it would be ridiculous to try her for infanticide for that death and then turn round and try her for murder for the other deaths. Gina’s lawyer has suggested that the charges all be reduced to manslaughter. The prosecutor counters with the possibility of the Crown raising insanity.

Gina’s symptoms are fairly typical of postpartum psychosis. The fact that she was mentally ill after the birth of her first child and recovered as soon as she became pregnant, indicates that hormones have played a significant part in her mental disorder. Since Gina is now completely sane, there is no way to prove conclusively that her mental state was connected to the birth
unless she has another baby in the future. If that were to occur, she would have to be closely monitored to protect both her and the baby.

The best hope for the defence under current Canadian law would be to rely on the reasoning in *Bessette*¹¹⁴ in which the accused, who had just given birth, strangled her six year old son. Ms. Bessette received a suspended sentence conditional upon psychiatric treatment. The reasoning that applies to infanticide, with all its deficiencies, could be imported into a manslaughter trial and used in Gina’s favour. Judges in infanticide cases seem to be willing to take into account all of the circumstances in which the accused finds herself. Thus, in Gina’s case, her social isolation, her sudden lifestyle change upon giving up her profession, and her biological condition would all be relevant factors. Expert testimony, although essential, would not be nearly as determinative in this case as in PMS cases, because there is a notion among laypersons that women are usually somewhat unstable after giving birth. Medical and social mythology would likely work to Gina’s advantage.

Gina’s present sanity does not preclude either the defence or the Crown from raising mental disorder. However, it is unlikely that a court would prefer this defence to a plea of manslaughter because of mental disorder as a result of childbirth. Of course, Gina’s infanticide-like defence would serve to perpetuate already entrenched stereotypes - the problem with all gender-specific defences.

As with Maxine, the rationale in the Butler Report could be applied if the law were to be changed. This would preserve a needed defence and, hopefully, minimize gender bias. Even if the infanticide provisions were to be repealed, it is likely that the reasoning - or, more appropriately, the unconscious judicial notice - behind them would continue in the foreseeable

¹¹⁴ Supra note 883.
future. This would build up a new body of stereotyped precedent that would help individual women at the expense of women as a whole.

3. **Cheryl - Psychosis and Neonaticide**

15 year old Cheryl has allowed her new born baby to drown in a toilet bowl. A psychiatrist says she may have been in a temporary psychotic state because of denial of the pregnancy and the shock of suddenly facing reality. A psychologist believes that Cheryl’s upbringing has created a susceptibility to mental disorder in the presence of extreme stress but he does not think Cheryl was "insane" at the time of the death. Cheryl has been charged with infanticide.

Cheryl’s situation is similar to those described in Chapter 6. Because she has been charged with infanticide, it is almost certain that she will either be acquitted or, if found guilty, released on probation. Canadian law, with all its faulty assumptions, works in favour of the young and vulnerable accused. Although the outcome is probably fair in most of these extreme cases, it would be preferable to reach the same result without having to rely on a gender-specific offence. It would also be preferable for the courts to take notice of the social factors surrounding these cases - poverty, immaturity, lack of education, restrictive view of morality within her community, fear, dependence on narrow-minded parents, isolation, perception of lack of community support, etc...

4. **Haruko - Menopause and Shoplifting**

Haruko has been the subject of a variety of diagnoses: estrogen deficiency, depression, kleptomania, lack of self-esteem, and empty nest syndrome. Her lawyer wonders if she should raise menopause as a factor in Haruko’s defence?

It is likely that Haruko’s social isolation and depression would be sufficient to have her transferred into a diversion program if she is willing to attend group therapy. Shoplifting
statistics have exploded the myth of the menopausal shoplifter. However, the insomnia and hot flashes resulting from menopause have almost certainly contributed to her depression. They have also made it more difficult for her to find work. This is a case for holistic legal and medical care, not for criminal conviction.

There is, however, a danger that middle aged female shoplifters who steal for economic reasons would be able to manipulate the criminal justice system by relying on menopausal stereotypes. This danger could be neutralized by ensuring that both male and female shoplifters are subject to the same criteria; for example, social isolation, environmental stress and depression, regardless of age. Maybe the male menopause (or "viropause") would be relevant here. 146

5. **Stavros - Impotence and Murder**

Stavros’ lawyer is beset by multiple diagnoses ranging from full psychosis, through hormone imbalance, to identity crisis. The root of the problem lies in Stavros’ impotence and his reaction to it. He has strangled a woman in a fit of rage but cannot remember the act itself – only the anger and humiliation. Since the killing, Stavros has received psychological counselling and cognitive therapy to help him change his perception of his sexuality. A urologist has assured him that, should psychotherapy fail, he could be helped by various medical techniques such as penile injections and implants.

As with Maxine, Stavros has a selection of possible defences: (1) mental disorder due to psychosis; (2) automatism due to a psychological blow that has produced a dissociative state; (3) lack of mens rea for murder; and (4) provocation. Under present law, Stavros’ lawyer would be best advised to argue provocation - relying on changes to this defence since Bedder. Under

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146 I recognize that, unless there is a fundamental shift in our beliefs about the inherent nature of men and women, supposedly neutral application of the law would be inclined to slide back into gender stereotyping in which women, far more than men, are diagnosed as clinically depressed. However, this does not mean that we should not try to change the law in small increments as well as large leaps.
Camplin, followed substantially by the Supreme Court of Canada in Hill, the court would be allowed to consider all of the circumstances, including the characteristics of the accused, even when applying the supposedly objective first arm of the test. Stavros’ lawyer could argue that these characteristics should include his macho background, his desertion by his wife, and his impotence. Therefore, the test would be whether an ordinary person similarly situated and similarly insulted would have been provoked.

In contrast to the previous female accused, it is unlikely that Stavros would escape incarceration completely. However, if his lawyer can show that effective treatment is available and that there is little risk of future violence, he may receive a reduced sentence.

Why is the most successful defence likely to be biological (hormonal) in the case of a woman and psychological (loss of control due to provocation) in the case of a man? In Maxine’s situation, a plea of provocation would probably be a long shot; in Stavros’ it is the only one likely to succeed. To repeat previous observations about attitudes to gender issues, Maxine’s loss of control is seen as internal - part of being a woman; while Stavros’ violent reaction is due to an external insult so devastating that it defeats his internal will. Maxine succumbs to female weakness; Stavros is literally unmanned.

If the law were to be changed along the lines of the Butler Report, would these attitudes change? I doubt it. Maxine’s mental disturbance may partially excuse her violent conduct but physicians and judges would probably continue to see its roots as internal to her and to women in general. Stavros’ mental disturbance might also lead to a partial excuse but they would likely identify its cause as external, despite the fact that impotence has been a triggering factor. We would thus be no further forward than the nineteenth reasoning of Charcot who attributed male hysteria to life stress rather than inherent characteristics. Once again gender neutrality would give
an appearance of equality of the sexes but the same old myths would be operating beneath the surface. The only answer is to take into account the realities of both men and women in their infinite variety of characteristics and circumstances. Without the ability to test the veracity of these realities, this, given our current knowledge of the human psyche, would be a futile exercise and utopian dream.

6. **Mike - XYY, Pedophilia and Violent Sexual Assault**

Mike has violently and sexually assaulted an eight year old boy. His lawyer, like Stavros', is confronted by a confusing variety of possible causative factors that might lead to a defence. Mike has been born with a genetic abnormality, raised with a rotten social background, and has been sexually abused as a child. His IQ is at the lower limit of normal but no one suspected that he had a genetic abnormality until after his arrest. Mike is sometimes attracted by women but is afraid of them. He escapes from feelings of inadequacy by drinking to excess. When injected with gonadotrophin releasing hormone, Mike does not show the pattern found by Berlin 1147 in "true" pedophiles.

If Mike’s lawyer tries to raise XYY as a defence by itself, he is unlikely to succeed. The inclination among criminologists and psychologists to believe in a connection between XYY and violent crime has been largely eroded by later studies. There are no Canadian legal precedents that recognize an XYY defence. The medical and scientific communities are divided about whether the presence of an extra Y chromosome creates a predisposition to any crime, let alone violent crime.

A "Rotten Social Background" defence is merely a theoretical possibility. Both scholars and judges recognize the effects of such a developmental environment but would hesitate to apply this defence because of floodgates concerns.

1147 Berlin, supra note 585.
Because of his occasional attraction to women, Mike cannot be classified as a "fixated" pedophile. Because of the violence of the assault, he could be characterized as a "sadistic," rather than "empathic," pedophile.\textsuperscript{1148} His history incorporates a number of factors that researchers have found to be common to pedophiles as a whole: prior sexual abuse, alcohol problems, fear of rejection, lack of impulse control (probably exacerbated by the XYY factor).

Current society, and therefore judges and juries, may view pedophiles as "sick" but this sickness is criminal rather than medical. Irresistible impulse is not recognized as a complete defence under Canadian law but some impulses are seen as more excusable than others. A woman who cannot resist the urge to shoplift is more likely to receive sympathy than the man who cannot resist the urge to sexually touch young children. Obviously these offenses differ greatly in kind; but would there be a difference if the first offender were a man and the second a woman? In a patriarchal society, a man who lacks the ability to exercise self-control is regarded as much more of a failure than a woman in similar circumstances. If his acts are criminal, his excuses must be stronger, especially if he is raising a biological defence.

As previously discussed, little is known about possible biological causes of pedophilia. Had Mike been a "true" pedophile, interested exclusively in pre-pubescent boys, he may have been able to rely on Berlin’s findings. In his case there is little point in raising biological abnormality. Although pedophilia is listed in the DSM, its definition does not describe causation. Therefore, at this stage of scientific knowledge, a purely psychiatric defence is unlikely to succeed. The cases described in Chapter 6 indicate that Mike’s lawyer will have an uphill battle

\textsuperscript{1148} See Chapter 4, Section II(C).
in court. Because of the violence of his attack, the court is likely to follow the rationale of cases such as *Dwyer*\(^{149}\), and insist on lengthy incarceration rather than release with treatment.

Pedophilia could be logically included as a "mental disturbance" as outlined in the Butler Report, but public reaction against child abusers is so strong that mitigation because of this "sickness" would probably be unacceptable unless effective treatment can be demonstrated.

Violent women are considered to be an aberration and may qualify for defences because they do not typify a danger of crime *en masse*. Violent men are seen as extreme examples of a masculine norm; men who are unable to control their impulses to hit out when their wishes are denied. Even when the abnormality of pedophilia is grafted on to violent masculine tendencies, the "less than a real man" image is not enough to kick in modes of reasoning that might apply to violent women. Thus the arguments that might prevail for a PMS accused are, at present, ineffective in the case of a man like Mike.

A holistic approach might lead to a reduction in charge. Cumulative evidence suggests that Mike has been born with a genetic disability that may increase his tendency to commit impulsive crimes. His background of deprivation and sexual abuse have removed social inhibitors that might have applied had Mike come from a more nurturing environment. Mike differs from the previous accused in that there is no evidence that his cognitive abilities have been affected during commission of the crime. There is no "black out" or sense of unreality, merely a lack of self-control. It would therefore be more difficult to introduce arguments about lack of *mens rea*.

Existing law does not afford Mike a gender-specific defence. Even if a male-specific pedophile defence could be formulated, I do not think it would warrant application. However, once gender mythology is swept aside, there is no philosophical reason why a pedophilia defence

\(^{149}\) See supra, note 1071.
should not deserve the same treatment as a PMS defence, provided there is reliable evidence to back it up.

7. **Marie - Epilepsy and Criminal Negligence**

Marie has a history of alcoholism and possible PMS. Since suffering concussion she has been treated for TLE. Her lawyer can find no support for an argument of somnambulism. Neither is there any evidence that Marie has returned to drinking. The remaining biological defences must rely on a confirmed diagnosis of epilepsy and a possible diagnosis of PMS or catamenial epilepsy. Marie's doctor has supplemented her anticonvulsants with hormone therapy which has reduced her negative premenstrual symptoms. She continues to be seizure free.

Marie's lawyer will have to contend with the unconscious effects on decision makers of multiple myths and stereotypes: the "drunken Indian," "the irrational female" and the "insane epileptic." She will also have to contend with the vagaries of epilepsy defences, described in Chapter 6. Under existing law, she would be best advised to plead guilty and argue for conditional release. Precedent suggests that she will be successful in view of the effectiveness of her new treatment. I have already discussed possible different approaches in Chapter 6.

8. **Kurt - Diabetes and Murder**

Kurt has stabbed a co-worker, Darrell, to death during a hypoglycemic reaction. The biological evidence in Kurt's case is fairly straightforward. The cause of his blackout is known and can be corroborated by expert testimony. His behaviour cannot be directly or solely attributed to the ingestion of alcohol.

Kurt has stabbed Darrell in a state of automatism. His lawyer could rely on the reasoning in *Quick* and subsequent cases to secure an acquittal. The prosecution could argue culpability because Kurt voluntarily ingested alcohol and neglected to eat. This might justify a conviction for manslaughter. It seems ironic that Kurt, who has actively contributed to his own abnormal
state is less likely to be convicted or supervised by the courts than Marie who, in a similar but non-violent state of mind, has committed a lesser crime.

CONCLUSION

I embarked upon this study in the hope that, by using a wide ranging multidisciplinary approach, I could reach an informed opinion about the efficacy and desirability of gender-specific criminal defences; in particular, biologically based defences for women. A number of writers, mainly feminists, have written about the pros and cons of PMS and post partum defences. Until now, no one appears to have considered equivalent defences for men. A few authors, interested in defences such as insanity and automatism have written about their connection with epilepsy and diabetes. These have not been compared with gender-specific defences in any systematic way.

In an effort to make theory relate to real life situations, I introduced in Chapter 1 a number of men and women who had committed crimes under circumstances that might entitle each of them to a defence based on biology alone, or biology in combination with other factors. I have revisited these people throughout this study, first with respect to medical assessment of their conditions, and second with respect to their current and possible future chances of a defence to criminal charges.

In Chapter 1, I presented my idea of "justice" as distinct from legal rights and stressed that it should include a concept of care. I believe that it is impossible to apply legal care without paying attention to the world view or perceptions of an individual accused and class of accused. To do this, those who run the legal system and apply the laws (still predominantly white middle-class men) must be brought to understand the reality of the lives of women and men of differing race, culture and class.
To understand on an intellectual level, and perhaps even an emotional level, human beings translate knowledge and experience into the symbols of spoken and written language. A recurrent theme throughout this study has been the power of language and the power of those who control its use and development. Women have historically been excluded from this process in the areas of law and politics. At one time women did have a voice as healers but this voice was eroded when men expanded the power and prestige of scientific medicine to the point where women were virtually excluded. I have attempted to deconstruct language and its application where relevant to the topic of this study, and have illustrated the presence of gender bias in situations ranging from research into cell biology to the formulation of legal defences.

Although I originally chose epilepsy and diabetes defences as "normal controls" to compare with gender-specific defences, it soon became apparent that these "neutral" areas of medicine and law were not free from assumptions and stereotyping common to gender-specific issues. In Chapter 2, I examined the power of mythology that deals with human sexuality and found that it pervades every aspect of our existence. Therefore, it should not be surprising to find that there may be no topic under the sun that is free from gender bias.

Not only is medicine not free from gender bias, in some areas, especially those directly connected with sexuality, it positively revels in it. Medical practitioners have applied gender bias in creating and treating "diseases" whose "symptoms" have often been manifestations of normality. Conversely, they have frequently discounted patients' actual experiences in favour of theories that support established stereotypes.

The interaction of the institutions of medicine and law sometimes resembles a ritualistic line dance. When their theories agree, each side comes together to create a combined ideology that seems impossible to budge. For example, when an expert medical witness can clearly state
that etiology, consequential behavioural and mental symptoms, and effective treatments, are widely accepted within his profession, legal practitioners are more than willing to accept his testimony as proof of the presence of a disease of the mind or as grounds for mitigation. Even when medicine and law disagree, each continues to forge parallel paths that are guided by mythical assumptions about sexuality and disease. In their dance, lawyers will pick partners from medicine that reinforce well entrenched principles. However, as I have shown in the case of epilepsy, if legal policy and medical theory diverge, the law will either bend or discard the medical viewpoint.

The danger for women and other disadvantaged groups becomes acute when law and medicine work in tandem to reach conclusions based on erroneous or misinterpreted data. Nowhere is this more striking than in legal defences that rely on supposed knowledge about women’s bodies and mental processes. These defences are almost always filtered through medical experts who interpret women’s reality for the court. The same is true of general defences that rely on a disease model, but "normal" men are not additionally burdened by harmful negative assumptions based on their biology.

As a general principle, I have concluded that gender-specific defences are harmful to women as a whole and to minorities of men, as long as they rest on theories that, in turn, base themselves on harmful mythology and erroneous "facts" about the nature of diseases thought to be peculiar to women or men. The PMS defence is a prime example. Like the story of the spider who swallowed the fly, it depends on a chain of theories that absorb each other to reinforce the myth of woman as irrational monster. These theories include the following deficiencies: biology - gender bias at the very level that examines the process of conception; medicine - inability to identify etiology, to classify and sub-classify accurately and consistently, or to treat effectively;
psychology - a tendency to stress internal and ignore external factors; sociology - until recently, a lack of attention to environmental factors that affect the lives of women, an assumption that the patriarchal system is cast in stone; criminology - problems similar to sociology, stereotypical notions about connections between women's bodies and crime.

Legal theorists, either consciously or unconsciously, draw from all of those disciplines to create an amalgam of their own. However, once a theory is established, traditional scholars rarely examine how it interacts with the worldviews of non-legal researchers. Once a legal theory is applied in practice, it develops a life of its own that is guided by precedent and stare decisis. This puts it in an isolated compartment labelled "law" rather than "justice" or compassion until, as happened in England, a new branch called "equity" must be created. Of all disciplines, law should be about life in the round. In its present application it is more about part of life in a single system.

I am not arguing that the law is completely inflexible. On the contrary, it is extremely flexible within its patriarchal boundaries. Sometimes reformers even step outside these boundaries when rigid rules make the law "a ass." This happened during nineteenth century reform of the writ system. However, there seems to be something about a hierarchical bureaucracy that regenerates rigidity, so that reforms that are introduced in the interests of justice become themselves mired in a new set of fixed, and often petty, rules and regulations.

This is the legal environment that must be taken into account before formulating gender-specific defences. As much as I dislike the well worn phrase "paradigmatic shift," I believe that this is what must occur before gender-specific defences are effective to protect individual women without prejudicing the position of women as a whole. Ironically, if there were such a shift to
the recognition of the values and realities of women and to the abolition of patriarchy, gender-specific defences would probably be unnecessary.

At the moment, although women have increased the effectiveness of their voices within Western society as a whole, the abolition of patriarchal systems is still a utopian dream. While keeping the ultimate goal in view, we must deal with the reality that presently exists; namely, a system pervaded with gender bias and misconceptions about the nature and roles of both sexes. Provisions like those for infanticide offer protection to individual women who deserve defences whether or not they are erroneously based. Osborne recognizes this when she cautions against throwing the baby out with the bath water.\textsuperscript{1150} I agree that it would not be just to leave a woman defenceless in the interests of the purity of feminist or any other ideology.

I have already discussed the recommendations of the Butler Report as a starting point for the creation of non gender-specific defences that rely on altered states of mind. However, it is vital that law reformers be constantly aware of the dangers of relying on gender-neutral language in the context of an inherently gender-biased society. Phrases like "spousal assault" and "domestic violence" have not decreased the frequency of violence against women. They have merely disguised the fact that the vast majority of cases involve men hitting out at women. Would the application of a provision such as manslaughter with mental disorder not merely put a semantic gloss on the application of old stereotypes?

A partial answer might lie in a constant process of consciousness raising in the formulation and application of defences that involve women's biology and psychology. This could include mechanisms to control for gender bias as suggested by The Biology and Gender

\textsuperscript{1150} Supra note 906.
Study Group\textsuperscript{1151} Everything possible must be done to distinguish narrow subgroups of women who should qualify for biologically based defences from women as a whole.\textsuperscript{1152} Greater efforts must be made to determine how and why biological, psychological and social factors interact within an individual to create a propensity for crime. Nothing should be examined on an "either/or" basis; for example, with an assumption that causation of crime must be either biological or environmental. Experiments and surveys similar to Shoham's\textsuperscript{1153} should be designed to find out if it is possible to determine the relative contributions of various levels of human functioning (including biology, personality and social norms) to criminal behaviour. Finally, we must revise our basic attitudes towards what we define as criminal deviance, especially as they pertain to women.\textsuperscript{1154}

This study has not come up with any great flashes of insight or easy solutions. Rather it has consolidated knowledge from a wide variety of sources that are usually examined solely in the context of their own narrow fields. It has asked more questions than it has found answers. However, it has hopefully identified areas and strategies for further study. Although I have conducted this study from a woman's point of view and have concentrated more heavily on women's issues, I wish to end by stressing that there can be no justice unless we recognize and rectify the harm done to men as well as women that results from perpetuating a male supremacist culture. Just as we cannot truly appreciate biology without an understanding of environment, we

\textsuperscript{1151} Supra note 208.

\textsuperscript{1152} This reasoning would apply to the type of men I have discussed and to people with epilepsy or diabetes.

\textsuperscript{1153} Supra note 775.

\textsuperscript{1154} For example, we should look at the values that have led us to absurd situation where prostitution is legal while soliciting is not.
cannot fully appreciate the reality of women, in all their diversity, without a comparable understanding of the reality of men.
BIBLIOGRAPHY


Brac, Datha Clapper (1979). Displaced - The Midwife by the Male Physician, in Hubbard et al. at 83.


Devasia, Leelamma & Devasia, V.V. (1989). *Female Criminals and Female Victims: An Indian Perspective,* Published by Vinod Nangia for Dattsons J. Nehru Marg, Nagpur.


Fried, Barbara (1979). "Boys Will Be Boys Will Be Boys: The Language of Sex and Gender" in Hubbard et al. at 37.


Golub, Sharon (1988). "A Developmental Perspective" in Gise at?


Hansard, April 8 & June 15, 1992. Debates over second and third readings of Bill C-49.


Jensen, Per et al. (1990). Sexual Dysfunction in Male and Female Patients with Epilepsy: a Study of 86 Outpatients, Arch. Sexual Behav., 19, 1.


Levine, Helen (1986). The Personal is Political: Feminism and the Helping Professions, in Miles & Finn.


Select Committee on Children, Youth, and Families: House of Representatives: One Hundred and First Congress, Second Session, June 28, 1990 - Subject "Victims of Rape."


Stiles, Deborah A. et al. (1987). The Ideal Man or Woman as Described by Young Adolescents in Iceland and the United States, *Sex Roles*, 17(5&6), 313.


Walsh, Mary Roth (1979). The Quirls of a Woman's Brain, in Hubbard et al. at 103.


Willocks, James (1993). "The Prize is Immortality," *Avenue, 14,* 3. (Glasgow University, Scotland)


SUPPLEMENTARY BIBLIOGRAPHY

(reviewed but not cited)


APPENDIX

TABLE OF CASES


People v. Grant (1977), 360 N.E. 2d 809 (Illinois App. Ct.).


People v. Santos (1982), N.Y. Crim Ct. No. 1K046229, Nov. 3.


People v. Yukl (1975), 372 N.Y.S. 2d 313.


R. v. Jacobs (1952), 105 C.C.C. 291 (Ont. Co. Ct.).


R. v. Smith (Sandie) [1982] Crim L.Q. 531 (C.A.)


R. v. Valiquette (1990), 60 C.C.C. (3d) 325 (Que. C.A.)


Reid v. Florida Real Estate Commission (1966), 188 So. 2d 846 (Fla. C.A., 2nd Dist.).


Steele v. Mountain Institution (1990), 60 C.C.C. (3d) 1, 80 C.R. (3d) 257 (S.C.C.)


Tingen v. Tingen (1968), 446 P. 2d 185 (Oregon).
