

The Episodic Dyscontrol Syndrome And Criminal Responsibility

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Introduction

A growing body of literature suggests that violent behavior, especially when it is episodic, explosive, and out of all proportion to the provocation, can be a manifestation of what is currently termed the episodic dyscontrol syndrome. As elaborated by Monroe (1970, 1978), it represents a subgroup of the more general category of episodic (vs. continual) behavior disorders, and is defined as an "interruption in the lifestyle and life flow of the individual, and involves either a single act or short series of acts with a single intention The common features . . . are precipitous onset of symptoms, equally abrupt remission, as well as the tendency of frequent recurrences."¹

The syndrome typically has been behaviorally defined,[†] but there is general agreement that in many cases a structural or functional brain defect is a necessary element of the total picture. Such a defect is presumably operative at the level of the limbic system and may be secondary to a wide variety of causes including, for example, physical trauma to the head, perinatal hypoxia, stroke, and encephalitis.³

New work has been reaching the literature⁴ in which attempts are made further to refine the concepts, standardize the criteria, and examine for the presence of this syndrome in criminal offenders. Further, the same authors endeavor to document the extent and degree to which "faulty equipment" in Monroe's terms (*i.e.*, a functional brain defect as opposed to "faulty learning") is responsible for the symptomatology of this syndrome.

Inevitably, such research raises many issues for practitioners of forensic psychiatry and psychology. For one, the possibility of improved treatment, *e.g.*, with certain anti-convulsant medication based upon new

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† Mark & Ervin (1970), for example, found four characteristics of the dyscontrol syndrome not all of which were always present at the same time: (1) A history of physical assault, especially wife and child beating; (2) the symptom of pathological intoxication — that is, drinking even a small amount of alcohol triggers acts of senseless brutality; (3) a history of impulsive sexual behavior, at times including sexual assaults; and (4) a history (in those who drove cars) of many traffic violations and serious automobile accidents.²

diagnostic conceptualizations, for our psychiatric or correctional patients cannot be ignored. But equally important is the pertinence of a diagnosis of episodic dyscontrol to the determination of criminal responsibility in an individual whose offense fulfills the criteria for a dyscontrol act.

It is our belief that the presence of a documented neurological deficit in an individual suffering from episodic dyscontrol should be considered strong evidence, under certain circumstances, for inability of the individual to conform his conduct to the requirements of the law by virtue of a mental defect. The case report that follows illustrates a situation where a defendant, convicted of a senseless and brutal crime, was granted a new trial because of a change in the insanity standard in the military. At the new trial, information from a detailed neuropsychological workup was presented that suggested a diagnosis of episodic dyscontrol and indicated neurological abnormalities on EEG and CAT scan. It significantly influenced the outcome of the proceedings.

Case Illustration

The patient, F., a twenty-year-old white male enlisted in the Marine Corps, was charged with the death of the wife of a Marine corporal. While the woman's husband was at work one evening, the patient and the woman had dinner at her residence. F. was apparently somewhat intoxicated, as he had consumed two six-packs of beer during the day preceding the offense and five cans during that evening. They engaged several times in sexual intercourse, and, while in bed together, began discussing intimate details of F.'s life, including the fact that he was pending trial in his home state on a charge of rape. The woman said that, should her husband come home, she would have to claim that F. had raped her. Further, she stated that her brother had been acquitted on a rape charge, even though she knew he was guilty. She began to tease F. saying that he, too, was probably guilty in spite of his angry protestations that he was not. As he defended himself with mounting irritation she began to laugh, which triggered in F. an intense rage. He placed his hands around her neck and began to count. In subsequent statements to the psychiatrist and in his own testimony at trial, he stated that he counted because his parents had taught him to use this technique in order to control his behavior whenever he was angry. He claimed that his aim was to stop her laughing, but the choking apparently produced a gurgling sound in the woman's throat which he interpreted as further laughter. After choking her and throwing her to the floor, he continued to hear the gurgling. He apparently proceeded to the kitchen, obtained a knife, returned to the bedroom, and inflicted three stab wounds in the woman's neck. He then jumped up and down numerous times with his full weight on her body. The woman died as a result of the wounds.

At the initial court-martial, F. testified that he remembered placing his hands upon her shoulders and counting. His memory appeared to waver about whether his hands were indeed on her shoulders or around her neck.

He claimed to remember nothing further until he found himself resting upon her body as it lay on the floor, dead. His first action after regaining control was to call his parents and tell them what he had done. Woken from their sleep, they advised him to go to the police. He then put on a pair of pants, woke the woman's sleeping child, drove with him to the local police station, explained what he had done, and surrendered the boy.

Pertinent past history indicated that while F. was ordinarily a quiet and inconspicuous individual, since childhood he had many documented episodes of violent destructive behavior precipitated by trivial irritations. Although from an intact home, he had been brought up by a father whose brutality and penchant for severe physical punishment had been manifested innumerable times. Interestingly, the father's father was also said to have used excessive physical punishment with his children.

Though F. had no history of neurological disease, repeated trauma to the head had been recorded. The most significant appeared to be as the result of an accident at an amusement park when at age thirteen he was knocked unconscious for some twenty minutes while getting off a carnival ride.

Prior to trial, three military psychiatrists performed detailed clinical evaluations of the accused. All agreed that in interview he showed no signs of psychosis and few, if any, demonstrable abnormalities in mental status. All three psychiatrists initially diagnosed F. as "explosive personality," but the two defense psychiatrists, feeling strongly that he had not been responsible during commission of the crime, proposed that he had suffered a gross stress reaction. Their inability, however, to convince the jury of the presence of any overwhelming environmental stress, in the face of unequivocal testimony from the government's witness that there were no signs of psychosis, led to a conviction for unpremeditated murder at the general court-martial. As noted above, the U.S. Court of Military Appeals reversed the conviction, holding that an improper standard for the assessment of criminal responsibility, *i.e.*, the *McNaughten Rule*, had been employed at the first trial whereas a standard closer to the American Law Institute Model Penal Code definition ought to have been employed.

It was with this background that the authors were asked to review the initial trial transcripts and the statement of facts, and render an opinion as to whether a further examination would be justified.

Both authors were impressed, in their review of the initial trial transcript, by the fact that the patient had not been adequately worked up from a neurological or a psychological point of view. That is, the examinations conducted by both government and defense psychiatrists consisted exclusively of clinical interviews. There was no evidence that any of the doctors had requested or obtained either psychological testing or any form of neurological assessment.

Given F.'s history of violent, impulsive behavior, out of all proportion

to the precipitants, the opinion was shared by both authors that both types of examinations were needed. Comprehensive psychological testing was felt to be valuable for all the reasons that make its use in these cases so widespread in detection of latent psychosis; some notion of the strength of internal controls, vulnerability to stress, and an assessment of whether and under what circumstances the individual might become psychotic, all are issues which can be illuminated by such testing.

Neurological assessment was indicated to exclude the possibilities of an organic basis for the dyscontrol syndrome that we suspected was present in the case. Convincing evidence of a structural or functional brain defect would raise serious questions about whether F., at the time of the offense, was able to conform his behavior to the requirements of the law.

Method

Psychological testing including the Wechsler Adult Intelligence Scale (WAIS) was administered both to assess intellectual functioning and to be an integral part of the Halstead-Reitan neuropsychological test battery. This also was administered, along with the Bender-Gestalt and Graham-Kendall Memory for Designs test to further explore the possibility of an organic brain syndrome. F. received a Minnesota Multiphasic Personality Inventory (MMPI) which, among other things, allowed the opportunity to explore for possible malingering, since the test has built in dissimulation scales. The Sentence Completion Test and, finally, the Rorschach, Thematic Apperception Test, and Projective Drawing were administered to overcome certain aspects of conscious resistance and provide a clinical feel for the interaction of impulses, defenses and unconscious motivations.

In addition to this testing, neurological workup was performed at the Institute of Psychiatry and Human Behavior at the University of Maryland School of Medicine. Here F. received a complete neurological examination, comprehensive electro-encephalography, and computerized axial tomography. The electro-encephalographic study included baseline and sleep tracings, those recorded with activation techniques such as hyperventilation and photic stimulation, as well as recording after the administration of 500 mg Alpha-Chloralose.

Results

Psychological testing results revealed an individual who attempted to present himself in an open and honest manner, with no evidence of any attempt to malingering or to deceive the examiner. He achieved a verbal IQ of 105, a performance IQ of 117 and a resultant full-scale IQ of 111, placing him in the bright normal range of intellectual functioning. There were subtle indications within the WAIS, notably deficits in short term learning and memory, that some of the impairment noted could be due to organic factors. The overall impression that emerged was that of a young

man with relatively intact neurotic facade who had the capacity for acute decompensation to altered states of consciousness, at times psychotic, when placed in situations that were either overly stressful or too vague, unstructured, and amorphous for him to grasp. The neurotic surface picture was characterized by anxiety, conflicts over his sexual identity, and attempts to intellectualize, rationalize, or deny many of his conflicts. Testing results also were consistent with a propensity for explosive acting out during these altered states of consciousness. In highly structured situations, the patient maintained adequate reality contact, but when the situation was unstructured and psychic conflicts came to the surface, his reality contact deteriorated rapidly and he became explosive, showing virtually no inner control. Attempts to counteract the loss of control were most often fruitless, and the end result was a completely psychotic resolution characterized by autistic thinking and confabulatory reasoning. Perceptual distortions, both visual and olfactory, *noted prior to the offense*, further suggested some organic process. These findings were felt to be both suggestive of the possibility of some organicity and highly compatible with a diagnosis of episodic dyscontrol syndrome from a psychological point of view.

The results of the neurological workup suggested that the patient was indeed suffering from some degree of organic dysfunction. Neurological history revealed in pertinent part that he had suffered head trauma on the carnival ride at age thirteen and was "out cold" for about twenty minutes afterwards. He claims to have been amnesic for the day following this episode. He admitted to suffering from headache literally "always." In his teens, his English teacher regarded him as a "day dreamer," and there were two to three episodes in which he fainted following exercises in junior high school. He recalled at least one episode of an absence state in which he could not account for how he had gotten from one place to another. It was also ascertained that the patient reversed letters and numbers in reading and spelling.

On neurological examination the patient was found to be ambidextrous but was relatively normal except for a clear difference in nasolabial folds, reduced on the right compared with the left and a "mild right-sided weakness of the right arm against resistance and on external rotation."

The Halstead-Reitan neuropsychological evaluation was performed on November 18, 1977 and included the Halstead Category Test, the Tactual Performance Test, the Seashore Rhythm Test, the Speech Sounds Perception Test, Finger Auscultation Test, Word Finding Test, Wide Range Achievement Test, Trailmaking Test - Parts A and B, Ocular Dominance Test, Strength of Grip, Lateral Dominance Test, and Aphasia Screening. While overall it was felt that he was able to function in a normal range, a more detailed analysis of the scores indicated a consistent weakness of the right arm and hand even though he preferred to use his right. Certain tasks as well were performed significantly more slowly with the right hand than with the left. The overall conclusion was

that the patient had motor and sensory impairment localized primarily within the left hemisphere.

Regarding the EEG, Dr. Monroe wrote the following consultation: "This man's baseline EEG was normal although he did show a large build-up with hyperventilation. After Alpha-Chloralose, this build-up was even greater, but there was little Theta activity in the pre-hyperventilation record; however, there were occasional bursts of Theta activity in the post-hyperventilation phase and also occasional positive spikes. This response is rated as a 2+ activation but with positive spikes probably has clinical significance. Therefore, I would suggest a trial on anti-convulsive medication."

Interestingly, in contrast with the findings of left hemisphere problems, the CAT scan performed on November 11, 1977 revealed "minimal compression of the right lateral ventricle, no other significant abnormalities." This was read as possibly representing "cerebral edema on the right side." Although recommended, a repeat CAT scan could not be obtained, and it remains questionable what the significance of these apparently contradictory findings could be. When contacted and apprised of the situation, another expert (Dr. Vernon Mark) felt that such a CAT reading did not rule out the possibility of pathology on the left rather than the right side.

The significance of these findings is discussed below.

Discussion

In our own clinical interviews of F., we had corroborated the findings of the earlier examiners regarding the absence of any signs of overt psychosis in this individual. We had from the beginning, however, suspected the possibility of an episodic dyscontrol syndrome so that the issues facing the authors in the light of the upcoming trial became, first, did F. suffer from an episodic dyscontrol syndrome at the time of the crime such that the criminal act was felt to be a dyscontrol act and, second, if so, to what degree, if any, did this diminish F.'s responsibility for the criminal behavior.

The results of the extensive evaluation of F. made it clear that he indeed did suffer from a syndrome of episodic dyscontrol. Monroe⁵ feels that many poorly defined conditions labeled with terms such as "reactive excitation," "reactive confusion," "explosive personality," and "episodic drinking" are actually examples of individuals who are suffering from episodic behavior disorders. These disorders are characterized by "precipitous onset of symptoms, equally abrupt remission, as well as the tendency for frequent recurrences."⁶ In the subgroup of episodic behavior disorders characterized as episodic dyscontrol, the "symptoms" are further defined as "a single act or short series of acts with a single intention carried through to completion with at least relief of tension or gratification of a specific need."⁷

Certainly F.'s history and behavior fit this definition. Further, his

history included many of the features found in individuals diagnosed as dyscontrol cases.⁸ There was, specifically, a long history of intrafamilial violence with frequent severe beatings by his father. There was also the history of head trauma referred to above. F. also demonstrated impulsive behavior involving cars, with one conviction for driving without a license and one for attempted manslaughter with a vehicle.

Another feature usually associated with the dyscontrol syndrome is pathological intoxication, in which relatively moderate amounts of alcohol trigger rage and/or drunkenness. In this regard, the government psychiatrist's report itself stated that he became "argumentative and pugilistic when drinking."

Regarding the crime itself, the primitive and uncontrolled nature of the violence, *i.e.*, repeated stabbing and stomping on top of strangulation, is quite characteristic of a dyscontrol act. Moreover, F.'s behavior after the commission of the crime was typical of dyscontrol behavior, usually the presence of remorse and the occurrence of spotty amnesia for aspects of the crime itself. In addition, F. made two suicide attempts in the weeks following his arrest. Mark & Ervin⁹ report that half of their series included suicide acts of a serious nature within weeks of the performance of the violent act.

Another feature of F.'s case that was compatible with this diagnosis was the presence of "soft" neurological signs on examination. The "minimal weakness" of the right side noted by the neurologist was elaborated upon by the findings in the Halstead-Reitan Test which found definite motor and sensory impairments localized within the left hemisphere.

Based on the above, the authors made the diagnosis of episodic dyscontrol syndrome in this individual, hypothesizing that the head trauma sustained at age thirteen was the initiating event. By so saying, we did not feel we were so much differing from the diagnosis of explosive personality offered by the original examiners, as we were placing the individual into a new diagnostic framework that would be more useful to us in analyzing the issue of criminal responsibility. The reasoning at the prior trial had been: "Explosive personality" is a "personality disorder;" personality disorders are, by definition, "not resulting from mental disease or defect": Therefore, this individual could not be relieved of criminal responsibility for his act.

This categorical judgment struck us as reflective of the state of psychiatry in the 1950s at the time the DSM I was issued, and took no account of the research such as Monroe's, that has been done in the last twenty years. Much of this work has as its point the notion that in many, if not all, cases of episodic violence, *ascertainable brain damage of a structural or functional nature* is present. Further, treatment of a somatic nature, including medication, or in some instances, psychosurgery, has been effective in some cases for relief of the episodes of violence.

In an attempt to distinguish those cases of episodic dyscontrol

syndrome with brain disease from others in which dyscontrol is either "learned" or "a way of life," Monroe has made use of special activated EEG studies, a "dyscontrol" scale and a careful correlation of these with behavioral characteristics and character traits. The category of "epileptoid" versus "hysteroid" dyscontrol embraces those individuals in whom it is felt that "faulty equipment" as opposed to "faulty learning" is the root of the dyscontrol problem. On a behavioral level, epileptoid dyscontrol is characterized by "an explosive immediate response to environmental stimulus that represents a short circuit between stimulus and action."¹⁰ In contrast to nonepileptoid dyscontrols, this behavior tends to lack premeditation; it is carried out in response to a precipitating event; it may engender more guilt, and occurs in individuals who are relatively less passive-aggressive in nature. These criteria all seem to be well satisfied by F.'s behavior. His act was explosive, immediate, and in direct response to the environmental stimulus provided by the taunting woman. His pathetic attempt to assert control by counting was over-ruled by the outburst of rage, strongly suggesting the kind of "short circuit" described. Further, the presence of guilt in the form of suicide attempts after the act, as well as the history of numerous acts similar in course, also fit the description.

In terms of neurological findings, the epileptoid dyscontrols show more CNS impairment and neurological stigmata, less amnesia, more prodromal motor restlessness and autonomic symptoms and a higher neurological scale. This scale, based upon a grading system developed by Monroe, measures the response to activation with Alpha-Chloralose in terms of both specific and nonspecific EEG abnormalities. A review of the EEG interpretation made it clear that F. fit Monroe's criteria for a significant response. Further, the results of CAT scan and of the Halstead-Reitan neuropsychological testing indicated the presence of neurological stigmata, presumably in the left hemisphere.

Therefore, based on the particular nature of F.'s explosiveness, his behavior after the crime, his performance on neurological testing, and upon the classifications pioneered by Monroe, we concluded that F. suffered from an episodic dyscontrol syndrome, epileptoid in type, and that the crime with which he was charged was in fact a dyscontrol act.

It is at this point in the process that the particular issues confronting the forensic clinician arise. We, of course, refer to the assimilation and synthesis of all the findings above into an opinion regarding the criminal responsibility of the accused. Neither Monroe, Elliott, Mark or Ervin has ever, to our knowledge, attempted explicitly to relate degree or type of dyscontrol to the question of criminal responsibility. In reviewing Monroe's discussion of the absence of "reflective delay" as characteristic of the epileptoid dyscontrol act on a dynamic level,¹ however, one cannot escape the implication that the individual so afflicted lacks the ability to control his behavior during the dyscontrol act. It is our opinion as well that to accept epileptoid dyscontrol as a legitimate entity and thereby to

accept "faulty equipment" as manifested by an absence or serious distortion of reflective delay at the root of the dyscontrol is virtually to accept that an individual so afflicted and performing such a dyscontrol act is unable, at the time of the crime, to conform his behavior to the requirements of the law.

We have no desire to debate here the virtues of the insanity defense compared to other methods of dealing with the mentally ill who become involved in the criminal justice system. We are committed to helping the Court insofar as we can to apply existing legal standards to the disposition of cases with a maximum of humanity and scientific accuracy. We feel obligated to make available to the Court what we feel to be the best and most recent research in psychiatry, psychology, and neurology; and we attempt to identify, assimilate, and interpret this material as fairly as we can. Clearly such a stance involves living with ambiguity and making judgments on the basis of the preponderance of evidence rather than "beyond a reasonable doubt."

Though still "experimental" the concepts we have presented were persuasive to the authors, although the concept and precise criteria for the organic or epileptoid dyscontrol syndrome are still evolving. We do not feel we would be more correct to have ignored this material, and insist, with the government psychiatrist, that in spite of the substantial evidence of brain dysfunction in our patient and despite the classic similarity of his history and behavior pattern to that of individuals with known neurological disease, our patient was merely suffering from a "personality disorder." We therefore concluded in our letter to the Court that F. was, in our opinion, not guilty by reason of insanity at the time of the offense by virtue of a mental defect, namely, episodic dyscontrol syndrome, epileptoid type.

At the second court-martial we testified to this effect, while the government psychiatrist, unimpressed by our findings, reiterated his point of view. The jury deliberated and eventually convicted F. of voluntary manslaughter, a finding that fell short of our own, but had the effect of substantially shortening the minimum period of F.'s incarceration. Thus, while not legally exempting our client from responsibility for his act, the Court was suitably impressed and clearly took into account our findings.

We believe it is necessary that forensic psychiatrists who deal with violent persons either in pre-trial or post-trial status, be aware of the syndrome of episodic dyscontrol both because of the possibilities for treatment through medication and because of the possible influence on their judgments of criminal responsibility. We believe that in selected cases, history and evaluation will be sufficiently impressive to change attitudes regarding this often "impossible" judgment.

Summary

We examined and evaluated a young man who had committed a brutal and senseless crime, and found the major criteria for an episodic

dyscontrol syndrome to be present. Using the work of Monroe, we concluded further that a functional — and probably a structural — brain defect was present such that this case fit the criteria of an “epileptoid” dyscontrol. It was the judgment (and testimony) of the authors that the individual, at the time of the crime, could not conform his conduct to the requirements of the law, by virtue of this mental defect. The jury, in its verdict, expressed qualified support for our view.

At one time, children who could not read were classified as either lazy or retarded. We have since come to recognize and delineate within that group a subgroup of dyslexics (*i.e.*, those with minimal brain dysfunction) who, while unable to read in step with their peers, are neither lazy nor retarded. Brain disease or “defect,” now well-documented, is responsible for their difficulties, and with that realization, we have been able to develop more effective means of treatment.

In the same way we feel that the designation, “Explosive Personality,” includes within it a subgroup of those who are impaired by brain dysfunction at the level of the limbic system. Just as dyslexic children do not respond to punishment because they cannot, so we feel that many “explosive” individuals do not exert control over their violent actions because they cannot. In both situations, recognition of the organic dysfunction is crucial and can lead to effective treatment and proper disposition.

The investigation of learning disabilities has saved many of its victims from careers as “retarded” citizens. We hope that similar advances in the area of organic dyscontrol will save many more from lengthy and needless incarcerations in penal institutions.

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