AMNESIA IN RELATION TO CRIME.

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WHEN a defence of insanity is put forward in answer to a criminal charge amnesia for the crime is not infrequently affirmed, in fact East (2) states that it is more often alleged than any other mental anomaly. The defence of amnesia is at times raised when there are no grounds for supposing that the prisoner is suffering from loss of memory, but there are undoubted cases where the crime, generally homicidal in character, has been committed during a disorder of consciousness or the memory of it subsequently has been lost. It is therefore of the greatest importance from a medico-legal point of view to distinguish between real and simulated amnesia. While amnesia may be simulated in cases where there is no mental disorder present, there are also instances where loss of memory is feigned by individuals in whom there are other reasons for regarding them as mentally abnormal. In this connection it must be realized that memory also is sometimes malingered; a prisoner who by reason of insanity accompanied by amnesia has escaped the responsibility for his crime may presently arrive at the conclusion that a persistence of his loss of memory will tend to keep him confined in an asylum, and therefore he asserts a remembrance of his crime, the story of which he is likely to have become familiar with at his trial or elsewhere. Not all such false memories, however, are definitely malingered. A patient may have heard the story of his crime so often that in the end he becomes convinced that he actually remembers it.

In order to investigate this subject we have examined and carefully inquired into the histories of 100 male inmates of the State Criminal Asylum at Broadmoor at whose trials amnesia for their crimes was alleged. The cases have not been in any way selected, except that as far as possible the more recent admissions to the asylum were taken; even so, many of the cases are several years old. This would seem to show that the defence is not so successful as its frequency of presentation would pre-suppose. It was noticed that practically all the patients were members of the labouring or lower middle classes.

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Age-Incidence.

An analysis of the age of incidence at the time of trial shows a gradual increase up to the fourth decade, followed by a corresponding decline in the number of cases as age advances. Amnesia is rarely put forward as a defence under 20 or over 60 years of age.

Table I.

Under 20 years	3
21–30 ,,	26
31–40 ,,	37
41–50 ,,	19
51–60 ,,	11
Over 60 ,,	4

The age of incidence among those who were regarded as malingerers or as doubtfully genuine was definitely lower than among the accepted cases. Out of 14 simulated and 8 doubtful cases there were only 3 over 40 years of age. No correlation could be established between the age-factor, and the likelihood of a persistence or recovery of the loss of memory.

Family History.

Inquiry into the family history revealed the fact that a psychopathic inheritance figures largely in these cases, and its presence may be regarded as of sufficient magnitude to constitute a predisposing factor. The findings in the cases were as follows:

Table II.

Insanity	32
Chronic alcoholism	28
Tuberculosis	14
Epilepsy	7
Suicide	7
Crime	7
Congenital blindness	1
Somnambulism	1

These figures include all cases, whether genuine or assumed, and it was found that a psychopathic heredity was present among the latter as noticeably as in the former.

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Personal History.

The presence of a psychopathic predisposition in these cases is well recognized, and investigation into the past history of a patient alleged to be suffering from amnesia becomes of great practical importance. Sullivan (4) pointed out that " in any case where amnesia, complete or partial, is alleged with regard to a crime involving a prolonged series of complicated and apparently purposive acts, it is reasonable to expect—though there may be exceptions to the rule—that there should be proof of the existence of one or more of these predisposing factors." Our findings, as shown in Table III, support this opinion.

Table III.

Chronic alcoholism	38
Mental stress	30
Head injury	20
Previous insanity	14
Previous amnesia	12
Malaria	12
War history (blown up, severe wounds, etc.)	10
Financial straits	10
Epilepsy	9
Shock	5
Somnambulism	1

In compiling this table only definite histories were included. Here, as with the family histories, positive findings were found with almost as great a frequency among the doubtful cases as in the genuine ones. It may therefore be concluded that while neuropathic traits are commonly found when loss of memory is alleged, their presence is no ground for the assumption that the amnesia is genuine.

Alcoholism.

In both the family and personal histories chronic alcoholism occupies a prominent position, especially so when it is recollected that only marked cases were included, and that in not a few others the addiction seemed from the available history to be above the present day average. A definite history of persistent teetotalism was obtained in only 3 cases.

Head Injury.

This is always a difficult factor to estimate ; in all probability a majority of people can produce evidence of a head injury of some kind at one time or another ; and when an individual thinks it is to his advantage he will no doubt

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magnify the occurrence. As far as possible, discrimination was exercised in evaluating the severity in the cases under consideration, and only definite histories, *e.g.*, absence from work due to the injury, unconsciousness at the time, or a resultant scar which could be examined, were taken into account. The result, 20%, is probably higher than would be obtained for the general population. Eager (1), investigating 100 cases of head injury, found that 12% exhibited states of amnesia. He further states that a common complaint was of pressure in the head, becoming aggravated before the amnesic attack.

Epilepsy.

Automatism with subsequent amnesia due to this cause has earned a favourite position among the possible defences to a charge of homicidal or other grave crime, but it is becoming increasingly recognized that loss of memory from this condition following serious crime is not of such frequent occurrence as was at one time supposed. On close investigation it is often found that the allegation of epilepsy is without a sound basis, and in fact not infrequently it is admitted by the patient after his trial that the idea of pleading epilepsy was evolved either by himself or his advisers. We know of one case where a man charged with murder was located in the prison hospital in a bed next to an epileptic, and the latter coached him in the signs and symptoms of epilepsy. At his trial the prisoner put forward a defence of epileptic automatism and thus escaped the full penalty of the law. East (3) points out that " a history of fits is usually forthcoming, and although there may be no more than the screaming fits of childhood or fits of temper in later years, they are sometimes offered to the jury as evidence of epilepsy ". On the other hand, a true epileptic who commits a crime for which he is legally responsible may trade on his history and simulate amnesia to avoid the consequences of his act. The following case illustrates this :

CASE 1.—Male, æt. 32, a carter. Patient is a genuine epileptic, and has had frequent severe fits since admission to the asylum. On the day of the murder he left work and spent about an hour and a half gambling with two friends, during which time he lost all his money. When play ceased they stood together talking at the corner of a street, and patient asked one of his friends to stand him a drink. This was refused. He then asked for a penny for his 'bus fare, and this was given to him. Patient then walked away, but returned in a few minutes and cut his friend's throat. He immediately ran away and disappeared in the crowded throughfare. About half an hour later he arrived at his brother-in-law's house looking dazed and worried, and said that he had had a bit of a row. When arrested later he said, " I don't remember anything. I remember putting my horse away and I don't remember anything more."

The behaviour of the murderer after the crime, his efforts to escape, the fact that he told his brother there had been a row and the motive for the crime (loss of his wages) made one sceptical as to the genuineness of his amnesia, and this was verified later, after the trial, when the patient admitted that the loss of memory was assumed.

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It is possible for an epileptic to commit crime during his first attack—a point that should not be forgotten.

There are cases, however, in which, although not epileptic, the amnesia is genuine enough, but the defence is not satisfied to leave it without the trappings of epilepsy.

In 9 only of our cases was a positive history of epilepsy, supported by subsequent observation, obtained. One was a case of Jacksonian epilepsy in which there was an authentic history of fits following a compound fracture of the skull.

Malaria.

Sullivan (4) mentions that the importance of malaria in connection with these cases has been emphasized by Dr. Anderson, of Glasgow. In our series a history of having contracted this disease was elicited in 12 cases—a percentage somewhat higher than would probably be found in an average group of 100 unselected males of similar ages.

Previous Insanity and Amnesia.

Fourteen per cent. had previously been insane, and 12 cases gave authentic histories of earlier attacks of amnesia. In addition there were several patients in whom a history indicating some previous slighter form of mental abnormality or tendency to nervous breakdown under strain was obtained, but they are not included in the figures given here.

Somnambulism.

There was one genuine case of this condition, which is worth quoting in full:

CASE 2.—Male, æt. 31, fireman. Crime: Murder of wife. Patient is a somnambulist and there is a strong family history of somnabulism; his eldest child and, with one exception, all his brothers and sisters, are sleep-walkers. On the morning before the crime patient met with a slight accident, a fall, and struck his head and elbow on the ground. He was treated at an ambulance station, but there is no evidence that he was rendered unconscious by the fall, or that the injury was in any way serious. During the day he complained of head pains and took some stimulant, and in the evening visited his doctor, who stated that the injuries were quite slight, and at the time of the visit the patient was quite sober. After the visit to the doctor he appears to have had a few more drinks, but evidence was forthcoming to show that when he returned home he was not under the influence of alcohol. He went to bed with his wife at about 11 p.m., and remembers nothing more till he woke to find himself battering his wife's head with a shovel. The shock of this was so great that he fainted. Later, when he realized that his wife was dead, he attempted suicide. He has no recollection of getting out of bed to fetch the shovel, and there was an entire lack of motive for the crime, as he lived amicably with his wife.

In several of our cases the crime was committed during the night or early morning, and the patient therefore had difficulty in stating when the amnesic

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period began, the state of clouded consciousness being more or less continuous with the dissociation of sleep. While these cases were genuine, there were no histories of earlier somnambulism, and after a full consideration of their circumstances it was felt that they could not properly be classed as true somnambulism.

One special feature to be noticed is that, while a very few cases were of impaired intellectual development, marked mental deficiency was absent Moreover no patient admitted the existence of certified mental defect among his relatives. This would suggest that repression or dissociation resulting in amnesia are not psychological defence phenomena which are exhibited by lesser developed minds.

Type of Crime.

In making this analysis only the more serious crime was included in those cases where more than one offence was committed.

Table IV.

(1) Murder	71
(2) Attempted murder or wounding	19
(3) Indecency	6
(4) Arson	2
(5) Acquisitive crime	2
Total	100

It is thus seen that the majority of crimes which are followed by amnesia are those accompanied by strong emotional reactions, as in murder and attempted murder. The graver the crime and the more repugnant to the normal mental content of the patient, the more likely it is to have been committed during a period of clouded consciousness, or the knowledge of it to have been repressed subsequently. Nearly 50% of the cases of murder were against a relative or sweetheart, and if we also include those of attempted murder or wounding of relatives or sweethearts, 61% of the cases are accounted for.

Table V.

(1) Murder of relative or sweetheart	48	61%
(2) Attempted murder or wounding of relative or sweetheart	13	
(3) Murder of other persons	23	29%
(4) Attempted murder or wounding of other persons	6	

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Suicide.

In 27 cases the patient attempted suicide at the time of the crime, and it is noteworthy that in all but one the crime was against relatives or sweethearts. Thus in 26% of cases in this series the offence was one of murder or attempted murder of a relative or sweetheart accompanied by attempted suicide, in all of which the amnesia was regarded as genuine.

The Amnesias.

After studying the past history, and observing and examining the patients individually, we formed the opinion that 78 could be regarded as genuine, 14 were almost certainly malingerers, several on their own admission soon after reception into the asylum, and 8 were classified as doubtful.

Table VI.

(1) Genuine	78
(2) Assumed	14
(3) Doubtful	8

Of the 78 who were regarded as genuine, 30 have recovered the lost memory, while in 48 the amnesia persists.

Memory recovered	30	
Amnesia persisting	48	including 3 paramnesia and 1 epileptic equivalent.
Total	78	

The recovery of the lost memory in the 30 cases that have cleared up was a gradual process taking place during the early months after the crime; the majority gave some time less than 6 months as the period in which remembrance occurred. One patient alleged that his memory returned to him three years after the crime, but the truth of this statement is to be doubted; another gave three days after the crime as the time, but this was an isolated and unusual history. Most of these patients state that their memory returned to them without any marked effort on their part to recover it; a frequent description is " it just came to me ". Actual attempts to remember, to penetrate the fog, seemed to lead to frustration rather than otherwise. They all emphasized the gradualness of the process. A sudden return of memory in an alleged amnesia is therefore to be regarded with scepticism; in all probability the amnesia itself was malingered, or, alternatively, the memory is assumed when the patient realizes that a persistent amnesia may contribute

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to his continued detention in an asylum. It is, of course, quite open to either a true or simulated case to invent a gradual return of memory.

Certain characteristics of the amnesic period were present in genuine cases with fair constancy, while in the simulated and assumed cases they were either absent or subject to considerable divergences. The beginning and end of the amnesic period are likely to be a little blurred, and the genuine case cannot accurately define the instant when his memory left him. He may remember with some clearness a definite act, such as having his dinner, and then state that, although he knows he got up from table and went out, he can only recollect this in a hazy way. The time of return to normal consciousness is often even more indefinite. As regards the actual amnesic state, the loss of memory prior to the committal of the crime is of much shorter duration than that occurring subsequently. In most cases it is only a matter of minutes before the crime, whereas it may be some hours or even days after it before normal consciousness resumes control.

Where the amnesia is only partial and the patient has a confused memory of the murder, the ideas accompanied by marked emotion are more likely to be remembered than those with less emotional tone; for instance a patient who says he remembers coming away from the crime, but not the crime itself, is in all probability a malingerer. This does not apply in cases of melancholic raptus, where, as Sullivan (4) points out, it is the explosive act itself which is most likely to be missing.

Statements made soon after the crime and seeming to show that the patient is fully aware of what he has done do not necessarily indicate malingering when loss of memory is alleged later. Several instances occurred in the cases under review illustrating the truth of this. For example, a man who killed two of his children was reported to have said to the policeman arresting him, "I did it for the best" and later, when charged, "Do what you like; they are gone. I wish I had done for the lot and myself too". The amnesic state in this case extends from half an hour before the crime to twenty hours afterwards, is undoubtedly genuine, and has now persisted unchanged for many years.

Paramnesia.

The development of a false memory is somewhat of a rarity; only three of our cases exhibited this phenomenon.

CASE 3.—Male, æt. 55, a retired business man. There is a strong psychopathic inheritance and his father committed suicide. He shot his sister with a shot-gun, and then turned it on himself by attaching a bootlace to the trigger and firing it with his foot. He was found seriously wounded with the gun still in position. On reception at the asylum he stoutly denied that he committed the crime, and stated that he and his sister had gone for a walk and that he had taken the gun with him to shoot a rabbit, but that he saw no rabbits and did not fire the gun.

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He further states that while walking in the field he saw two men, who first shot him and then his sister. He remembers putting his handkerchief to his head and seeing his sister lying on the ground; after that he remembered nothing until he found himself in hospital. He still maintains his innocence, and although he has been questioned several times since his reception some years ago he has not varied in his story. It is quite clear that he believes it himself, and that it is a genuine case of paramnesia.

Types of Mental Disorder.

While many cases may be regarded as no more than episodes in the course of an attack of some recognized psychotic disorder, there are others in which the crime and subsequent loss of memory are in the nature of transitory phenomena in individuals of psychopathic constitution. Impulsive crime followed by amnesia occurs with some frequency in states of depression, but is almost unknown in maniacal phases; it is rare in schizophrenia and in paranoid reactions.

Melancholia.

Many of the depressive states are associated with delusional ideas which are ultimately responsible for the ensuing criminal outbursts. Conviction that a wife is unfaithful may lead to her murder, or a father who is depressed about his business and fears his children will not be provided for may kill them rather than that they should suffer, apart altogether from the truth of his forebodings.

The following case illustrates the type of crime associated with melancholic states, and also exhibits the characteristics of genuine amnesia described above:

Case 4.—Male, æt. 52, bootmaker. Murdered his daughter, æt. 5, by cutting her throat with a razor. His family history is defective; one cousin was insane and a brother suffered from fits. His past history gave evidence of previous mental breakdown of depressive type on two occasions. He says his doctor thought he would have to certify him. For some time prior to this crime repeated unemployment and financial difficulties made it a problem for him to provide for his family, and he became depressed and broken down in health. On the day of the crime his wife was out and he was sitting brooding in the kitchen, while his daughter was playing in the garden. A neighbour's child refused to allow his girl to hold a doll and slapped her face, whereupon his daughter ran in to him crying. He took up a razor that was kept in the kitchen for paring corns and cut her throat. The child called out, "Don't, Daddy", and screamed. This attracted the attention of his stepson, who summoned help. When this arrived he was still bending over his daughter cutting at her throat. When he was pulled away he did not resist, and appeared to be "quite dazed and not to know what he was doing or where he was". On admission to the asylum he was reported to be "in a condition of melancholia with stupor".

The amnesia was total, and the amnesic period extended from the time his daughter ran in from the garden until an hour or more afterwards. Exactly how long elapsed between the time his daughter came into the kitchen and the attack is not known, but in all probability it was only a few minutes. As regards the end of the amnesic state, he vaguely remembered his neighbours pulling him by the

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shoulders, and this was followed by only a confused recollection of the happenings of the next few days. His memory for this blank period and the recollection of his crime came to him gradually during the fifth and sixth months after the crime.

Paranoidal States.

While there was no case of true paranoia, several of the patients exhibited delusional ideas, usually combined with a depressive element. The delusional cases included those with the more marked histories of alcoholism.

CASE 5.—Male, æt. 44. Murder of daughter by cutting her throat and attempted suicide by same method. Mother was alcoholic and a cousin was sent to a reformatory. He had been strongly alcoholic and several times charged with drunkenness. For some months prior to the crime he had given up drink. He was out of work and depressed on that account. He had hallucinations of sight, complaining that lights were played upon his walls by neighbours for ulterior motives. He thought that he was a marked man. He objected to having his hair cut by a barber as he had discovered marks on his head; he also thought people were trying to hypnotize him. He studied phrenology. Many of these ideas persist, over twenty years later. He is reticent, and says that while he knows he was right about the lights and other things, it would be better for him not to explain. He believes there to be some connection between the lights and the camera obscura. On the night of the crime he remembers playing cards with his family until about midnight, and then his mind is a blank until he came to himself in hospital nine days later. The amnesia persists unchanged. The story is that at about 1.30 a.m. a son of his awoke to find his father in his room with a razor in his hand; he said "Don't", and his father kissed him and went away. Shortly afterwards his father called to him; he went upstairs and found his sister lying in a pool of blood; both she and the father had their throats cut, and the latter said, "Give me a drink and let me die". There was no apparent motive for the crime.

The patient is constantly agitating for his release from the asylum, and while this would explain his reticence about his delusions, it lends added reason for belief in the genuineness of his amnesia, which he describes as "the one thing he has to thank God for".

Schizophrenia.

Amnesia is rare in dementia præcox, and only 3 of our cases could be classed under this head. Amnesia without other mental symptoms is not likely to be due to dementia præcox. Two were cases of murder and the third of attempted murder, and in all the criminal act was carried out with an impulsive violence characteristic of this condition. Two of them had been certified insane on previous occasions.

In all three memory has returned; in fact two of them allege they do not remember that it was lost. It may be that these are not really instances of amnesia. Perception is good in this disease, and the mute, apparently stuporose case is frequently aware of all that is going on in his vicinity; it may be that a similar state of affairs exists in their amnesias.

CASE 6.—Male, æt. 32. Attempted murder of wife and two children by attacking them with a knife. There is a strong family history of insanity; his father

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committed suicide and a sister and uncle are insane. His mother was alcoholic. He served in France during the war, was shell-shocked and treated in military mental hospitals. He was certified in 1915. He has delusional ideas regarding his treatment in military hospitals, alleging that a foul disease was injected into him. He is very religious, and believes he has had to suffer for "the one above".

On the night of the crime he and his family went to bed in the usual way. About half an hour later he started to behave in a strange manner and made "unusual noises". In alarm his wife left the room; he followed her. Eventually she succeeded in quietening him, and they returned to bed, when he suddenly attacked her and the children with a knife which he had secreted. Then he rushed out of the house and ran for some long distance practically naked.

On admission to the asylum his mind was a blank for a period of about fourteen days covering the crime. He was solitary and negativistic; for nearly two years he refused either to see his wife and children or to accept letters from them. Latterly he has improved and is now more approachable; he says he remembers all he did, and that he has never suffered from any loss of memory. He states that he did what he did on account of the disease he was inoculated with at Netley.

Epilepsy.

The following case may be quoted as an example of genuine amnesia due to epilepsy:

CASE 7.—Male, æt. 31, a gardener. Patient is a genuine epileptic and has severe fits at long intervals. He states that his fits started after leaving the army; at first they were mostly nocturnal, but later he had them in the daytime as well. On the day of the crime he and his wife visited a neighbour, and whilst on the visit he complained of feeling ill, with pains in the head. He returned home, accompanied by his neighbour. As he continued to feel unwell he went into his back yard for some fresh air, and the neighbour went with him. He remembers turning to come in, and the next thing he remembers is seeing the neighbour lying on the ground with a wound in the head and himself with a chopper in his hand. He then realized that he must have wounded his neighbour, and gave himself up to the police. He was in the habit of chopping wood in the yard. There was no apparent motive for the crime. The loss of memory for this period persists.

Psychoneuroses.

The following is an example of amnesia in a case of psychoneurosis:

CASE 8.—Male, æt. 24. Two cousins had tuberculosis. Always timid and neuropathic, reacting abnormally to ordinary strains of life. Murdered a woman with whom he had been on intimate terms for some months.

On the day of the crime they were out for a walk and quarrelled; she flew at him and he caught hold of her, then he remembers nothing more until he saw her lying dead at his feet with her head battered in. He became frightened, and ran home saying he had killed a woman. This amnesia has persisted unchanged for several years. There was no clear motive for the crime apart from the quarrel, and it was clearly unpremeditated, as the prisoner had no weapon, and used his boot to inflict the severe injuries; and, finally, there was no attempt at escape.

Some of the characteristics of simulated amnesia are shown by the following case:

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CASE 9.—Male, æt. 25. Negative family history. Patient was a heavy drinker, but apart from this there was no medical history of importance. At the time of the crime he was living with a friend and his wife, and he shot the latter while the husband was away from home. He stated that drink was free in this household, and that he had been indulging heavily. He remembered the husband leaving the house in the morning, and believed he went to his room. Then there was a blank, and when he came to himself he seemed to feel something gripping at his hips and falling from somewhere on his head. Then another blank, and he remembered pouring out a drink, discovering a terrific din in his ears and a smell of cordite in his nostrils. Then he walked out of the house and found his revolver on the ground outside, looked in the window and saw his victim on the ground. He returned to the house, and wrote a note to the husband admitting his guilt. This loss of memory was not regarded as genuine, and since the trial he has admitted it to be false.

The amnesia was patchy, and the emotional experience—the actual shooting—was alleged to be forgotten, while such an incident as pouring out a drink was remembered. In spite of his assumed amnesia he immediately and unhesitatingly accepted his responsibility for the crime.

THEORETICAL CONSIDERATIONS.

Psychologically amnesia may be regarded as being dependent on one of the following conditions:

(1) Failure of association.
(2) Dissociation.
(3) Repression.

The first group consists of cases in which there is a defect in the fixation of impressions and a failure of association of ideas, and includes the imbecile and dement who are unable to register and retain their impressions, and consequently cannot reproduce them. Amnesia of this type is termed "anterograde." This class of case has not been included in the present paper.

Amnesia due to dissociation or repression is always dependent upon a failure of reproduction and is retrograde. In normal memory, in addition to an impression being fixed, retained and reproduced, it must be recognized as forming a part of our previous experience. Some cases show illusions of memory, and tell a complicated and entirely false story with obvious conviction.

In endeavouring to interpret the underlying mechanism in the varieties of amnesia encountered it is necessary to consider—

(1) Cases of total and permanent amnesia.
(2) Cases of total and temporary amnesia.
(3) Cases where the crime was remembered for a short time after it was committed and then completely forgotten.
(4) Cases where there is a confused memory of the crime, but no details can be remembered.
(5) Cases in which a false memory is developed.

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Dissociation.

Cases produced by this phenomenon provide the most dramatic instances of amnesia. When dissociation occurs there is a sudden rupture in the stream of consciousness and a gap in the continuity of ideas. The content of consciousness of one moment is independent of and unaware of that of the preceding moment. It is in such a period that the criminal act is committed. Later another rupture of the stream occurs, and the earlier field of consciousness associated with the normal personality of the patient reasserts itself, and the experiences and acts committed between the two breaks are then completely obliterated from the memory. This is similar to the condition found in somnambulism, where the somnambulistic state is totally ignorant of the ordinary or normal state. In these cases it is while the dissociated system of ideas is in the field of consciousness that the crime is committed, and on return to the normal state of consciousness there is total amnesia of the crime and of the events which immediately preceded and followed it.

Dissociation will explain some of the cases of Class 1 with total and permanent amnesia. The tendency in these cases is for the beginning and end of the amnesic period to be more sharply defined than in those due to repression. This dissociation of ideas may also afford an explanation of certain cases which, while professing no amnesia of the crime, yet state that they felt that they had to commit it, and that some force other than their normal self was directing and compelling them. Such patients will probably say that they at first resisted, but ultimately gave in to this force. There is a dissociated system of ideas, but here the patient is aware of its existence and fails to realize that it is part of his own consciousness.

Repression.

A second and larger group of cases are to be explained by the mechanism of repression. Some of the cases in Class 1 and those in the remaining classes are accounted for by this process.

As a result of the crime a conflict is established between the crime complex and the customary trend of consciousness representing the normal personality; this is solved by a repression of the painful memory of the crime and its attendant circumstances.

In cases where the amnesia is complete and sudden in onset (Class 2 and some of Class 1), it is reasonable to assume that the patient was aware of his actions at the time of committing the crime, but that the conflict so set up was so acute that repression took place almost simultaneously and total amnesia was immediately established, in many to remain for ever, and in others to clear up as the conflict becomes less acute with the lapse of time.

In the third class it may be considered that the conflict is less acute, and

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therefore repression will not take place till some time afterwards, during which period the patient would remember and be able to give some account of his crime. It is this class of case, where the criminal may make statements to friends or to officials at the time of arrest, or even voluntarily give himself up, that calls for special care, for these patients are likely to be considered *primâ facie* as malingerers. Genuine cases of this character undoubtedly do occur, and they can be explained if this application of the conception of repression be accepted.

Amnesia produced by repression is recoverable, and in a good number of cases the memory does actually return, thus differing from those due to dissociation, where the condition is permanent. As has been described above, the return of memory is gradual; at first the recollection is hazy, dim and lacking in details and slowly becomes complete. This reappearance may be brought about by association tests and subsequent questioning, by dreams, through a chance word or action of a nurse or other patient, or most likely without any obvious stimulus.

This recovery of memory may be explained by supposing that after the trial and sentence, and with the passage of time, the need for repression becomes less urgent, and there is, therefore, a relaxation of vigilance on the part of the repressing forces.

Cases of the fourth class comprise those in which repression is not absolute and the patient has a confused idea of the crime, but is unable to recall the details. The ideas most coloured by emotion are the ones remembered; for instance the patient may remember the actual crime, but not his subsequent movements. In these cases of partial amnesia the memory is not patchy, as is often alleged by the malingerer.

Finally, in the fifth class a false memory is developed. This is a step further than an amnesia due to repression, and a possible explanation is that in these cases the conflict is so acute that a simple repression is insufficient, and a false memory is projected into consciousness in order to obtain mental equilibrium. It is usual to find that cases of paramnesia connected with crime are combined with projection.

Conclusions and Diagnosis.

While the differentiation between true and simulated amnesia is often a simple matter, at times much difficulty may be experienced, and much time and attention to detail is required before one may arrive at a decision.

(1) Amnesia cannot be diagnosed on the patient's word alone. His story must be checked by known facts, independent evidence being absolutely essential before an opinion can be formed. The first account given by the patient is of paramount importance, and should be recorded with all the detail

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he can provide. Subsequent variations in his story are to be regarded with scepticism. While real recovery of memory does not occur until some weeks or months after the crime, allowance must be made for some slight alteration in the memory defect from day to day in a few cases where the loss of memory is only partial. A patient who remembers points in his favour and conveniently forgets everything else is probably malingering.

(2) A history of chronic alcoholism or of other indications of a psychopathic personality, including a previous loss of memory, is frequently elicited.

(3) The existence of a neuropathic heredity is to be expected in a fair number of cases.

(4) The character of the alleged amnesic period is of foremost value. In genuine cases the beginning and more especially the end are frequently blurred, and usually the loss of memory prior to the committal of the crime is of much shorter duration than that of the subsequent period before normal consciousness resumes control. Where the amnesia is partial and the patient has a confused recollection of his acts, the ideas accompanied by marked emotion are remembered, while those with less emotional tone are not.

(5) Statements made soon after the crime showing a knowledge of the act are not incompatible with genuine amnesia due to a later repression.

(6) The crime is frequently without motive, and is carried out in a way which shows that the individual was not acting with premeditation, and he makes no attempt to escape from the consequence of his actions.

(7) A sudden return of memory almost certainly indicates malingering.

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