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Pathological Intoxication and Alcohol Idiosyncratic Intoxication—Part II: Legal Aspects

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ABSTRACT: The law does not generally allow alcohol intoxication as a defense in a criminal matter. Among the exceptions may be pathological intoxication, or PI, or its current psychiatric correlate, alcohol idiosyncratic intoxication (AII). Because of the lack of specificity in the medical concept and the varying approaches by different authors, careful analysis and adherence to current standards are necessary. Relevant laws, particularly that of the model penal code, are reviewed, as are three cases which demonstrate the issues involved. Actual testimony is presented to illustrate possible misuse or inappropriate use of the concept.

KEYWORDS: psychiatry, jurisprudence, intoxication, alcohol, pathological intoxication, responsibility, alcoholism

The law, not only in the United States but in most countries, has taken a conservative stance when the claim is made that unacceptable behaviors were a result of alcohol intake or alcoholism or both.

A colorful pronouncement on the hesitancy of courts to excuse behavior for alcohol abuse put it quite pungently [*1*]:

> The law is not the creation of such barbarous and insensible animal nature as to extend a more lenient rule in the case of a drunkard, whose mental faculties are disturbed by his own will and conduct, than to the case of a poor demented creature afflicted by the hand of God.

I previously [*2,3*] have reviewed the interrelationships of alcohol use and criminal responsibility. Generally, the use of alcohol is not a defense, despite the frequent arguments over whether alcoholism is a disease or insanity. Coke stated it this way: "A drunkard who is a voluntarious demon hath no privilege thereby; whatever ill or hurt he doeth, his drunkenness doth aggravate."

Where alcohol has caused a persistent psychosis, the person may be found not guilty by reason of insanity under the ordinary insanity rules. Some states use the expression "settled" or "fixed" insanity in such a case. Similarly, in some places, a defense of unconsciousness or unawareness may be introduced—either as a full or partial defense. Intoxication may thus reduce charges or act in mitigation. Where there is a claim of behavior adduced by alcohol resulting in homicide, the elucidation of the alcoholic condition may result in a reduced

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charge such as second degree murder or manslaughter. Involuntary intoxication may be a defense in criminal matters, and an alcohol reaction may be utilized as a defense in those jurisdictions which require a specific intent for a crime in contrast to general intent, a nuance that still befuddles the best of legal minds.

The relation of alcohol and crime requires no elaboration here other than to reiterate that a high percentage of crimes occur under the influence of alcohol, and therefore the interrelationship of crime and alcohol intake is a most important medicolegal issue.

The American Law Institute rule, or Model Penal Code, has formulated another exception to the general rule of responsibility for behaviors under alcohol. For example, that rule as adopted in New Jersey states (1) that intoxication of the perpetrator or actor is not a defense unless it negatives an element of the offense; (2) where recklessness is an element and the person is unaware of a risk had he or she been sober, such unawareness is immaterial; and (3) intoxication is not a mental disease within the concept of the rules for nonresponsibility. More directly related to the subject matter of this paper is the stipulation that intoxication may be a defense if (1) it is not self-induced (a rare event indeed), or (2) it is pathological. In either of these two cases, the defendant can make such a claim (an affirmative defense) if because of such intoxication, the perpetrator at the time lacked substantial and adequate capacity either to appreciate its wrongfulness or to conform his conduct to the requirements of the law.

"Pathological intoxication" as defined in the law means intoxication grossly excessive in degree, given the amount of intoxicant, to which the actor does not know he is susceptible.

This definition correlates to a fair degree with the definitions in *Diagnostic and Statistical Manual of Mental Disorders* (DSM) II and DSM III. In DSM II, pathological intoxication (PI) is an acute brain syndrome manifested by psychosis after minimal alcohol intake, the important words being *psychosis* and *minimal* alcohol intake. DSM III no longer refers to psychosis but directs the definition of the successor term, alcohol idiosyncratic reaction (AII), to marked behavioral change—usually to aggressiveness, due to the recent ingestion of an amount of alcohol insufficient to produce intoxication in most people. Crucial, however, is the current requirement that the amount of alcohol be insufficient to produce intoxication in most people. The DSM III gives as an example such atypical behavior (atypical for the individual when not drinking) occurring in a shy, retiring, mild-mannered person after one weak drink. Certainly the explicit inference is that aggressive explosive behaviors in association with ordinary intoxication or drunkenness would not justify a diagnosis of PI or AII, nor would most other behavioral reactions in association with significant intake of alcohol.

The ambiguities of the use of the term, "pathological intoxication" has been discussed in the companion paper (Part I). Nonetheless, it remains the expression ensconced in law and therefore must be specifically used as a reference point in communications with the legal system. Not surprisingly, the exception given by the law to allow nonculpability in cases of PI creates a demand for review of the condition, while at the same time other similar severe alcohol reactions will not allow such leeway. The door is thus open to use and abuse by attorneys and professional witnesses when PI or AII is at issue.

Case 1

Before the adoption of the Model Penal Code rule in New Jersey in 1979, a 29-year-old policeman went to a wedding, had an unknown amount of alcohol—apparently six to seven glasses of whiskey, and was noted to be intoxicated. Afterwards he went to a bar; from that point he had no recollection.

Later that night—about 4 a.m.—he went "berserk" at home, shooting up his own home with his parents fleeing into the night. His father was awakened by a crash of breaking glass and found his son rambling, smashing furniture, babbling, and so forth. The son went to the

cellar and started shooting up the basement, and during this period he called a policeman friend and spoke of people being against him, taking his enemies with him, being deserted, hostages, morphine, and so forth in a disorganized and incoherent fashion.

The police were called and when he appeared armed on the lawn, he was shot in the legs and was brought to the hospital with a traumatic fracture of the left ankle. He awakened 4 h later in a clearly lucid condition, asking what happened and why he was in a hospital; he thought that he had been in an automobile accident. Drug screening was negative, as was the electroencephalogram (EEG) and neurological examination. Diagnosis at the hospital was toxic exogenous encephalopathy. He had no hangover; a psychiatrist who saw him a month later made a diagnosis of PI.

The subject had no prior psychiatric history, no difficulty in functioning, and a modest alcohol history. Periodically he would have up to six drinks in an evening; there was no history of any type of misbehavior. His associates reported that when he drank he was never nasty or giddy. He was a poor driver, not well coordinated, and had trouble remembering routes.

He had a history of two possible concussions in automobile accidents. He also had been a boxer several years earlier and had fought extensively.

On examination, he was pleasant, affable, cooperative, without any apparent psychopathology. He was a high school graduate; on the Wechsler Adult Intelligence Scale (WAIS),he had a verbal score of 133, performance score of 94 (full scale: 117). In view of the great disparity, he was referred for neuropsychological testing, which reflected right tempero-parieto-occipital malfunction and some left auditory nerve deafness. EEG was normal.

The picture was one of bizarre and destructive behavior, hallucinations, paranoid expressions, amnesia with rapid recovery and no sequelae.

The only issue as to a diagnosis of PI was the apparent intake of at least a moderate amount of alcohol—beyond any minimal intake level. He was charged with assault with a deadly weapon, but was found not guilty by reason of insanity and released. (He was also removed from the police force and advised to avoid alcohol—in view of his history and evidence of right-sided brain damage.)

Case 2

A 38-year-old chronic alcoholic (for 15 years) drank up to 2 quarts of vodka per day. He intermittently attended Alcoholics Anonymous, but was hospitalized several times for detoxification, alcohol withdrawal syndrome with seizures, and delirium tremens. At one point, he was on phenytoin. His alcohol tolerance gradually diminished with marked effects from two to three double shots. He had had periodic alcoholic blackouts with drinking. He allegedly had stopped drinking for nine months prior to the incident in question and was on phenytoin and chlordiazepoxide. On the day of his mother-in-law's funeral, he felt anxious, had one bottle of beer. Leaving the cemetery he had two 2-oz. (60-mL) glasses of blackberry brandy, returned home, had coffee, then went for a ride, having a blackberry brandy and one or two beers. Stopping by a doughnut shop, the car in front of him was slow in starting, so he yelled at the driver. Some adolescents standing nearby called him common, insulting names; he left the car and yelled at them, and returned to the car. As he did so, the adolescents threw stones at him. He claims that the next thing that he remembers was a broken windshield. What he did do was to drive the car onto the sidewalk, killing one adolescent and injuring two others. He claimed not to remember turning around or driving over the curb. A witness stated that he drove away with his lights off.

Here one is confronted with self-reports as to amount of alcohol intake—usually not a very reliable basis for an opinion. The history was one of longstanding alcoholism with varying complications, decreasing tolerance, claimed amnesia of only a moment's duration, and an explosive or inappropriate overreaction while under alcohol.

Clearly he was "drunk" and recognized this, having sought to get coffee to sober up, and overreacted greatly when provoked. The concept of pathological intoxication was dropped as no witness could be obtained to state that this represented such a case. He was not a defendant who would arouse much sympathy (in contrast to Case 3) and pleaded guilty to a lesser charge.

Case 3

A 43-year-old policeman from a major city outside New Jersey apparently made a wrong turn and crossed the river into New Jersey. Confused, he cut into a parking lot on a major street of the adjacent New Jersey city, where he had never been before, and turning around pulled partly into the street, blocking a bus that had pulled up. The time was about 10 p.m. The policeman, in civilian clothes, jumped from his car and pounded on the bus doors. The bus driver, concerned about such behavior, refused to open the bus door. The policeman then went to the front of the bus, pulled out a gun, and shot into the bus twice. At that very moment, a police car pulled up and two policeman jumped out, their guns blazing. The policeman involved fell with seven bullets and was immediately hospitalized with serious injuries. He made a good recovery, but was now faced with serious charges.

In New Jersey, illegal discharge of a firearm is a serious charge; the law requires a minimum three-year sentence. Probation is not allowed. Such a penalty would be quite severe, particularly for a policeman with 21 years of service, including two disciplinary actions: one for drinking and the other for sleeping in a car.

A blood alcohol taken shortly after the shootings was 0.233%.

The defense attorney obtained an opinion from a nonpsychiatrist concerning the policeman's state of mind at the time, based on an intake of 15 bottles of beer between 11 a.m. and 3:30 p.m. on the day at issue. The policeman's last recollection was about 3:30 p.m.; he recalled nothing until about three weeks later. The report of the "expert" stated:

> All individuals with 0.233% alcohol in their blood are extremely intoxicated. The acute depressant reactions on the central nervous system of this level of blood alcohol content, besides severe impairment of motor coordination, distortion of the sensorium, and clouding of the intellect to the point of confusion and disorientation, imposes profound psychological changes and corresponding deviant behavior. In its irrationality this behavior takes on the quality of impulsive and unpremeditated action and lacking any sense of right and wrong.

Ignoring, at this point, the attribution of a mental state to a blood alcohol level and the sweeping generalization, one might point out that the fact of intoxication, even if granted, is simply not a defense under the law.

The psychiatrist reviewing the above report for the prosecution disagreed that *all* individuals with a blood level of 0.233% would be extremely intoxicated. Based on multiple studies, about 95% of people with those blood levels would show some signs of drunkenness (some drinkers have reached the level of 0.4% without apparent clinical drunkenness, despite the usual quite severe defects at this level).

> For a wide variety of reasons, one cannot determine a mental state from a blood alcohol level alone, particularly of a degree which would compromise mental functioning to the degree usually required by the law for exculpation. No information has been presented that would indicate the intoxication to the degree it was present, was not self-induced or was the result of pathological intoxication.

Reference was made to a study in California that the average blood level in drunken driving arrests was 0.24%.

At the trial, the defense focused on a claim of PI, this being the only feasible strategy under the circumstances to attempt to avoid responsibility under the law. The same defense

witness who had prepared the above report now testified. He related that people usually show symptoms of drunkenness at 0.10, begin to stagger at 0.15, are grossly intoxicated at 0.2, and border on stupor at 0.3.

The hypothetical question indicated that the policeman had on other occasions imbibed about 15 bottles of beer in a similar time period and, though intoxicated, had never exhibited any bizarre or violent reaction.

The witness then stated that such an individual would develop tolerance to alcohol, then develop amnesias, indicating persisting brain damage as well as a loss of tolerance:

> It goes to the point of having hallucinations and delirium. You see pink rats crawling out of plaster on the wall. This is classic. This is already the sign of damage, brain damage, and that is what is called pathological intoxication.

The witness then defined it as a profound, severe intoxication more than the person would normally get from this amount of drinking, that hallucinations were on the way, and that there were retrograde amnesia and irrationality (no actual hallucinations were reported at any time). He then stated that the defendant could drink less than he would normally and have manifestations of PI and that he probably had for the first time, perhaps, a pathological intoxication.

On cross-examination, the witness again spoke of a progression on alcoholism so that such drinkers evolve into being victims of pathological intoxication, based on a sudden loss of tolerance. He further stated that the significant factors in his now making a diagnosis of PI were the loss of memory and a lack of a prior history and that history was the only way to determine brain damage.

The prosecutor, in cross-examination, attempted to attack the purported amnesia, pointing out other possibilities such as the severe traumas that the defendant had suffered as well as the possibility of repression and even deliberate misrepresentation.

One could also point out that amnesia can occur with many forms of drinking and that gray-outs and blackouts are not uncommon in chronic alcoholism. Most important is the claim of three to three and one-half weeks of amnesia from a one-day drinking period—certainly not in keeping with any of the literature on PI.

The witness also tended to use the expression "pathological drinking" in a way to equate it with pathological intoxication.

The psychiatrist witness for the prosecution focused both on the definitions in the psychiatric diagnostic system and the requirements in the statute, as well as on the clinical characteristics of PI and AII as used in psychiatry.

The jury found the defendant not guilty, accepting the claim of pathological intoxication. It is possible that the associated facts of the case were the determinants for the jury decision and that the jury empathized with a policeman of 21 years of service with a generally good record involved in a bizarre behavioral episode in which no one was injured. Nonetheless, the case represents a misuse of a medical concept for a legal purpose. The facts would indicate that the defendant, having had 15 bottles of beer until midday and in all probability more beyond that, was intoxicated, got lost on his way home, panicked, and overreacted when he was frustrated in what was probably an attempt to get directions.

Justice may have triumphed, but the rational use of scientific evidence in the courts was the loser.

Conclusion

PI, or AII, remains a concept that has unique clinical and legal aspects. Psychiatry is a field in which parameters of diagnosis are fluid and nonexclusive; even with recognition of that fact, this disorder is more amorphous and arguable than most other clinical classifications. Despite the concern about whether or not AII merits recognition as a distinct clinical

entity, it is acknowledged currently as such, and as such, psychiatrists would adhere to the standards applied to such a diagnosis. Therefore, distinction should be made between AII, which is *the* pathological intoxication in a diagnostic sense, and *a* pathological intoxication, which has been applied broadly to a variety of behavior patterns found with significant alcohol intake. This distinction, based on amount of intake of alcohol, may be arbitrary, but it is an essential consideration in the effort to have uniformity and consistency in diagnosis.

Three cases have been presented: one where a PI-like reaction with psychosis occurred with probably moderate intake, one with impulsive-aggressive behavior in association with chronic severe alcoholism, and one in which aggressive behavior occurred with heavy alcohol use. All required careful psychiatric review for legal purposes. In the last case, an example of actual testimony was presented to illustrate the ease with which legal and psychiatric concepts can be muddied and inappropriately used, as well as the problem of the battle of the experts where it should not exist.

Psychiatrists should be aware of the complexities of the failure to adhere to established guidelines and would serve the profession best by a conservative stance in applying psychiatric standards to legal rules. Whether or not PI or AII merits the special status now being given by the law represents another sociolegal policy matter which also deserves continuing scrutiny and recognition that psychiatrists do not determine the rules under which they operate as advisers to society. In particular, psychiatrists may find this review helpful in their roles as policy consultants or in providing input to their legislatures should their own states be considering the adoption of the Model Penal Code rules.

References

[1] *State v. Noel*, 102 NJ 659, 133 A 274, 1926.
[2] Perr, I. N., "Alcohol and Criminal Responsibility," *Journal of Forensic Sciences*, Vol. 21, No. 4, Oct. 1976, pp. 932-943.
[3] Perr, I. N., "Blood Alcohol Levels and 'Diminished Capacity'," *The Journal of Legal Medicine*, Vol. 3, April 1975, pp. 28-30.

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