Medically Recognised but Legally Invisible: Women-Centric Hormonal Mental Disorders as a Criminal Defence under the Bharatiya Nyaya Sanhita, 2023

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Abstract: This chapter examines the legal invisibility of women-centric hormonal mental disorders under Section 22 of the Bharatiya Nyaya Sanhita, 2023. Although modern psychiatry recognises conditions such as Premenstrual Dysphoric Disorder (PMDD), postpartum psychosis, and catamenial psychosis as serious mental health disorders capable of impairing cognition, judgment, and behavioural control, Indian criminal law continues to apply narrow insanity standards based largely on the traditional cognitive model established in M'Naghten's Case. Consequently, hormonally induced psychiatric conditions affecting women often remain medically recognised but legally unacknowledged. The chapter analyses the relationship between hormonal mental disorders and criminal responsibility through doctrinal, comparative, and feminist perspectives. It argues that the present legal framework inadequately accommodates temporary or partial psychiatric incapacity and fails to address gender-specific psychological realities linked with menstruation, childbirth, and reproductive health. Comparative jurisprudence from the United Kingdom, Canada, the United States, Australia, and New Zealand demonstrates evolving judicial approaches toward diminished responsibility, postpartum psychiatric disorders, and hormonally linked mental incapacity. The chapter further highlights the gender bias embedded within traditional insanity jurisprudence and examines the issue through constitutional principles of equality, dignity, and mental healthcare under Articles 14, 15, and 21 of the Constitution of India. It concludes by proposing reforms such as statutory recognition of hormonal psychiatric disorders, introduction of diminished responsibility, psychiatric evaluation mechanisms, and greater integration between criminal law and mental healthcare jurisprudence.

IndexTerms: Bharatiya Nyaya Sanhita, 2023; Section 22 BNS; Women-Centric Hormonal Mental Disorders; Premenstrual Dysphoric Disorder (PMDD); Postpartum Psychosis; Legal Insanity; Criminal Responsibility; Diminished Responsibility; Feminist Criminal Jurisprudence; Mental Health and Criminal Law; Gender Justice; Hormonal Psychosis.

I. INTRODUCTION

The idea of "mental illness" in criminal law has traditionally been shaped around visible, severe, and often male-centred psychiatric conditions such as schizophrenia, psychosis, or bipolar disorder. Conditions that primarily affect women, especially those connected with hormonal fluctuations, have remained largely outside the legal conversation. Yet modern medical science increasingly recognises that hormonal changes can significantly affect cognition, emotional regulation, impulse control, perception, and behaviour in certain women. Disorders such as Premenstrual Dysphoric Disorder (PMDD), postpartum psychosis, postpartum depression, premenstrual syndrome (PMS) with severe psychiatric manifestations, and menopause-related psychiatric disturbances

are now medically acknowledged as serious mental health conditions rather than merely "emotional" or "temporary" phases.[1] Women-centric hormonal mental disorders may broadly be understood as psychiatric or neuropsychological conditions arising from hormonal changes associated with menstruation, pregnancy, childbirth, postpartum recovery, or menopause. These disorders are unique because they emerge from biological processes specifically linked to the female reproductive system. In many cases, the symptoms extend beyond ordinary mood swings and may involve paranoia, hallucinations, dissociation, suicidal ideation, aggression, impaired judgment, or loss of behavioural control.[2]

However, criminal law has been slow to acknowledge this reality. The law still tends to treat hormonal disturbances as medically secondary or legally irrelevant, even where medical evidence clearly establishes their psychiatric impact. The relationship between hormonal imbalance and criminal behaviour is uncomfortable but important to discuss. Criminal acts committed during episodes of severe hormonal psychiatric disturbance may not always arise from rational intent or conscious criminality. In cases involving postpartum psychosis, for example, mothers have sometimes harmed themselves or their children while experiencing delusions or complete breaks from reality.[3] Similarly, severe PMDD has been associated with episodes of impulsive violence, self-harm, emotional dysregulation, and diminished cognitive functioning.[4] So the issue is not whether hormones "excuse" crime in a simplistic sense, but whether the law adequately understands how biologically triggered mental disturbances can affect criminal responsibility.

A noticeable gap therefore exists between medical science and criminal jurisprudence. Psychiatry today adopts a far more nuanced understanding of mental illness, recognising that mental incapacity can be temporary, cyclical, hormonally induced, or fluctuating. Criminal law, on the other hand, still largely relies on rigid nineteenth-century standards of insanity rooted in cognitive incapacity.[5] The traditional legal test generally asks whether the accused knew the nature of the act or understood that it was wrong. This binary approach leaves little room for conditions where awareness may exist partially, but behavioural control, perception, or emotional regulation are severely impaired due to hormonal psychiatric episodes.

Historically, gender-specific mental conditions have remained invisible within criminal law frameworks. Legal systems often dismissed women's hormonal suffering as "hysteria," emotional instability, or weakness rather than legitimate psychiatric conditions deserving legal attention.[6] Even where courts occasionally acknowledged postpartum mental illness, the recognition remained fragmented and inconsistent. India, however, still lacks a comprehensive legal framework specifically addressing hormonally induced psychiatric conditions in criminal law. The replacement of the Indian Penal Code, 1860 with the Bharatiya Nyaya Sanhita, 2023 provides a fresh opportunity to revisit these questions. Section 22 of the BNS, which substantially reproduces the earlier insanity defence under Section 84 of the IPC, states that an act is not an offence if committed by a person incapable of knowing the nature of the act, or that what they are doing is wrong or contrary to law, by reason of unsoundness of mind.[7] While the language appears neutral, its practical application continues to reflect conventional understandings of insanity that rarely account for women-centric hormonal psychiatric disorders.

The central research problem of this chapter lies in examining why legally recognised insanity standards fail to accommodate hormonally induced mental disorders affecting women. Accordingly, this chapter has three primary objectives. First, it seeks to examine whether hormonal mental disorders may be interpreted within existing criminal defence jurisprudence. Secondly, it analyses the doctrinal and constitutional limitations of the BNS framework, especially from the perspectives of equality, dignity, and gender-sensitive justice. Thirdly, the chapter evaluates comparative jurisprudence from jurisdictions such as the United Kingdom and the United States to explore possible reform models for India.

II. Understanding Women-Centric Hormonal Mental Disorders

A. Concept of Hormonal Mental Disorders

Hormonal mental disorders refer to psychiatric or psychological disturbances that arise primarily because of hormonal fluctuations within the body. In women, these fluctuations are commonly associated with menstruation, pregnancy, childbirth, postpartum recovery, and menopause. For a long time, these conditions were casually dismissed as "mood swings" or ordinary emotional behaviour. However, contemporary psychiatry does not treat them so lightly anymore.[8] Medical science now accepts that

[1] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 171–75 (5th ed. text rev. 2022).

[2] Ian Brockington, Menstrual Psychosis and the Law, 21 Archives of Women's Mental Health 645, 647–49 (2018).

[3] Susan Hatters Friedman & Phillip J. Resnick, Child Murder by Mothers: Patterns and Prevention, 162 Am. J. Psychiatry 1578, 1580–82 (2005).

[4] Jennifer L. Payne et al., Premenstrual Dysphoric Disorder: Burden of Illness and Treatment Update, 22 J. Psychiatry & Neuroscience 1, 3–6 (2019).

[5] M'Naghten's Case (1843) 10 Cl. & Fin. 200 (HL).

[6] Elaine Showalter, The Female Malady: Women, Madness and English Culture, 1830–1980 55–79 (Virago Press 1987).

[7] Bharatiya Nyaya Sanhita, No. 45 of 2023, § 22 (India).

[8] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 171–75 (5th ed. text rev. 2022).

hormonal changes can significantly influence brain functioning, cognition, impulse control, emotional regulation, and even perception of reality in some cases. Hormones such as estrogen, progesterone, cortisol, and serotonin-related neurochemical regulators play an important role in maintaining emotional stability and behavioural control.[9]

When these hormonal levels fluctuate sharply, particularly during reproductive cycles, they may affect neurotransmitter systems in the brain, producing symptoms ranging from anxiety and depression to aggression, dissociation, paranoia, and psychosis. From a neuropsychological perspective, endocrine imbalance can interfere with the functioning of the prefrontal cortex and limbic system, both of which are associated with decision-making, emotional regulation, and impulse management.[10] Severe hormonal psychiatric conditions may actually diminish a person's capacity to regulate behaviour or fully appreciate consequences during particular episodes, which becomes especially relevant in criminal law because criminal responsibility traditionally assumes rational choice and conscious intention.

B. Major Disorders Relevant to Criminal Responsibility

(a) Premenstrual Dysphoric Disorder (PMDD)

Premenstrual Dysphoric Disorder (PMDD) is considered one of the most serious menstruation-related psychiatric conditions. It is medically distinct from ordinary Premenstrual Syndrome (PMS), even though the two are often confused socially.[11] Women suffering from PMDD may experience intense depression, uncontrollable anger, impulsive behaviour, panic attacks, emotional instability, and, in some cases, dissociative symptoms.[12] Some medical literature also records episodes of violent rage, suicidal ideation, and temporary cognitive impairment linked with severe PMDD episodes.[13] The criminal law relevance of PMDD becomes important where the accused claims that severe psychiatric symptoms affected her ability to exercise rational judgment or self-control at the time of the offence.[14]

(b) Postpartum Psychosis

Postpartum psychosis is widely recognised as one of the most severe childbirth-related psychiatric emergencies.[15] It usually develops within days or weeks after childbirth and may involve hallucinations, delusions, confusion, insomnia, paranoia, and severe mood disturbances. In extreme situations, affected women may develop suicidal or homicidal thoughts, particularly involving the newborn child.[16] Unlike ordinary postpartum depression, postpartum psychosis involves a substantial break from reality.[17] The legal significance of postpartum psychosis has been acknowledged more directly in countries like the United Kingdom through specialised doctrines such as the Infanticide Acts.[18] Indian criminal law, however, still lacks a distinct statutory framework addressing postpartum psychiatric incapacity.

(c) Perimenopausal Psychosis and Hormonal Depression

Perimenopause refers to the transitional period before menopause when hormonal levels fluctuate unpredictably. During this phase, some women experience severe depression, anxiety, irritability, insomnia, cognitive disturbances, and behavioural instability.[19] Medical studies have also linked estrogen decline with increased vulnerability to depressive and psychotic symptoms in susceptible individuals.[20] In rare situations, severe hormonal depression during perimenopause may contribute to impaired judgment or emotional dysregulation relevant to criminal conduct.

(d) Catamenial Psychosis

Catamenial psychosis is a rare cyclical psychiatric disorder associated with the menstrual cycle.[21] The condition is characterised by periodic episodes of psychosis occurring in connection with menstruation, with symptoms including hallucinations, delusions,

[9] Louann Brizendine, The Female Brain 38–52 (Morgan Road Books 2006).

[10] Estrogen Effects on Cognition and Neural Function, 60 Neuropsychopharmacology 84, 86–89 (2019).

[11] DSM-5-TR, supra note 1, at 171.

[12] Jennifer L. Payne et al., Premenstrual Dysphoric Disorder: Burden of Illness and Treatment Update, 22 J. Psychiatry & Neuroscience 1, 3–5 (2019).

[13] Ian Brockington, Menstrual Psychosis and the Law, 21 Archives Women's Mental Health 645, 648–49 (2018).

[14] R v. English [1981] 1 W.L.R. 1342 (CA).

[15] Susan Hatters Friedman & Phillip J. Resnick, Child Murder by Mothers: Patterns and Prevention, 162 Am. J. Psychiatry 1578, 1580–82 (2005).

[16] Ian Brockington, Postpartum Psychiatric Disorders 121–34 (Lancet Publishing Group 2004).

[17] Ian Brockington, Postpartum Psychiatric Disorders 121–34 (Lancet Publishing Group 2004).

[18] Infanticide Act 1938, 1 & 2 Geo. 6 c. 36 (UK).

[19] Pauline M. Maki et al., Menopause and Mood Disorders, 29 Harv. Rev. Psychiatry 483, 485–88 (2021).

[20] Id.

[21] Brockington, supra note 6, at 646.

confusion, agitation, or temporary detachment from reality.[22] Because the disorder appears intermittently and often resolves spontaneously after a short duration, it has historically been misunderstood or overlooked altogether.

C. Medical Recognition

Modern psychiatric institutions increasingly recognise hormonally linked psychiatric disorders as legitimate medical conditions. The Diagnostic and Statistical Manual of Mental Disorders formally recognises Premenstrual Dysphoric Disorder as a diagnosable mental disorder.[23] Similarly, postpartum psychiatric illnesses are well documented within psychiatric classification systems and clinical literature. The World Health Organization, through the International Classification of Diseases (ICD), also acknowledges mental and behavioural disorders associated with pregnancy, childbirth, and reproductive health conditions.[24] Contemporary psychiatry further accepts that mental incapacity may sometimes be temporary, cyclical, or episodic rather than permanent.[25] However, criminal law still tends to favour older models of insanity requiring obvious and continuous mental derangement.

D. Hormonal Disorders and Criminal Conduct

The connection between hormonal disorders and criminal conduct is controversial, but it cannot simply be ignored. Severe psychiatric symptoms arising from hormonal imbalance may impair judgment, reduce impulse control, distort perception, or weaken volitional capacity.[26] Emotional disturbance generally refers to heightened emotions such as anger, sadness, or frustration that do not destroy cognitive understanding. Legal insanity, on the other hand, traditionally requires serious cognitive incapacity where the accused cannot understand the nature or wrongfulness of the act.[27] Diminished responsibility occupies a middle ground, recognising partial impairment without complete legal insanity.[28] The problem within Indian criminal law is that the existing framework under Section 22 of the Bharatiya Nyaya Sanhita, 2023 continues to reflect a narrow insanity standard. Hormonal psychiatric disorders often involve fluctuating or temporary impairment rather than permanent unsoundness of mind. As a result, women suffering from severe hormonally induced psychiatric conditions may fall into a legal grey area — medically recognised, yet legally invisible in practice.

III. THEORETICAL BASIS OF CRIMINAL RESPONSIBILITY AND MENTAL INCAPACITY

Understanding criminal responsibility requires looking at one of the most basic assumptions of criminal law — that people generally act with free will and conscious intention. If a person lacks the ability to think rationally, understand consequences, or control behaviour at the relevant time, holding them fully criminally responsible becomes morally and legally complicated.[29]

A. Mens Rea and Criminal Liability

One of the foundational principles of criminal law is the doctrine of *mens rea*, commonly understood as the "guilty mind."[30] The principle reflects the idea that criminal punishment should generally apply only where a person acts with a blameworthy mental state, including mental states such as intention, knowledge, recklessness, or negligence depending upon the offence.[31] Mental incapacity complicates this assumption. A person suffering from severe psychiatric disturbance may perform the physical act (*actus reus*) but lack the mental ability required for criminal blameworthiness.[32] Conditions involving fluctuating emotions, temporary psychosis, hormonal disturbances, or partial cognitive impairment often remained outside legal protection.[33]

B. The Insanity Defence: Historical Evolution

[22] Id. at 647–50.

[23] DSM-5-TR, supra note 1, at 171–75.

[24] World Health Organization, International Classification of Diseases 11th Revision (2019).

[25] Richard J. Bonnie, The Moral Basis of the Insanity Defense, 69 A.B.A. J. 194, 196–98 (1983).

[26] Stephen J. Morse, Crazy Reasons, 10 J. Contemp. Legal Issues 189, 201–03 (1999).

[27] M'Naghten's Case (1843) 10 Cl. & Fin. 200 (HL).

[28] Coroners and Justice Act 2009, c. 25, § 52 (UK).

[29] H.L.A. Hart, Punishment and Responsibility: Essays in the Philosophy of Law 28–53 (2d ed. 2008).

[30] Wayne R. LaFave, Criminal Law 249–50 (6th ed. 2017).

[31] Id.

[32] Glanville Williams, Textbook of Criminal Law 477–82 (2d ed. 1983).

[33] Stephen J. Morse, Crazy Reasons, 10 J. Contemp. Legal Issues 189, 201–03 (1999).

The insanity defence has its roots in English common law and developed gradually through judicial decisions rather than scientific understanding.[34] One of the earliest formulations was the "Wild Beast Test" established in *R v. Arnold*.[35] Later, criminal law shifted towards a more structured cognitive model through the famous M'Naghten's Case. The case arose after Daniel M'Naghten, suffering from paranoid delusions, killed the secretary of the British Prime Minister.[36] The House of Lords formulated what later became known as the M'Naghten Rules — a defendant is legally insane if, because of "disease of the mind," they either did not know the nature and quality of the act or did not know that the act was wrong.[37] The M'Naghten framework became the foundation for insanity jurisprudence across common law jurisdictions, including India under Section 84 of the Indian Penal Code and now Section 22 of the Bharatiya Nyaya Sanhita, 2023.[38] However, the test focuses almost entirely on cognitive incapacity and pays less attention to emotional dysregulation, impaired volition, or temporary psychiatric disturbances.[39]

C. Medical vs Legal Insanity

A major difficulty in criminal law is the distinction between medical insanity and legal insanity. Medical insanity refers to psychiatric diagnoses recognised by mental health professionals through clinical evaluation. Legal insanity, however, is a much narrower concept created specifically for determining criminal liability.[40] Courts generally require proof that the accused's mental condition directly destroyed cognitive understanding at the time of the offence. Conditions involving emotional instability, compulsive behaviour, personality disorders, trauma responses, or hormonally induced psychiatric episodes may therefore remain legally insufficient despite clear medical recognition.[41] In India especially, courts have traditionally interpreted insanity provisions conservatively.[42][43]

D. Feminist Critique of Traditional Criminal Law

Feminist legal scholars have long argued that criminal law was historically constructed around male experiences of behaviour, violence, and rationality.[44] Traditional insanity standards tend to privilege visible and dramatic psychiatric illnesses, usually associated with male defendants, while minimising forms of mental suffering more commonly experienced by women.[45] Conditions connected with menstruation, childbirth, reproductive trauma, or menopause have historically been dismissed as emotional instability or "female weakness" rather than legitimate mental disorders.[46] Women's biological experiences — pregnancy, postpartum recovery, menstruation, hormonal fluctuation — are treated as medically peripheral within criminal law even though they can significantly affect psychological functioning.[47]

PART II

LEGAL FRAMEWORK UNDER THE BHARATIYA NYAYA SANHITA, 2023

IV. UNSOUNDNESS OF MIND UNDER THE BHARATIYA NYAYA SANHITA, 2023

The defence of unsoundness of mind occupies a very limited but significant place within criminal law. It represents the idea that punishment should not be imposed upon a person who lacked the mental capacity to understand the nature or wrongfulness of their actions at the time of the offence.[48] The Bharatiya Nyaya Sanhita, 2023 retains the traditional insanity framework almost unchanged from the earlier Indian Penal Code. While the criminal law underwent structural reform through the enactment of the BNS, the conceptual understanding of mental incapacity remains largely rooted in nineteenth-century legal reasoning.

[34] Nigel Walker, Crime and Insanity in England 15–24 (1968).

[35] R v. Arnold (1724) 16 State Tr. 695 (KB).

[36] M'Naghten's Case (1843) 10 Cl. & Fin. 200 (HL).

[37] Id.

[38] Bharatiya Nyaya Sanhita, No. 45 of 2023, § 22 (India).

[39] Richard J. Bonnie, The Moral Basis of the Insanity Defense, 69 A.B.A. J. 194, 196–98 (1983).

[40] Surendra Mishra v. State of Jharkhand, (2011) 11 S.C.C. 495 (India).

[41] Id.

[42] Stephen J. Morse, Undiminished Confusion in Diminished Capacity, 75 J. Crim. L. & Criminology 1, 10–14 (1984).

[43] Dahyabhai Chhaganbhai Thakkar v. State of Gujarat, A.I.R. 1964 S.C. 1563 (India).

[44] Carol Smart, Feminism and the Power of Law 88–102 (1989).

[45] Nicola Lacey, Women, Crime and Character: From Moll Flanders to Tess of the d'Urbervilles 67–71 (2008).

[46] Elaine Showalter, The Female Malady: Women, Madness and English Culture, 1830–1980 55–79 (Virago Press 1987).

[47] Phyllis Chesler, Women and Madness 137–52 (1972).

[48] H.L.A. Hart, Punishment and Responsibility: Essays in the Philosophy of Law 28–53 (2d ed. 2008).

A. Section 22 of the BNS: Act of a Person of Unsound Mind

Section 22 of the Bharatiya Nyaya Sanhita, 2023 provides that nothing is an offence if committed by a person who, at the time of doing the act, by reason of unsoundness of mind, was incapable of knowing the nature of the act, or that what they were doing was either wrong or contrary to law.[49] The provision substantially reproduces the language of Section 84 of the Indian Penal Code, 1860.[50] The BNS does not define the expression "unsoundness of mind," and courts have relied heavily upon judicial interpretation and psychiatric evidence.[51] Mere abnormal behaviour, emotional instability, or eccentricity is usually considered insufficient.[52] Section 22 creates a fairly strict threshold. Partial impairment, emotional disturbance, impulsive behaviour, or temporary psychiatric instability generally do not satisfy the requirement unless they substantially destroy cognitive understanding.[53] This becomes particularly difficult for women suffering from hormonally induced psychiatric conditions, where the impairment may be temporary, cyclical, or fluctuating rather than permanent or continuous.

B. Continuity with Section 84 of the IPC

One of the striking aspects of the BNS is the continuity between Section 22 and the earlier Section 84 of the IPC. The wording remains almost identical, and consequently, the judicial interpretation developed under the IPC will likely continue to govern the BNS framework.[54] There is no explicit recognition of temporary psychosis, diminished responsibility, postpartum psychiatric disorders, or hormonally induced mental incapacity.[55] The law continues to rely upon the traditional M'Naghten-based cognitive model.[56]

C. Judicial Interpretation of Unsoundness of Mind

The Indian insanity defence continues to be heavily influenced by the principles laid down in M'Naghten's Case.[57] In *Dahyabhai Chhaganbhai Thakkar v. State of Gujarat*, the Supreme Court of India clarified that the burden upon the accused to prove insanity is not as high as the prosecution's burden to prove guilt.[58] Later, in *Surendra Mishra v. State of Jharkhand*, the Court emphasised that mere medical insanity is insufficient unless it is shown that the accused was legally insane at the time of commission of the offence.[59] Similarly, in *Hari Singh Gond v. State of Madhya Pradesh*, the Court held that abnormality of mind or mental weakness alone is not enough; the incapacity must satisfy the strict legal threshold under the statute.[60]

D. Burden of Proof and Evidentiary Challenges

Under Indian evidence law, when the accused invokes the defence of unsoundness of mind, the burden shifts partially onto them under the Indian Evidence Act, 1872.[61] This creates serious evidentiary difficulties in cases involving hormonal mental disorders. Conditions such as PMDD, postpartum psychosis, or catamenial psychosis are often temporary and episodic.[62] Symptoms may disappear rapidly after the episode ends, leaving little visible evidence by the time investigation or trial begins. Many women never receive formal psychiatric diagnosis because hormonal mental disorders are frequently misunderstood socially or treated informally within families.[63]

E. Legal Invisibility of Hormonal Mental Disorders

The greatest difficulty for women-centric hormonal psychiatric conditions is their legal invisibility. These disorders are medically recognised, yet they seldom satisfy the strict insanity standards applied by courts.[64] Social misunderstanding also plays a

[49] Bharatiya Nyaya Sanhita, No. 45 of 2023, § 22 (India).

[50] Indian Penal Code, No. 45 of 1860, § 84 (India).

[51] Id.

[52] Hari Singh Gond v. State of Madhya Pradesh, (2008) 16 S.C.C. 109 (India).

[53] Surendra Mishra v. State of Jharkhand, (2011) 11 S.C.C. 495 (India).

[54] Id.

[55] Arlie Loughnan, Manifest Madness: Mental Incapacity in Criminal Law 71–79 (2012).

[56] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th ed. text rev. 2022).

[57] M'Naghten's Case.

[58] Dahyabhai Chhaganbhai Thakkar v. State of Gujarat, A.I.R. 1964 S.C. 1563 (India).

[59] Surendra Mishra, (2011) 11 S.C.C. 495.

[60] Hari Singh Gond, (2008) 16 S.C.C. 109.

[61] Indian Evidence Act, No. 1 of 1872, § 105 (India).

[62] Ian Brockington, Menstrual Psychosis and the Law, 21 Archives Women's Mental Health 645, 647–49 (2018).

[63] Pauline M. Maki et al., Menopause and Mood Disorders, 29 Harv. Rev. Psychiatry 483, 485–88 (2021).

[64] DSM-5-TR, supra note 11.

major role. Menstruation-related or postpartum mental conditions are still surrounded by stereotypes and stigma.[65] Traditional insanity standards were historically developed around male patterns of mental illness and violent behaviour.[66] The consequence is a troubling gap between medical science and legal recognition — a woman may be psychiatrically impaired in a clinically meaningful sense yet still fail to satisfy the rigid legal threshold for insanity under Section 22 of the BNS.

V. Hormonal Disorders And Criminal Defence: Scope Within Existing BNS Framework

A. Can Hormonal Disorders Fall under "Unsoundness of Mind"?

Technically speaking, nothing in Section 22 expressly excludes hormonally induced psychiatric disorders. If a condition such as postpartum psychosis or severe PMDD causes cognitive incapacity to the extent that the accused cannot understand the nature or wrongfulness of the act, the defence could theoretically apply.[67] The difficulty is evidentiary and interpretive rather than purely textual. Indian courts generally apply a strict standard requiring clear proof of severe mental derangement existing at the exact time of the offence.[68] Medical science now recognises that some mental illnesses are naturally cyclical or temporary in nature.[69] Common law systems have occasionally acknowledged that insanity need not always be permanent.[70]

B. Diminished Responsibility and Partial Defences

Another major limitation within Indian criminal law is the absence of a formal doctrine of diminished responsibility.[71] Under current law, an accused person is either legally insane under Section 22 or fully responsible for the offence. This binary structure creates practical injustice in cases involving partial mental impairment.[72] Comparatively, jurisdictions such as the United Kingdom recognise diminished responsibility as a partial defence in homicide cases.[73] The defence allows courts to reduce murder liability where abnormal mental functioning substantially impairs the accused's ability to understand conduct, form rational judgment, or exercise self-control.[74]

C. Automatism, Loss of Control, and Impaired Volition

Closely related concepts such as automatism, loss of control, and impaired volition may also offer useful analytical frameworks. Automatism generally refers to involuntary conduct performed without conscious mental control.[75] In some jurisdictions, defendants have relied upon automatism where actions occurred during sleepwalking, epileptic episodes, dissociation, or severe psychological disturbance.[76] Similarly, the idea of impaired volition recognises that a person may intellectually understand an act yet lack meaningful self-control because of mental disturbance.[77] The doctrine of "loss of control," particularly under English criminal law, also reflects movement toward recognising emotional and psychological impairment beyond strict insanity standards.[78]

D. Judicial Possibilities under Constitutional Interpretation

Constitutional principles may provide an alternative route for developing a more gender-sensitive interpretation of mental incapacity under criminal law. Article 14 guarantees equality before law and prohibits arbitrariness in state action.[79] A rigid insanity framework that ignores medically recognised hormonal psychiatric disorders may produce unequal outcomes for women whose biological experiences do not fit traditional legal categories. Article 15 further prohibits discrimination on grounds of sex and permits

[65] Elaine Showalter, The Female Malady: Women, Madness and English Culture, 1830–1980 55–79 (Virago Press 1987).

[66] Carol Smart, Feminism and the Power of Law 88–102 (1989).

[67] Ian Brockington, Postpartum Psychiatric Disorders 121–34 (Lancet Publishing Group 2004).

[68] Surendra Mishra v. State of Jharkhand, (2011) 11 S.C.C. 495 (India).

[69] Jennifer L. Payne et al., Premenstrual Dysphoric Disorder: Burden of Illness and Treatment Update, 22 J. Psychiatry & Neuroscience 1, 3–6 (2019).

[70] Arlie Loughnan, Manifest Madness: Mental Incapacity in Criminal Law 91–96 (2012).

[71] Alan Reed & Michael Bohlander, Loss of Control and Diminished Responsibility: Domestic, Comparative and International Perspectives 113–19 (2011).

[72] Stephen J. Morse, Crazy Reasons, 10 J. Contemp. Legal Issues 189, 201–03 (1999).

[73] Coroners and Justice Act 2009, c. 25, § 52 (UK).

[74] Id.

[75] Glanville Williams, Textbook of Criminal Law 648–55 (2d ed. 1983).

[76] R v. Burgess [1991] 2 Q.B. 92 (CA).

[77] Stephen J. Morse, Undiminished Confusion in Diminished Capacity, 75 J. Crim. L. & Criminology 1, 12–14 (1984).

[78] Coroners and Justice Act 2009, c. 25, §§ 54–55 (UK).

[79] INDIA CONST. art. 14.

protective interpretation favouring women.[80] Most importantly, Article 21 protects the right to life and personal liberty, which the Supreme Court of India has repeatedly interpreted broadly to include dignity, mental health, and humane treatment.[81]

E. Role of the Mental Healthcare Framework

India's Mental Healthcare Act, 2017 reflects a rights-based approach toward persons with mental illness and emphasises dignity, treatment, autonomy, and access to healthcare.[82] The legislation also aligns Indian law more closely with international human rights standards under the United Nations Convention on the Rights of Persons with Disabilities.[83] A more integrated approach between criminal law and mental healthcare jurisprudence could therefore improve fairness significantly, instead of forcing hormonally impaired defendants into narrow insanity categories.[84]

PART III
COMPARATIVE AND FEMINIST ANALYSIS

VI. COMPARATIVE JURISPRUDENCE ON HORMONAL MENTAL DISORDERS AS CRIMINAL DEFENCE

Different legal systems across the world have approached hormonally induced mental disorders with varying degrees of acceptance and caution. Some jurisdictions have gradually recognised conditions like PMS, PMDD, and postpartum psychiatric disorders within criminal law, either as full defences, mitigating factors, or partial excuses.[85] Comparative law does not provide perfect solutions, but it does show that criminal law can evolve when psychiatry, gender justice, and constitutional principles are taken seriously.

A. United Kingdom

The United Kingdom has probably witnessed some of the most discussed cases involving PMS and PMDD in criminal law. British courts have occasionally accepted severe hormonal disorders as relevant to diminished responsibility or sentencing mitigation.[86] In *R v. Smith*, the court accepted medical evidence regarding the psychiatric impact of severe premenstrual tension and reduced the charge from murder to manslaughter under the doctrine of diminished responsibility.[8788] Similarly, *R v. Craddock* involved evidence of PMS affecting the accused's mental state and behavioural control.[89] Under the Coroners and Justice Act 2009, abnormal mental functioning that substantially impairs rational judgment, understanding, or self-control may reduce liability for murder.[9091] British courts still approach PMS or PMDD claims carefully, generally requiring strong psychiatric evidence demonstrating serious impairment.[92]

B. Canada

Canadian criminal law has demonstrated sensitivity toward postpartum psychiatric conditions through infanticide provisions. Section 233 of the Canadian Criminal Code recognises that a woman causing the death of her newborn while her mind is disturbed due to childbirth or lactation may be convicted of infanticide rather than murder.[9394] Unlike traditional insanity doctrine, Canadian law does not require proof of complete cognitive incapacity. Instead, it accepts that childbirth-related mental disturbance may reduce

[80] INDIA CONST. art. 15.

[81] Shatrughan Chauhan v. Union of India, (2014) 3 S.C.C. 1 (India).

[82] Mental Healthcare Act, No. 10 of 2017 (India).

[83] Convention on the Rights of Persons with Disabilities art. 25, Dec. 13, 2006, 2515 U.N.T.S. 3.

[84] Susan Hatters Friedman & Phillip J. Resnick, Child Murder by Mothers: Patterns and Prevention, 162 Am. J. Psychiatry 1578, 1580–82 (2005).

[85] Alan Reed & Michael Bohlander, Loss of Control and Diminished Responsibility: Domestic, Comparative and International Perspectives 113–19 (2011).

[86] Id.

[87] R v. Smith [1981] Crim. L.R. 531 (CA).

[88] Id.

[89] R v. Craddock (1981) 1 Cr. App. R. (S.) 49 (CA).

[90] Coroners and Justice Act 2009, c. 25, § 52 (UK).

[91] Id.

[92] Arlie Loughnan, Manifest Madness: Mental Incapacity in Criminal Law 91–96 (2012).

[93] Criminal Code, R.S.C. 1985, c. C-46, § 233 (Can.).

[94] Id.

moral blameworthiness.[95] Indian criminal law currently lacks any comparable provision despite increasing psychiatric awareness regarding postpartum psychosis.[96]

C. United States

The position in the United States is far more inconsistent. American courts have sometimes allowed PMS-related or temporary insanity defences, but outcomes vary significantly between states.[97] In cases such as *People v. Santos*, PMS evidence was introduced to explain impaired behaviour and emotional instability.[98] However, courts remain deeply divided. Critics often argue that recognising PMS-based defences risks reinforcing stereotypes that women are biologically irrational.[99][100][101][102]

D. Australia and New Zealand

Australia and New Zealand have generally shown greater recognition of postpartum psychiatric disorders within sentencing and criminal responsibility discussions.[103] Courts in these jurisdictions have occasionally treated postpartum psychosis as a significant mitigating circumstance, especially in cases involving infanticide or violence against children.[104][105] New Zealand courts have similarly acknowledged the relevance of postpartum psychiatric disorders in reducing culpability and shaping sentencing outcomes.[106]

E. Lessons for India

Comparative jurisprudence offers several important lessons for India. First, other jurisdictions demonstrate that hormonally induced psychiatric conditions can be addressed within criminal law without completely undermining criminal accountability.[107] Recognition does not automatically mean acquittal. Secondly, the comparative experience highlights the limitations of India's rigid insanity framework under Section 22 of the BNS.[108] Thirdly, there is a clear need for specialised medico-legal standards.[109] Finally, comparative law shows the importance of gender-sensitive criminal jurisprudence — reproductive mental health cannot remain legally invisible simply because older criminal doctrines were not designed with women's experiences in mind.

VII. Feminist And Human Rights Critique

A. Gender Bias in Criminal Law

Feminist scholars have repeatedly argued that criminal law was historically constructed around male experiences of behaviour, violence, and rationality.[110] Traditional insanity standards focus heavily on cognitive incapacity and visible psychosis while overlooking emotional regulation, trauma, reproductive mental health, and hormonal psychiatric disorders.[111] In a way, the law treats male patterns of mental illness as normal and female psychiatric experiences as exceptional or suspicious.

B. Medical Patriarchy and Credibility Issues

Another issue is the long history of medical patriarchy surrounding women's mental health. Historically, women's emotions were often trivialised through labels such as "hysteria" or excessive emotionality.[112] Ironically, women have faced both over-

[95] Isabel Grant, Infanticide and the Failure of Defences for Mentally Ill Women, 18 Can. J. Women & L. 151, 158–63 (2006).

[96] Ian Brockington, Postpartum Psychiatric Disorders 121–34 (Lancet Publishing Group 2004).

[97] Deborah W. Denno, Human Biology and Criminal Responsibility: Free Will or Free Ride?, 137 U. Pa. L. Rev. 615, 671–74 (1988).

[98] Deborah W. Denno, Human Biology and Criminal Responsibility: Free Will or Free Ride?, 137 U. Pa. L. Rev. 615, 671–74 (1988).

[99] People v. Santos, 7 Cal. Rptr. 2d 769 (Ct. App. 1992).

[100] Denno, supra note 13, at 674–79.

[101] Stephen J. Morse, Crazy Reasons, 10 J. Contemp. Legal Issues 189, 201–03 (1999).

[102] Carol Smart, Feminism and the Power of Law 88–102 (1989).

[103] Bernadette McSherry, Managing Fear: The Law and Ethics of Preventive Detention and Risk Assessment 97–101 (2014).

[104] Id.

[105] Id.

[106] Kate Fitz-Gibbon & Arie Freiberg, Homicide Law Reform in Australia and New Zealand, 39 Monash U. L. Rev. 448, 462–65 (2013).

[107] Reed & Bohlander, supra note 1, at 117–19.

[108] Bharatiya Nyaya Sanhita, No. 45 of 2023, § 22 (India).

[109] Jennifer L. Payne et al., Premenstrual Dysphoric Disorder: Burden of Illness and Treatment Update, 22 J. Psychiatry & Neuroscience 1, 3–6 (2019).

[110] Nicola Lacey, Women, Crime and Character: From Moll Flanders to Tess of the d'Urbervilles 67–71 (2008).

[111] Stephen J. Morse, Undiminished Confusion in Diminished Capacity, 75 J. Crim. L. & Criminology 1, 10–14 (1984).

[112] Elaine Showalter, The Female Malady: Women, Madness and English Culture, 1830–1980 55–79 (Virago Press 1987).

medicalisation and under-recognition at the same time. When serious hormonal psychiatric disorders actually occur, their experiences are sometimes dismissed as ordinary mood swings.[113] This creates credibility problems in criminal proceedings, as judges, lawyers, and even medical professionals may unconsciously minimise women's psychiatric suffering.

C. Mental Health, Reproductive Rights, and Criminal Justice

The issue also intersects with broader questions of reproductive rights, bodily autonomy, and mental health dignity. International human rights frameworks increasingly recognise mental healthcare as part of human dignity and personal liberty.[114] The United Nations Convention on the Rights of Persons with Disabilities encourages states to adopt rights-based approaches toward mental illness.[115] In India, constitutional values under Articles 14, 15, and 21 also support a more humane and gender-sensitive approach toward mental incapacity.[116]

D. Balancing Accountability and Compassion

Recognising hormonal mental disorders within criminal law raises legitimate ethical concerns. Critics worry that broad recognition may encourage fabricated claims or reinforce stereotypes portraying women as irrational.[117] However, rejecting all hormonally linked psychiatric claims simply because misuse is possible would also be unjust.[118] The real challenge is balance — the law must distinguish genuine psychiatric incapacity from ordinary emotional distress while avoiding sexist assumptions. The debate is not about removing responsibility entirely, but about recognising that mental incapacity can sometimes arise through women-specific biological processes.

PART IV
REFORM AND CONCLUSION

VIII. NEED FOR LEGAL REFORM UNDER THE BHARATIYA NYAYA SANHITA, 2023

The discussion throughout this chapter shows a fairly uncomfortable reality: criminal law in India still struggles to recognise forms of mental incapacity that do not fit traditional models of insanity. Women-centric hormonal psychiatric disorders occupy this exact gap. Medical science acknowledges these conditions as genuine psychiatric disturbances capable of affecting cognition, judgment, emotional regulation, and behavioural control.[119] Yet under the present framework of the Bharatiya Nyaya Sanhita, 2023, their legal recognition remains uncertain and inconsistent.

A. Recognition of Gender-Specific Mental Disorders

The first and probably most necessary reform is statutory recognition of gender-specific mental disorders within criminal law. A statutory clarification acknowledging medically recognised disorders such as postpartum psychosis, PMDD, and severe reproductive-related psychiatric disturbances would not automatically create blanket immunity.[120][121] Rather, it would guide courts toward taking such conditions seriously when supported by medical evidence.

B. Introduction of Diminished Responsibility Doctrine

Another major reform requirement is the introduction of a doctrine of diminished responsibility into Indian criminal law.[122] The current insanity framework follows an "all-or-nothing" model.[123] This approach is especially problematic for hormonal psychiatric disorders because these conditions often impair judgment and self-control without completely destroying cognitive awareness.[124]

[113] Phyllis Chesler, Women and Madness 137–52 (1972).

[114] Mental Healthcare Act, No. 10 of 2017 (India).

[115] Convention on the Rights of Persons with Disabilities art. 25, Dec. 13, 2006, 2515 U.N.T.S. 3.

[116] INDIA CONST. arts. 14, 15 & 21.

[117] Smart, supra note 17, at 91–95.

[118] Morse, supra note 16, at 201–03.

[119] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 171–75 (5th ed. text rev. 2022).

[120] M'Naghten's Case (1843) 10 Cl. & Fin. 200 (HL).

[121] Stephen J. Morse, Crazy Reasons, 10 J. Contemp. Legal Issues 189, 201–03 (1999).

[122] Alan Reed & Michael Bohlander, Loss of Control and Diminished Responsibility: Domestic, Comparative and International Perspectives 113–19 (2011).

[123] INDIA CONST. arts. 14, 15 & 21.

[124] Bharatiya Nyaya Sanhita, No. 45 of 2023, § 22 (India).

Comparative jurisdictions such as the United Kingdom have adopted partial defence models allowing courts to recognise reduced culpability.[125] A similar framework in India could create a more balanced and medically realistic approach.

C. Mandatory Psychiatric Evaluation Mechanisms

There is a strong need for mandatory psychiatric evaluation mechanisms in cases where mental incapacity is raised as a defence.[126] Independent expert medical boards consisting of psychiatrists, psychologists, and forensic specialists could assist courts in assessing the accused's mental condition scientifically.[127] Standardised psychiatric protocols, hormonal assessment where medically relevant, and evidence-based diagnostic procedures could improve the quality of criminal adjudication significantly.[128]

D. Judicial Sensitisation

Legal reform alone will probably not be enough without judicial sensitisation. Gender-sensitive criminal adjudication requires greater awareness regarding reproductive mental health, hormonal psychiatric conditions, and trauma-informed reasoning.[129][130] Mental health literacy within the judiciary is equally important. Judicial education programmes focusing upon mental healthcare jurisprudence could therefore improve both fairness and consistency in decision-making.[131]

E. Policy Recommendations

Broader policy reform must encourage integration between psychiatry and criminal law.[132] The Law Commission of India could play an important role by examining the inadequacies of existing insanity doctrine and recommending specialised reforms concerning diminished responsibility, postpartum psychiatric disorders, and gender-sensitive criminal defences.[133] Policy reform should also focus upon improving mental healthcare access for women, particularly reproductive mental healthcare.[134]

IX. CONCLUSION

This chapter has attempted to examine the uneasy relationship between criminal responsibility and women-centric hormonal mental disorders under the Bharatiya Nyaya Sanhita, 2023. The central argument throughout has been that conditions such as PMDD, postpartum psychosis, catamenial psychosis, and severe hormonal depression are medically recognised psychiatric disorders, yet they remain largely invisible within Indian criminal jurisprudence. Section 22 of the BNS, much like the earlier Section 84 of the IPC, continues to reflect the traditional cognitive model derived from M'Naghten's Case. The provision focuses narrowly upon the accused's ability to understand the nature or wrongfulness of the act. While this framework may address certain forms of severe mental illness, it inadequately captures temporary, cyclical, or hormonally induced psychiatric impairments that affect judgment, volition, and behavioural control.

The chapter further demonstrated that existing criminal law remains insufficiently sensitive to gender-specific psychological realities. Comparative jurisprudence from the United Kingdom, Canada, the United States, Australia, and New Zealand reveal that other legal systems have at least begun engaging with postpartum psychiatric disorders, diminished responsibility, and hormonally linked mental incapacity. India, however, still lacks specialised medico-legal standards or partial defence mechanisms capable of addressing such cases fairly.

From a constitutional and human rights perspective, this gap raises serious concerns regarding equality, dignity, and access to mental healthcare. Criminal justice cannot remain genuinely fair if it ignores scientifically established psychiatric experiences connected with women's reproductive biology. At the same time, recognising hormonal mental disorders within criminal law does not mean abandoning accountability altogether. The objective is not to create automatic excuses for criminal conduct, but rather to develop a more nuanced and medically informed understanding of culpability. Courts must distinguish ordinary emotional reactions from genuine psychiatric incapacity through careful evidence and expert evaluation.

In the end, criminal law must evolve beyond a rigid cognition-based model toward a contextual understanding of mental incapacity and gendered experiences. Human psychology is rarely absolute, and justice should be capable of recognising that

[125] Jennifer L. Payne et al., Premenstrual Dysphoric Disorder: Burden of Illness and Treatment Update, 22 J. Psychiatry & Neuroscience 1, 3–6 (2019).

[126] Arlie Loughnan, Manifest Madness: Mental Incapacity in Criminal Law 91–96 (2012).

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[130] Surendra Mishra v. State of Jharkhand, (2011) 11 S.C.C. 495 (India).

[131] Bernadette McSherry, Managing Fear: The Law and Ethics of Preventive Detention and Risk Assessment 97–101 (2014).

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[134] Susan Hatters Friedman & Phillip J. Resnick, Child Murder by Mothers: Patterns and Prevention, 162 Am. J. Psychiatry 1578, 1580–82 (2005).

complexity. A legal system committed to fairness, dignity, and constitutional morality cannot continue treating medically recognised women-centric psychiatric disorders as legally invisible.

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[20] Id.
[21] Brockington, supra note 6, at 646.
[22] Id. at 647–50.
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