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Part I.—Original Articles.

PSYCHOGENIC AMNESIA: THE REFUSAL TO REMEMBER.*

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THE differential diagnosis of a presenting symptom is usually to be found as a section of an article on a disorder in which the particular symptom is common. Thus one learns a great deal about the widely different pathological processes responsible for epigastric pain in a description of peptic ulcer, and much about headache in descriptions of cerebral tumour or migraine. Amnesia is peculiar in this respect in that succinct expressions of its differential diagnosis are rarely found in the description of individual disorders.

This peculiarity probably arises from the striking nature of the symptom, which has tended to be isolated as a subject in itself. One result of this has been the elevation of amnesia as "loss of memory" to an eminence undeserved by its clinical importance, where it poses as an entity out of keeping with its diversity, certainly to the lay world and, we suspect, to a large section of the medical profession.

Gillespie (13) rightly says, "A discussion on amnesia must involve both physiologic and psychologic concepts," as must a discussion on weakness of the legs, but it must be made clear that uncertain gait is merely a common incidental to the different pictures of emotional stumbling and general paralysis. Many authorities lend support to a superficial interpretation of their opinions as favouring the homogeneity of amnesia, examples associated with trauma or Korsakow's syndrome being cited to illustrate certain aspects of problems under discussion without the distinction from psychogenic amnesia being clearly maintained, even although each remark is clear and pertinent in its own context.

Amnesia is very common during wartime (29), but is by no means a rarity in peace, and we have the impression that its incidence was increasing before the war.

EXCLUSION OF ORGANIC AMNESIA.

The psychiatrist is concerned with amnesia arising out of emotion and mental conflict, and however difficult the disentanglement of psychogenic from organic amnesia may be on occasion, the difference between them should not be minimized.

As a generalization, organic amnesia is concerned more with failure of registration and more so of retention than with the process of recall, which is the seat of failure in psychogenic amnesia.

Abeles and Schilder (1) recorded cases of amnesia with loss of personal identity

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in diseases as far apart as arterio-sclerosis and schizophrenia, and as carbon monoxide poisoning and hysteria, but do not make as clear as is desirable the vast difference between the amnesia of cerebral softening and malingering, or between the organic and the psychogenic in general.

The investigation of amnesia involves a full clinical history and physical examination, with laboratory and X-ray aid where necessary. The dissection of amnesias into separate functions, such as personal or everyday memory gaps or isolated mathematical failures, and their relationship to various organic diseases, localized or not, is a task for the neurologist, as is the consideration of the phenomenon of good retention in toxic states, despite the presence of disorientation, except in so far as the symptoms may be psychogenically coloured.

The only safe differentiating process is to consider the symptoms in relation to the total picture presented, regarding the amnesia as a comparatively minor manifestation overshadowed in importance by the whole reaction. There is no single criterion for clinical application.

If complete intellectual capacity is present from the beginning the amnesia is probably psychogenic, but confusion and disorientation may be prominent in the complete absence of organic changes, varying from mild uncertainty and agitation to a profound abeyance of intellectual qualities indistinguishable from a temporary confusional psychosis (23). On the other hand, traumatic amnesia in boxers and footballers is compatible with behaviour apparently identical with that to be expected where complete intellectual capacity exists. This last observation raises queries. Several footballers we have examined who claimed not to remember what happened after a head blow, although they continued to play intelligently, have been theatrical personalities, akin to the " simple, superficially well adapted, extraverted type of personality " described by Sargant and Slater (29) in their paper on amnesia, and boxers as a group are a fruitful field for psychoneurotic reactions. The unquestioned occurrence of the " punch-drunk " variety of dementia is perhaps a reason for ascribing some of these fistic amnesias to organic causes when hysterical reactions would be a more accurate label. Verjaal (32) takes the view that so-called traumatic amnesias are all psychogenically determined and are not organic defect phenomena, but his blunt opinions are not generally accepted.

The points made by Lennox (21) about epileptic amnesia are applicable fairly generally. Very often a patient with an organic amnesia attempts to proceed with his work; even though his behaviour is obviously abnormal and although sympathy and care are provided, he remains puzzled and unhappy. The patient with a psychogenic amnesia shows the opposite of each point, but by no means invariably.

Psychogenic amnesia is more usually selective and convenient, but trials and emotional conflicts are so widespread that sometimes an excellent precursory psychogenic situation can be made out in undoubted organic cases. The end-point of psychological amnesia is more often clear-cut, but an organic amnesia may appear to be equally clear-cut. Thus a recent patient remembered cycling into a village near York, and, next, distinctly recalled getting off his cycle to speak to friends on the far side of York, where his home lay, but this was not the whole story. His friends remarked upon abrasions and bruising of his face, and he then noticed that the front mudguard of his cycle had disappeared. He continued towards home, and remembered his arrival and actions thereafter quite clearly. It transpired that he had spoken to his friends on the near side of York, so that he had ridden through the town without being able to recall this part of his journey, although he gave an accurate description of certain actions and a conversation preceding it. In other words, he was registering and retaining impressions correctly while he was disoriented in time and space—a well-known organic phenomenon. The amnesic periods of general paralysis are often clear-cut, although they are not often prolonged. Russell (27) never observed a retrograde amnesia longer than seven days in head injury cases, so that anything longer would suggest psychogenesis.

If organic changes, progressive or temporary, are discovered in the nervous system, it is necessary to consider whether the amnesia can be accounted for as a purely organic phenomenon, as it may be in cerebral growths, inflammations and degenerations, in epilepsy and toxic states, or whether psychogenic factors have also to be weighed in deciding the mechanism of origin. The organic changes may

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not be causal but merely act as precipitating agents. An organic amnesia may be followed or widely overlapped by a psychogenic failure of recall, as is commonly seen after head injuries, and sometimes in alcoholism and epilepsy. Schilder (30) emphasizes the particular value attached to the head in an individual's psychological experience and the frequency of psychogenic symptoms after a threat to the brain.

The hysteric uses his own conception of an organic disease as the structural skeleton for his symptoms, and this symptomatic basis is most satisfactory for his purpose when the simulated disability has existed or in some measure still exists. Freud (11) pointed this out in 1905, describing psychological symptoms referable to a diseased organ or one previously diseased and terming the process somatic compliance.

Hysterical amnesia is particularly liable to follow organic amnesia occasioned by head injury, arteriosclerosis or toxic confusions, provided that the patient has a sufficiently hysterical personality. For this reason it is not valid to exaggerate the extent of organic amnesia in head injuries because amnesia follows cerebral trauma and not fractured limbs, any more than it would be justifiable to conclude that because a fractured skull was followed by hysterical amnesia, there were no organic changes present.

Not only may organic changes and their effects dovetail with or facilitate psychogenic amnesia, but the two conditions may exist side by side without connection. Lastly, any organic bodily changes may produce reactive emotion, and this emotion facilitate psychogenic disturbances.

Differentiations of Psychogenic Amnesias.

There are two main divisions of psychogenic amnesia which are well recognized—the hysterical, described by Gillespie (13) as a " device intended to facilitate escape from the consequences of evasion of duty which is often nothing more than malingering," and the affective, an escape from the memory of an intolerable experience. The latter may not be mentioned unless asked after. A tendency exists to discuss both together as if they were the same thing—an assumption made more readily because hysterical amnesia is preceded by emotion and often by prolonged or intense emotion. If a man avoids a district because it contains the house in which his only son died, and another avoids a district because the police are there watching for him, these two men cannot be considered as exemplifying the same reaction, although they share a common aversion. The two chief groups of psychogenic loss of memory are similarly different, although the same type of mechanism is probably operating in both.

It is to be expected that sometimes it is impossible to place a particular amnesia comfortably into one division or the other—a type of situation common to the diagnosis of a great many conditions and particularly to psychological disorders, gradations between standard psychoneurotic reactions being as common as the complexity of personality responses would lead one to suppose. Hysterical symptoms may thus easily appear in anxiety states arising out of inadequacy due to obsessive compulsive habits of thought, and so on, the various labels being only useful descriptive terms for grouped human reactions, and not diseases. In this case, despite the difference between clear-cut examples of each, there can be no final separation because in the last analysis both reactions arise out of what appear to the patients to be intolerable situations. It is the setting of the symptom that is different, sometimes vastly different.

Sargant and Slater (29) in a recent paper describe amnesias and fugues occurring especially in hysterics and anxiety states, frequently in depressives and hypochondriacs and sometimes in schizoid personalities. They record amnesia in an obsessional psychoneurosis, and in two cases of plain malingering, and discuss amnesia in head injury and epilepsy, illustrating the symptomatological nature of the condition. Many of their cases followed severe battle stress. Roughly speaking constitutional weakness was inversely proportional to the stress needed to precipitate symptoms. In their opinion the discipline of service life makes amnesia more easily detected; they found " large gaps retrospectively in the patients' memory of the past," and state that such gaps " are often overlooked in civil life." But this kind of amnesia, for an acute emotional experience which

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should normally be remembered, to which the patient would not willingly draw the physician's attention and which can be easily overlooked, should be separated from an amnesia which may be malingered and is in any case advanced by the patient as his presenting symptom. Both varieties are distinct from the vague, hypochondriacal memory disturbances which sometimes follow head injuries, even very minor head injuries (30).

Defensive Amnesia.

Where amnesia is not complained of and is purely defensive against the pain generated by highly emotional memories, we propose that the term "defensive amnesia" be used to describe it. We do not think that the term "hysterical amnesia" can be bettered at present for the usual "loss of memory" which, in peacetime certainly, is by far the commoner. The dramatic fugue, which so often characterizes the hysterical amnesia, could never occur in a defensive amnesia.

The Data from Our Cases.

This contribution treats of 30 cases of hysterical amnesia, the diagnosis being made by positive evidence of a psychogenic process consistent with such a diagnosis and by the exclusion of other causes. Our cases were all serving men of the R.A.F., so we are unable to comment on sex incidence, but according to Kanzer more men than women develop this symptom (19). Their ages varied between 16 years and 44. Kanzer's patients were chiefly between 20 and 40 years of age, and 25 of our 30 were in this age-group—three being under 20 and two over 40. The average was a shade over 26. Kanzer found married patients in the majority, but only 11 of our series had been married. One would want very careful age-grouping and large numbers of cases to make any assessment of marital influences.

The Constitutional Factor.

Sargant and Slater drew attention to the evidence of constitutional predisposition to psychoneurotic disorders provided by the life-histories of many of their cases and we can confirm this observation. Many of our patients could be fairly described as hysterical personalities apart from their amnesia, being egocentric, over-dependent, and immature to a degree. Some were of the superficially well adapted, extraverted type described by Sargant and Slater, others being dull, submissive and generally nervous (25), but inclined to entertain ambitious day-dreams of a kind akin to schizoid meanderings.

In the early days of the war a point system for the assessment of predisposition was devised at Matlock by Air-Commodore Gillespie, Wing-Commander Rumball and one of us (C. C. G.), in which points are scored for certain positive traits of personality, character and temperament, which experience has shown indicate a predisposition to neurotic breakdown. It was found satisfactory for purposes of comparison to regard any score of six and over as indicating heavy predisposition, and 21 of our 30 cases scored six or more, the average predisposition rating for the whole group being 6·5, the score varying from 0 to 10.

Intelligence.

No estimate of the intelligence quotient was attempted in the majority of our cases. Only six had reached the rank of corporal or higher, but this is offset by the further facts—that the hospital is reserved for ranks other than officers, and that the average duration of service of 26 of our cases was rather less than one year. The other four averaged nearly 14 years' service. Seventeen patients were engaged in "general duties," that is, had no skilled trade whatsoever, and only two were members of air crews. One man was dull and backward, almost to the level of being a high-grade feeble-minded person; another was an honours B.Sc. We have the impression that the level of intelligence was not so low as might be expected in hysteria in general, even among those of our cases where the principal diagnosis was hysteria.

Diagnosis.

The amnesia was an hysterical manifestation in each case, but in only 20 was hysteria the primary diagnosis, two of these showing acute anxiety symptoms and

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another being admitted in an hysterical stupor. Six were psychopathic personalities, five inadequate and one aggressive, three of them showing evidence of acute anxiety. The remaining four were schizoid personalities.

Precipitating Causes.

Prolonged emotional dissatisfaction, with frustration and self-pity, arising from service routine, discipline and monotony and associated with a craving for home, sympathy and security, was a factor in the majority. In at least twelve it was the only precipitating factor discovered. Several had worked up grudges against the service, in three cases aggravated by ideas of reference, and in these prolonged disgruntlement had crystallized into an obsessing idea—" I can't stand it; I must get away," a fugue following.

Three men were experiencing acute emotional conflicts about a fiancée, two about their father. Only two or three had run away from danger. Failure to obtain a commission and responsibility beyond acceptance were occasional. One patient was remorseful about a dereliction of duty. Gillespie (14) says, " In peacetime most cases I have seen of recent years were flying from justice in some sense or another, and all of them recovered their memory in a short time, with varying degrees of gradualness and grudgingness." Our cases were flying from authority and not justice. Four suggested a recent trivial head injury as the cause of the symptom, and several others mentioned some minor head injury received years before.

Eight had been drinking more than usual, only two of them excessively. As a rule we considered the alcoholic indulgence a neurotic symptom, like the amnesia, although the question arises whether there has been a brief organic amnesia providing a pattern for an hysterical prolongation.

Fugue.

Twenty patients had fugues. In five cases the fugue lasted less than eight hours, in eight more than twelve hours and less than one day, in three it persisted over several days, and in four it lasted from two weeks to two months.

Amnesias without fugue were more likely to be associated with brief, highly emotional experiences which are excluded from memory. They were not defensive amnesias, because the loss of memory was the presenting symptom and behaviour was theatrical. They were demands for sympathy or recognition or both.

Physical Examination.

In no case was an organic disease process discovered in the nervous system or elsewhere.

About a half-dozen patients showed most of the following signs: General appearance of illness or of distressing, chronic anxiety; loss of weight; dark shadows under the eyes; dilated pupils, sometimes sluggish in reaction; exaggerated tendon reflexes; increased perspiration, most noticeable on the palms; tremors of fingers and eyelids; jerky muscle movements.

At the risk of appearing irrelevant we should like to define our atttiude to these changes, which can be taken roughly as signs which can be grouped as the physical evidence of anxiety. Any one sign and sometimes several can be present under conditions of first-rate health. Most severe anxiety states show several of these signs and they are sometimes prominent in other psychoneuroses, but severe anxieties can occur in their absence. A peculiar irregular twitching of the eyeballs, seen best when examining the disc with an ophthalmoscope, is the most exclusively " neurotic " sign we know, but it is oftener not present and is by no means pathognomonic when found. These physical signs are of more significance if they clear under treatment, but they are not then of much use in diagnosis, which in any case must be made irrespective of their presence.

Several described anxiety dreams, and more complained of headaches. A few wanted relief from insomnia.

Of the 30 patients, 24 returned to duty and 6 were invalided directly from the hospital. More may have been invalided since.

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The Running Away of Children.

Amnesias and fugues are rare in children (19), but children frequently run away, in mixed emotional states deriving from insecurity, frustration, disappointment and resentment. They run from their parents or guardians, sometimes to punish them, sometimes as a dramatic protest, usually with the idea of winning success and recognition elsewhere.

The wanderings of restless or inquiring younger children and the simple wilfulness of some youngsters are excluded. One of our patients ran away at 13 years. He went soon after tea, when his parents were away for the day, leaving a note for them on the kitchen table. He had vague but grandiose ideas of making his fortune and confronting his parents with his success, achieved despite them. About nine o'clock in the evening it was cold and dark, and he grew frightened and decided to return. Having made this decision he became acutely affected by humiliation and shame at the collapse of his determination, and raced back in a frantic effort to get his note before his parents saw it. He had a fugue and amnesia at 22.

Another patient ran away for a day when he was 10 and for three days when he was 13, being brought back by the police after a general alarm; on neither occasion was there any question of amnesia, yet at 17 he had a fugue with amnesia while in the Navy and again at 18 in the R.A.F., having been invalided from the Navy for schizoid personality associated with amnesia. Some change had taken place between the ages of 13 and 17 which transformed a running-away into a fugue with amnesia.

It happens often in adults that a fugue commences as a running-away comparable in every way to a childish escapade. Kanzer described a man who having given a worthless cheque, went off, leaving a note for his wife stating that he would never return until he had made good and was able to redeem his cheque, but was found wandering in an amnesic state a few days later. Men have run away, begun drinking heavily and then developed amnesia, and many of our patients began their fugue in full consciousness. A colleague, Flight-Lieutenant J. Walsh, explained the mechanism of amnesia to a disgruntled member of an air-crew who had disappeared for a time from his station. During this patient's stay in hospital he ran away to his home twice, without developing a further amnesia. It is not hard to find cases indistinguishable from an hysterical fugue with amnesia except that there is no amnesia.

Case.—A paranoid personality, not included in our series, was disturbed by ideas of reference, acute sensitivity to fancied neglects and slights, and was sometimes the victim of good-natured banter from his more robust colleagues. He developed grudges and feelings of inadequacy and was sent to Matlock, where he showed apparent progress and later was posted to a new unit in Cornwall. A week after commencing there his symptoms were worse, he felt that his thoughts were read, experienced feelings of unreality and began to drink more alcohol than usual, finding himself distinctly more susceptible to its action. One Friday night his mates were particularly persistent with their leg-pulling, and following this he reported, "I could stand it no longer, I had to get away. Early the next morning I rode off on a bicycle to the village and took a taxi from there to the nearest main line station. I shared it with an airman going on leave and we travelled to Bristol together. He didn't suspect anything; I didn't want him to know. When I got to Bristol I was in a sort of black-out; I didn't know what I was doing. I hung around the station all Saturday night—I was dazed. I could only think I must get away, that's all, and on Sunday I suddenly thought of Matlock and went there, getting in at 22.00 hours. I can remember practically nothing." This is a good example of emotional preoccupation to which we shall refer later.

Kanzer drew attention to similarities between many cases of amnesia with fugue and frightened children or fainting youths. Six of our patients gave a history of having fainted when younger. Certainly the comparison of many, if not most, hysterically amnesic patients with children is inevitable, and as a group they are immature and childishly fanciful. H. G. Wells thought that children were such delightful actors because their natural, easy, dramatic sense was unspoiled by adult inhibitions and self-criticism, and in the hysteric this uncritical play-acting persists to a degree that is sometimes almost incredible. Gillespie (14) penetrates

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to the core of this observation by his suggestion that the hysterics should henceforward be termed the histrionics.

Abeles and Schilder state that almost always the patients have been living with close relatives and ran away from parents, the family or their representatives, doing themselves no harm, or very little. Our cases were all away from home, but if superior officers represent parental surrogates, the conception holds, and the infantile nature of the reaction is further illustrated.

Emotional State before the Amnesia.

The amnesia was preceded by an acute emotional upset in at least 43 of the 71 cases reported by Kanzer. The origin of the emotion varied: in younger people blighted love was common, in older persons business worries in men and domestic problems in both sexes were frequent, while criminal responsibility of some kind was often found at any age-period. In all cases the total situation produced a degree of anxiety or fear, while symptoms, such as depression, insomnia, loss of appetite, lack of concentration, anxiety dreams and emotionalism were common. The origins of the conflict often appear slight to anyone except the patient, but the facile emotional reactions that follow frequently obtain the sympathy and concern of the patient's immediate circle. Several of our patients mentioned that they were acutely conscious of a failure of memory in small things before the amnesia, their description suggesting the absent-mindedness associated with preoccupation and mental distress. Eventually they became limited in their ideas to a recurring theme: " I can stand it no longer; I'd sooner be dead; nobody cares about me." The self-pity associated with the idea that " nobody cares " was very common.

Some of our cases seem to have worked themselves into a genuine state of fatigue arising out of prolonged emotion. Such fatigue is not always easy to detect, because the ability to carry on with routine duties persists in spite of quite severe symptoms.

Case.—An intelligent corporal, a schoolmaster in civil life who had supplemented his interests with energetic activities in scouting, play production and athletics, became gradually and increasingly dissatisfied with service routine. His grudges came to a head when he was frightened by parachute jumping and angered by a failure to obtain a commission. He came to hospital with severe hysterical fits, and as part of his investigation was sent for an electro-encephalographic examination in the company of another corporal. On the way he staged a very severe fit on Birmingham station, sufficiently dramatic to produce a policeman's report stating: " I found the man very ill, and on account of his serious and dangerous condition had him removed at once to hospital." Following his EEG he was brought back and his adventure ignored. After a few days he had an amnesia and fugue; he was found eight miles away in his carpet slippers, and was taken to a police station in a confused state. A reliable eye-witness stated that he looked ill and harassed to an extreme degree. He was treated by being bluntly informed that it was now clear that his health was excellent, and that he was being sent back to his unit as a malingerer to be court-martialled for deliberately attempting to evade his duty. This high-handed approach is not recommended, but it produced a complete cessation of fits, the story of the amnesia and the request for a few weeks longer in hospital to get thoroughly fit. Even exposed in this way he remembered to snatch at possible favours. About the amnesia he said: " I was upstairs in the occupation room; I felt absolutely fed up. No one seemed to care what happened to me; I felt I just had to go somewhere, anywhere. I went out about eleven o'clock and walked along the main road. In the first village I came to I realized people were looking strangely at me, and when I came to another little hamlet two men took me to the police station. When the nursing orderly arrived it gave me such a shock, as I realized the position I was in. For a moment I could recall nothing since I was upstairs in the occupation room." It is to be noticed that he started his amnesia when the nursing orderly arrived to fetch him.

Kanzer states that attacks most often come on when the patient is alone, travelling in a train or walking in the street. In the case just described, the fugue began in a crowded occupation centre, and the inability to recall was noticed when a nurse arrived to fetch him. The next case is interesting in this connection.

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CASE.—An inadequate psychopath with a predisposition score of nine. He had run away for a day at the age of 13. A few months after joining the R.A.F. he was found wandering by his mates and taken back to camp. Several months later he was released for civilian factory work for nine months, during which he worked at the same bench as his wife. On his recall to his unit he became depressed and could not eat or sleep. After three weeks of rising emotional tension he lay on his bed in his billet after duty one January evening while his three room companions comforted him in vain. About 10 p.m. he left them; they said nothing, and he thinks they presumed he was going to the lavatory. He slipped out of the house—it was cold and raining—but after a few minutes he made his way to a large tree in the corner of a field where, by lying on his back, he could wriggle under the barbed wire surrounding the grounds. He climbed an embankment on to a side road which led to a main road, and kept along this. He soon came to a village, where a boy passed him on a bicycle and fell off turning a corner. The patient hid in a doorway, feeling alarmed, as he did not want to be discovered and yet thought he should go forward and help. He then thought he heard a man helping the boy, and when it was quiet he went on again. In about three hours he saw a chink of light from a hut near the road. He had only slippers on and no greatcoat, and was soaked and very cold. He was strongly tempted to approach the light, but went on for about a hundred yards and then went back. In the hut he found a soldier on duty, and in reply to questions told him he could remember nothing, "I felt too unhappy to think." The soldier telephoned through to a larger hut, where the patient was bedded for the night.

Here, again, the commencement of the amnesia can be fixed at a definite moment, the same moment as in the previous case, when the patient was first asked for information about himself. Until then he was aware of his identity and of the necessity to hide to escape detection. The possibility of suggestion coming from the first questioner of a patient found wandering or who has given himself up must be considered. In some cases it almost certainly occurs. Eysenck (9) provided evidence which cast doubt on the increased suggestibility of hysterics as compared with average groups of the community. In these two cases we feel the amnesia commenced because of the active desire of the patients, the picture being complicated in the second case by a degree of fatigue.

Other hysterical symptoms in addition to the amnesia are rare. Kanzer quotes two cases of hysterical blindness in his 71 amnesias. This is an extreme form of the visual component often used by the patient to reinforce his conception of a blotting out of memory. Such phrases as "everything went black," "a veil came over me," "a fog came before my eyes," "I suddenly saw black" and so on are often heard.

THE FUGUE AND SUBSEQUENT BEHAVIOUR.

Fugues may be of short or of long duration. An artificial but convenient dividing line is at eight hours, for at least after this time the patient is almost always forced to seek sustenance.

In short fugues the patient is more likely to wander aimlessly, to be highly emotional, to be found agitated and confused and generally to give an impression of being ill. Often hunger, cold or other distress leads the patient to seek help from convenient strangers, or his dress or behaviour is calculated to arouse interest. In long fugues the patient travels far, appears perfectly self-possessed and lives in every way like a healthy human being except that he is not where he should be. He may exhibit some distress when found or on his return, but it is clear that his condition has not given rise to notice by the many people who must have seen him.

When taken under care they may claim an amnesia only for the period of their flight, or the loss of memory may be retrograde to any extent up to the whole life. They may give their names or state that they are unaware of their identities. In our experience the short fugues are less often complicated by loss of personal identity. If identity is not vouchsafed they sometimes reveal useful hints leading to their identification, or they may give no help whatsoever. The experiences remembered may refer to the precipitating emotional setting or may be the central piece of what is forgotten (19); e.g. a husband or the recent birth of a baby may be denied recall.

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The following is an example of amnesia claimed for the whole of life.

CASE.—An immature, undersized youth cycled to his 16-year-old girl's house and made love to her, reclining on a couch. The intensity of her caresses startled him considerably and he rolled to the floor and bumped his head. He was sexually inexperienced, and the passion of the youthful Delilah had roused counter feelings and a sense of temptation of which he had hitherto been ignorant and he was disturbed and frightened. He started to cycle home, and from that moment claimed to have forgotten his whole life. This complaint was still present when he came to hospital two months later. He carried a diary, regularly kept, which contained his new experiences and abounded with such quotations as " Saw my first aeroplane to-day," " Played a funny game called football." His vocabulary, ability to behave in his surroundings and absorb knowledge were phenomenal if his story could be accepted. Any slip he made about his past he attempted to explain by saying that he had looked it up in his diary, as he thought his doctor would like to know about it. Here we have a naïve, childish phantasy, played out with great relish. As Hurst (11) says, " He has no difficulty in adapting himself to his new surroundings " . . . he can read and write, and has all the elementary knowledge he acquired as a child, but anything recently learned, such as soldier's drill, is forgotten."

Kanzer reports a kind of reactive depression occasionally met after fugues. Stengel (31) describes a depressive state initiating fugues. Most of our cases had depression before the fugue, but its nature appeared to us to be superficially reactive to situations that were considered intolerable.

Gillespie says, " Amnesia suggests shame." We found this in a few of our cases, concerning sex or duty, if by shame is meant an emotion arising out of the forgotten experiences. Sargant and Slater found about one in ten of their cases with a sense of guilt. A much commoner and more potent cause of shame is the humiliation that accompanies the decision to end a fugue, especially if the fugue has been preceded by a highly emotional state.

Stengel has written of fugues having in mind recurrent compulsive wandering rather than amnesia. Several of his cases had travelled abroad and been absent over months. They were often psychoneurotics and sometimes schizophrenics, but included a large number of epileptics. He regards psychic auras and dreamy states as psychologically determined, and his fugues in these cases are identical with post-epileptic automatism, even if they last over several days. We feel that his subject only slightly overlaps ours. The whole character and background of the cases is different. From an R.A.F. point of view, for instance, it is as difficult to deter an aircrew epileptic from flying as it is difficult to persuade an hysteric to fly.

DURATION OF THE SYMPTOM.

The duration of the symptom, as opposed to the length of amnesia claimed, may be brief if handled correctly, or may be prolonged over many years (2). This is subject to the gain achieved by persistence, the interest and sympathy aroused and the manner of handling by doctor and relatives.

Kanzer says that the amnesia never clears up when the patient is alone, and that as a rule the patient is found in a populous place. He was referring to hysterical loss of memory seen in peacetime—the usual variety. We have shown that sometimes a retrograde amnesia only commences when the patient is first spoken to. A defensive amnesia is usually a limited period in the past when first discovered.

Treated only by general care and observation memory may not return, or may come back in whole or in part, often in a dramatic way, perhaps a voice in a dream revealing the truth (19), or a tree or a face brings back a flood of memories. The same manner of recall has occurred under persuasion, an amnesic period often being kept back. Hopwood and Snell (16) reported that patients often remembered as the need for repression became less urgent.

In cases where memory has not returned in hospital but where the patient has been identified by relatives, Kanzer reports that such patients will go away freely with the claiming relatives, even although denying knowledge of them, saying, " I suppose it must be my husband," or some other phrase suitable to the occasion.

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Treatment.

We have had almost uniform success in getting patients to face their memories by simple persuasion. In only four of our cases was an intravenous barbiturate employed, twice with a nursing sister present and twice without. Hospitalization is an advantage to simple persuasion. During the first interview the amnesia is played down by concentrating on the general life-story, and reassurance given as the interview ends that recall will be obtained at the next session. At this session one starts with the last thing remembered, and confidently persuades the patient to tell what happened in absolute chronological order. His attention is repeatedly forced back if he attempts to jump events or evade the issue with such remarks as "It must have been" or "I've been told." The patient's self esteem should be borne in mind. Usually recall is rapid, the majority in less than half-an-hour, but the physician must be prepared for a much longer interview.

The difficulties encountered are proportional to the duration of the amnesia as a symptom, and especially to failed attempts by others to obtain recall.

Case.—A youth, aged 16, collapsed after losing a long race on which he had set his heart. The race was run at about three on a Saturday afternoon. He was taken to the station hospital, and on admission was described as follows: "Could be roused by stimuli and firm requests; quasi-unconsciousness; behaviour strongly suggestive of emotional upset. N.S. normal." Four hours later he was weeping copiously. Reluctantly admitted he was all right, but complained of a complete amnesia covering a period from about 12.30 until the early evening. On the next day he was "unable to stand, complaining that the blood rushed from his head, patchy anaesthesia to pin-point and cotton-wool, no recall of amnesia."

During the next week he was seen two or three times by a specialist in neurology, but there was no recall of the amnesia and he was sent to Matlock. At the second interview the recall of the memory was undertaken. Between half-past three and four o'clock a very detailed account of his conduct between 12.30 on the Saturday, the far point of his retrograde amnesia, and 1.15 was obtained. There was much snapping of fingers and repeated "Ahs," as each trickle of memory came. Progress was so slow that he was given seven and a half grains of intravenous pentothal slowly over the next hour, but his highly circumstantial story could only be obtained up to 2.15 during that time. The injection was finished, but a complete block seemed to have been reached and no further recall was obtained during the next hour. At this stage the physician ordered coffee for himself, made up the fire and settled down comfortably. As he sipped the coffee he remarked, "There's plenty of time; just relax; it will come back if you think of anything that comes into your mind. Don't bother to make any effort." In a few minutes the patient snapped his fingers once more and the final details came rushing out, including the rising emotion as lap succeeded lap during the race, and he saw a good chance of victory dwindle to nothing while he suffered the agony of physical exhaustion, repeating to himself over and over again, "I can't go on; I'm finished; I can't go on." The whole story was complete before seven o'clock. In this case the patient was plainly and deliberately out-acted.

In the two cases of amnesia for the whole preceding life which we met simple persuasion was easily effective.

It is easy to wrap a cloak of mystery round this simple procedure. Sargant and Slater say they treat the patient as a whole, but think it essential to remove the amnesic gaps. We fully agree. They find their patients "often rather unsusceptible to direct hypnosis," and use intravenous barbiturate as the method of choice. They then sift the information, which is a mixture of truth and phantasy, and attempt an "emotional synthesis." Patients often confabulate, as Sargant and Slater suggest. We have the impression that phantasy is more often met with under hypnosis or narcosis than with simple persuasion. This tendency to romantic embellishment is not peculiar to psychogenic conditions, Russell (27) reporting it in organic amnesias following head injuries, and in such cases false accusations are sometimes made.

Our experience leaves us in no doubt that narcosis or hypnosis is rarely required. We consider such methods are better avoided, as they add importance to a symptom to which far too much attention is already paid, and also provide a peg on which

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the patient can hang the recovery of his memory. We hold this view despite the widespread reliance placed on narcosis or hypnosis (4, 10, 13, 15, 17, 29, etc.).

If narcosis is used, sodium amytal or pentothal are commonly chosen, given very slowly intravenously. The narcotic is thought to reduce mental resistance, acting as a cortical depressant, and to have some unspecified action on the brain stem and autonomic centres. In our opinion the reduction of cortical control to the limited degree that still allows of an accurate recounting of past events must be slight, and we believe the value of narcosis lies in the suggestive value produced by the injection, the paraphernalia required, and the feeling experienced as the drug begins to take effect.

CASE.—An observer who ran away before an operational flight was given intravenous pentothal in the presence of a nursing sister of the R.A.F. He soon began to answer questions, described excessive drinking and then said "I had a woman" rather boldly, followed at once by a hurried "er—I met a girl," having one eye on the nursing sister and showing that his cortical faculties were very little impaired. The same patient confessed later that he could have recalled the whole story at any time. A week before the fugue he had bumped his head and been told by his M.O. that he had just missed concussion. This gave him the idea, and being frightened of flying he had solved his conflict in the manner that seemed best to him.

We have noted remarks like "I remember—with this of course," pointing to the needle in the arm, which indicates either suggestion or a process of guarding self-esteem.

Cardiazol injections (18, 22, 24, etc.) have been used to recall memories, so whatever specific aids lie in barbiturates are presumably shared by convulsants.

Gillespie (13) describes a case of recall under narcosis as a "physiologic process (narcosis) undoing a presumably psychologically produced inhibition." Our conception of the role of barbiturates forces us to reject this description completely.

THEORETICAL CONSIDERATIONS.

The dramatic qualities of hysterical symptoms and their miraculous cures have been constantly recurring themes for uninformed comment in the public press almost as long as popular journalism has existed, and there has been a complete failure or unwillingness to strip off the coverings of medieval magic from the histrionic hysteric. Of the hysteric's repertoire, "loss of memory" easily holds pride of place in the esteem of reporters and readers, and the kind of information displayed before a credulous public can be gauged by a few extracts from a typical article in a journal with a good reputation for providing reliable knowledge in a skilful and entertaining manner. It was headed "Amnesia—Civilian Shell Shock," and examples of amnesia were presented in hero and heroine style. It reported that 20,000 men and women in the U.S. experienced this symptom every year, that it lasts most often a few days, but may continue for years. Then, "When the amnesiac does remember his true identity, he forgets everything that happens during his seizure." It would be difficult to imagine a short sentence so full of arrant nonsense. It styles the symptom as a seizure, implying inevitability, and encourages the dangerous and erroneous belief that the recovered patient can never recall his acts during amnesia, thereby providing a ready-made defence for those acts. The loss of memory is described as a protective mechanism, usually not faked, and an authority from the New York Psychiatric Institute is quoted as saying, "Amnesia is as hard to simulate as a heart attack; the very real anxiety and sense of loss that a true amnesiac displays can't be feigned." A case of amnesia of eight years' duration cured by an operation on the brain, thus proving that the original loss of memory was due to head injury, was also quoted. These journalistic snippets of plain fact and embroidered fancy are a direct incitement to any impressionable and hard-pressed potential neurotic. "When the popular press reports one of them there is usually a small epidemic of them and I wonder whether some of them are feigned" wrote Ross (26). We have noticed an increasing tendency to use amnesia as a defence in criminal cases against charges of desertion, cruelty and so on. As a rule the dramatic picture of the distraught man wins valuable sympathy.

The problem of the mechanism of hysterical amnesia resolves itself into finding an explanation for a loss of memory which occurs at a moment suitable to the

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patient, or at a time to draw attention to his unhappiness, and which he can be persuaded to remember without the artificial aid of drugs or hypnosis. It is a loss of memory during which his behaviour remains civilized and governed by elementary knowledge and rules acquired during his lifetime, even when the amnesia is retrograde for the whole life, during which he can travel, control himself in traffic, speak his own language, and generally make it quite obvious that any knowledge essential to his immediate comfort is retained. Since the loss of memory can be resolved the fault is clearly with recall.

Normal Remembering.

It is a truism that a tremendous amount of everyday observation is so lightly registered that for all practical purposes retention does not occur. The moving panorama of a busy street loses itself in the kaleidoscope of innumerable similar pictures; a familiar sweep of rural scenery hardly seems to show one autumn different from another, and there is a tremendous process of reduction into composite impressions. Only the unusual and the interesting are retained and available for recall. It is not fully realized that what is unusual and what is interesting are different for each observer, the consequence of a purely personal attitude and viewpoint.

Bartlett (3) said, " Remembering is the imaginative reconstruction or construction built out of the relation of our attitude towards a whole active mass of organized past reactions and experience." It is a personal recall made in the light of the individual's total experience at any moment and his immediate attitude to life. Of forgetting, Schilder says, " Apparent disturbances of memory and judgment are merely the expressions of emotional attitudes and are not due to a more or less fixed inability."

In general, excluding abnormal states of depression, memory favours the recaller. As Gillespie says, there is unwitting selection and accentuation as character and temperament develop. Distortion always exists, and is roughly proportional to the emotion which was aroused by the substance of what is remembered. Wexberg (33) wrote, " Every human being remembers what he needs and forgets the rest." Adult memories are largely interpreted in words, and a memory can best be expressed to others by verbalization. Gillespie points out that early experiences are in visual terms, a child remembering a large, globular, soft object giving pleasure and not a breast as such; a " biologic need is necessary to translate early impressions to present psychological concepts." Frequently in grown-ups there is an absence of verbalization descriptive of experience, and this is especially so with emotions at any stage of life. Like pain sensations, emotions are difficult to recapture.

Amnesia is the keystone of Freudian psychology, and psychoanalysis is the recall of memories which are hidden by a hypothetical force called repression, an unconscious force not recognized by the patient. The buried memory retains its emotional attributes and energy and is responsible for symptoms (11). Gillespie (13) describes a woman who remembered five objects easily. A box was substituted for one object and none could then be recalled. It was discovered that the box reminded the woman of a peculiarly unpleasant group of ideas of a closely personal sort and the unpleasant association produced an immediate forgetting, " the automatic operation of the superego " being the phrase used to describe this result. No distinction can be drawn between this and the sudden blocking of thought that develops in any adult who finds himself saying something which might reveal an action or opinion he is anxious to keep secret and to which shame might be attached, or the silent confusion of a child suddenly faced with a question or situation threatening to expose what had seemed safely hidden. On such occasions there is a sudden rush of emotion arising more from the immediate situation than from the buried thoughts, and until the sufferer has had time to balance the situation, an outwardly apparent paralysis of thought may continue.

It is difficult to draw a distinction, except one of degree, between a memory that is almost in consciousness but is threatening and distasteful, and a memory that is also threatening and distasteful but is so far from recall because of time, new memories, changing concepts and perpetual distortion that it is impossible to recall without special methods of treatment. Gillespie speaks of the " operation of the

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ego itself " when an emotional content threatening self-preservation or some valued function, such as vision, may be unendurable " and repression results. He adds that " hysterical amnesia is something different." We suggest it may not be different, only simpler.

Everyday Forgetting.

We mention everyday forgetting here for completeness. There are two kinds at least. The first is based on a conflict of wishes when the less desired memory is usually ignored, the second occurs because of simple preoccupation with some other train of thought. We doubt if a concept such as repression is needed to explain either.

Recall has been divided into simple mechanical, or reflex, on the one hand, and recall involving voluntary effort, a higher function, on the other hand. We do not like this division. We prefer the first to be called impersonal recall, and include all memories of fact or opinion that do not involve personal and emotional considerations, whatever the degree of complexity resulting intellectual processes may reach. This is rare in a pure form, since the second variety of recall, the personal, is almost bound to intrude into any but the simplest memories, and introduce its special emotional colouring.

Preoccupation.

We regard preoccupation as a rather neglected factor in psychopathology. We divide it into intellectual and emotional preoccupation, as is usually done. Intellectual preoccupation is the use of impersonal recall in thinking and the name preoccupation merely serves to indicate that such thinking reduces the attention paid to extraneous sensations. A man drove his car for over an hour late one night along lonely country roads and through sleeping villages, over a route which was very well known to him. He was intellectually preoccupied with a problem, and on arriving at the gate leading to his garage he was suddenly faced with a demand for activity, opening the gate and the garage doors, which broke off his train of thought. At the same time he realized that he could not recall anything of his drive. He did not complain of this forgetting because he recalled his processes of thought and realized that preoccupation had reduced his attention to the passing scene and knew that had an accident threatened or a policeman given a signal he would have responded satisfactorily. In other words there was satisfactory registration of the facts of a situation from moment to moment, but no retention.

Emotional preoccupation produces the same effects as intellectual preoccupation in regard to noticing passing objects, but the mind is taken up with an absorbing emotion. Clearly a degree of emotional intensity cutting off external observation completely is almost a pure theoretical postulate; in practice preoccupation is a varying mixture of both, and one is reduced to the consideration of the havoc played with memory by emotional experiences. Frequently people have been accused of distortion and lying under such circumstances. When taking information from patients it is often impossible to differentiate lying from confabulation and confabulation from the truth. It will be convenient here to consider how emotional preoccupation may be linked with the development of hysterical amnesia.

Kanzer found an acute emotional disturbance preceding the symptom in 43 of his 71 amnesias, and in our own cases there was usually a rising tide of emotional distress and self-pity before the loss of memory developed. Taking a hypothetical service case, his emotion culminates in an absorption with the idea " I must get away, I can stand it no longer, I don't care if I die," and he leaves on his fugue. It is conceivable that he walks on heedless of the elements and his surroundings, and may cover several miles during some hours, until circumstances, such as the physical discomfort of cold and wet, or weakness or hunger or the intervention of someone who has noticed his distress force him back to immediate reality. His reverie ceases and he finds himself lost, with no recollection of the way he has come, nor can he give an account of his thoughts during his emotional preoccupation as can the man who experiences intellectual preoccupation, and this for several reasons. Firstly because his thoughts are personal and private, and concern matters he would not wish to discuss with a stranger, secondly because they are limited to a central idea, thirdly because they are chaotic about this idea, and fourthly because

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emotion cannot easily be translated into words. As well as this he suddenly realizes his predicament and is suffused with shame. If he is familiar with the popular conception of "loss of memory," it is an easy step for him to say, "I can't remember anything; where am I?" Assuming this chain of events to be a reasonable possibility, it can only be a factor in an amnesia and fugue which is preceded by an acute emotional predicament, short in duration, with an amnesia extending only for the duration of the fugue and without any claim to loss of identity. In fact, even where confusion and anxiety are present and the patient looks ill and shows some physical evidence of prolonged anxiety, the resolved amnesia shows that observation was normal in most cases and may have been acute. Nevertheless, genuine emotional preoccupation is a factor sometimes, and due allowance should be made for it.

Fatigue.

In association with genuine emotional preoccupation as a facet of the structure of some cases of hysterical amnesia, the question of fatigue should be considered. Davies (7), in special tests with pilots in an experimental cockpit, found a tendency to diminution in the number of things to which a tiring man could pay attention. Indicators at the periphery of the control field especially tended to be neglected. The histories of pilots under difficulties and suffering from fatigue suggest that there is a gradual sacrifice of what appears to be less important. With a failing engine attention becomes eventually restricted to consideration of this mechanical defect. A soldier on a long route march may be alive with numerous interests at the start, be they concerned with the passing scene or with his natural grouses, but increasing fatigue gradually reduces the range of his thoughts and leaves him eventually preoccupied with one anxious idea, "I want to get back; I must get back." This is a comparable situation to the wearying psychoneurotic who is left with one obsessional idea, "I must get away."

It remains true, however, that genuine emotional preoccupation and fatigue are prominent in only a few cases.

Comparison with Children.

The running away of the adult hysteric is in every way similar to the running away of children, except when amnesia is present. Some adults have no amnesia, some start off without amnesia and some put their amnesia forward in a tentative manner. Otherwise both run away because of grievances and depression, both are pulled up by the same reason, a need for help and protection in their predicament, and both show confusion and anxiety expressive of their original emotion and of the shame attached to their immediate problem and surrender. In the adult a sharper realization of his position probably adds to the acuteness of apprehension, and he meets this situation by using the concept of amnesia with which he is familiar. The child does not complain of amnesia because he is unaware of such a possibility.

Another childish characteristic, which normally becomes increasingly under control as age advances, is a tendency to minor panic reactions with an apparent blocking of thought. These reactions are not communal responses to genuine danger, which may be more severe in adults, but the reactions of children caught in difficult circumstances which threaten their pride. Such a child may be dumb and unable to speak, or he may, because of his fear, whether justifiable or not, lie spontaneously—"I didn't, I didn't," or "I can't remember." Once the lie is told the child is prone to stick to his story, and needs gentle handling. Both the child and the hysteric are likely to become entangled in a web of phantasy of their own weaving. We believe this minor panic reaction is important, since many hysterical amnesias make it plain from their later revelations that they were perfectly aware of their own identity and situation right up to the moment when they were first questioned, and there may have been a sudden panic decision to take refuge in the phrase "I can't remember."

The Refusal to Remember.

Gillespie (13) states that the hysteric uses "a concept of forgetfulness as a symptom, as of paralysis or anaesthesia . . . depending on what has been read

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and how he has been examined." If the reasons for the episode appear trivial and the whole adventure rather futile, this is because of the stunted emotional development of the hysteric. Gillespie adds, " He knows at least at the beginning that he is simulating but does not know why. He may realize that he wants sympathy." We are doubtful, however, whether the hysteric's ignorance of his reasons is often genuine; our cases of amnesia knew well from what they were running, and knew well what they would like done about it.

The ease with which most amnesic hysterics can be persuaded to remember without hypnosis or narcosis seems to us to be a vital point in understanding the mechanism of amnesia; memories are yielded up to patient persuasion by the physician. The hysteric does not forget, he only refuses to remember. As a patient said, " I realize that it was just that I didn't want to remember. I was excited and felt I wanted to do myself in or be alone and live my own way, away from everyone. I couldn't make friends."

An amnesic patient of Gillespie's failed to see him, although she saw everything else in the consulting room. This is a caricature in visual terms of the mental process of amnesia. We saw a colleague's patient being demonstrated to a gathering of doctors as a cured hysterical blindness. The patient had become annoyed by some petty restriction, and when asked to tell the doctors how he felt he peered round the room and said, " What doctors ? " Hysterical deafness is a simple form of the same refusal. The diagnosis of malingering is strongly suggested by such symptoms.

The amnesia occurs because the patient does not wish to remember. We cannot see the need for the conception of dissociation in considering this symptom. It is a striking fact that dramatic cases of so-called dissociation have not become more common despite a great increase in the number of psychoneuroses, diagnosed and described by a much larger number of trained observers.

The Total Picture.

In handling these cases the important considerations are those concerning the man's total personality and his ability to respond to difficulties in his environment. The refusal to remember is a superficial symptom, but it may be attached to a deep psychological disturbance. Culpin (6) recorded a case of a man cured of an hysterical symptom, who went off and committed suicide, and the symptom may occur in any form of mental disorder. This is no reason, however, for exaggerating the importance of the symptom itself.

The Fugues.

Sargant and Slater suggest " a specific constitutional tendency to fugues and other forms of disorders of consciousness." Brown (5) found that about 7 per cent. of hysterics showed possible direct heredity of hysterical reactions. How small this percentage would be if individual hysterical symptoms were considered we can only imagine. The opinion of Sargant and Slater can be viewed as an expression of belief that there is an essential difference between amnesia and hysterical paresis of a limb, but we have failed to find any psychological difference. We have seen no cases where parents have had fugues or amnesias, but hysterical symptoms so often imitate parental disabilities, psychogenic or not, that we would not be surprised if we met such cases. Hysterical symptoms are often built up on a genuine organic defect, of which mental disorder or a low intelligence quotient are examples, so the question of some minor organic defect being a constituent of the total picture of hysterical amnesia cannot be completely rejected.

Malingering.

Dillon and Masani (8) have shown how far a malingerer may go. We have had several cases where the claimed amnesia was an undiluted fabrication; the following is an example:

Case.—A member of a motor boat crew with an amnesia of six weeks' duration, in which he had wandered to many towns, stayed in numerous hotels, borrowed money from friends, and for one week had stayed at his fiancée's home. A well-educated, thoroughly spoilt young man, who was under-manager in the family business in which he had never done a stroke of work. He had his own car, which he used

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exclusively for joy-riding, and was engaged to be married to a girl well liked by his people. He produced two counterfoils from hotels at which he had stayed near his home, and at which he had run up large bills, but the proprietors, knowing who he was and believing he was on leave, thought nothing of it. One week before the fugue started he had fallen down in the blackout and sustained a slight bruise on his head. X-ray was negative. The situation was discussed with him at some length and he was told that on the morrow the truth would be expected. The next day the story was unveiled. His fiancée had come down to see him and, having little work to do and being fed up, he decided to accompany her on her homeward journey in spite of her pleadings against this. On arriving at her home he realised what he had done, and being afraid to return to his unit he started to wander. At one period in the six weeks he even visited the town in which his unit was, determined to return, but his courage failed him at the last moment. In this case there was never the slightest doubt as to his ability to have told his story from the start, and this he admitted.

There is no clear distinction between hysteria and malingering in such cases. Gillespie says, referring to hysterical amnesias, " It is difficult to believe in most of them, perhaps in any of them, that memory was ever beyond the effort of voluntary recall." He adds that malingering is " difficult to differentiate from amnesia," that it is an attempt " to evade crude external difficulties of a contemporary kind of which he is perfectly well aware," and he suggests " that all the grosser symptomatic manifestations of hysteria are the joint manufacture of the patient and the too credulous physician, and that study of these gross symptoms has served only to obscure understanding of the underlying mental constitution." Wexberg states that " every hysterical attack lies on the borderline between psychoneurosis and simulation." When to these opinions one adds the statements of Kanzer, of Sargant and Slater, among many, that malingerers are constitutionally inadequate and their stories the product of severe psychopathic personalities, it may be wondered if any separate treatment is required for malingerers, as opposed to hysterics. We think they deserve separate notice because of their close relationship to ordinary hysteria. They represent a group where there can be no question of the ability to recall the lost memories if there is the will to do so, and in our view the refusal of the hysteric to reveal the truth is hardly to be distinguished.

None of Kanzer's patients confessed feigning, but Sargant and Slater found 9 of 32 patients with amnesia lying deliberately, and we found a higher proportion than that. Hysterics and malingerers have the child's selfishness; they assume the right to take what they can get without obligation. They develop emotionally conditioned beliefs in the rightness of their claim to sympathy or advancement, and are indifferent to the nature of their symptoms, which are merely means to a justifiable end.

A warning should be uttered about a too easy approach to malingerers. There is a present tendency to stress the frequency with which predisposition and psychopathy are discovered, and from that to argue that all malingerers are psychopaths. It is a small step from this to the statement that all liars for personal gain are excusable psychopaths—an ideal approach which can only be adopted as a practical guide under peril. Rymer (28) recently pointed out how often a defence of amnesia in the form of " everything went black " is made in murder trials, and gave his opinion that such temporary aberrations do not exist. Similarly we feel that an hysterical or malingered amnesia should never be a defence for any misdemeanour whatsoever. We would go further and say that since an amnesia provides proof of an attempt to deceive it should weigh against the culprit as a confession of guilt. This would not, of course, alter the consideration given to any mental imbalance or psychological disorder which might be found at the same time.

Conclusions.

1. The effects of organic factors should be estimated when considering amnesia.
2. Psychogenic amnesia is an hysterical symptom following emotion.
3. When a psychogenic amnesia is not complained of and is purely defensive against emotional anguish, the term " defensive amnesia " is suggested.
4. Predisposition and the hysterical constitution are basic precursors of amnesia.
5. Complicating fugues are considered.

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6. Memory is divided into personal and impersonal recall, the latter including all memories of fact or opinion not involving personal or emotional considerations.

7. The possible importance of emotional preoccupation or fatigue in the genesis of the symptom is considered.

8. A comparison is made with child behaviour.

9. The hysteric does not forget, he refuses to remember. The process is active, as pointed out by Freud long ago.

10. The refusal is conscious or near conscious, and can be overcome by simple persuasion, which is the treatment of choice.

11. The importance of the symptom itself has been much overvalued. It is the total clinical picture that matters. The symptom can occur in serious mental disturbances.

12. The difference between hysterical amnesia and malingering is only one of degree.

13. Psychogenic amnesia should never be a defence for any misdemeanour whatsoever. It should weigh against the culprit as a confession of guilt, as an admission of the recognition of something he wishes to forget. In such cases due consideration should be given to any mental disturbance present.

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DISCUSSION.

Dr. W. Sargant said that he had listened with very great interest to Squadron-Leader Parfitt's paper because he had always found many problems in this subject still unsolved. He really had only one criticism to make, and that was on the distribution of total amnesia. At Sutton they had seen a very large number of amnesic syndromes—over 250—and only a minority were of the relatively simple and superficial type which could approximate so closely to malingering. In the majority the aetiology and pathogenesis, especially in the patients who had undergone really severe physical and psychological stresses, seemed to be rather complex. As a result of his experience he would put forward some considerations of a more deterministic kind than were fashionable.

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He agreed with Kraepelin's opinion that the hysteric was born and not made by his environment or of his own will. However much the pure endogenous depressive would welcome an attack of amnesia to relieve his troubles, he did not seem able to develop it even by subconscious means unless there was also a constitutional tendency to other hysterical traits in his personality. Pure anxiety states were similar; the patients did not seem able to obtain relief from their untold sufferings by genuine amnesia unless they had other hysterical traits in their make-up.

The most interesting material, and the bulk of cases, occurred at the time of Dunkirk, the Battle of Britain, and the bombing of London. It was very striking that in recent acute amnesias, occurring after great stress, the intravenous injection of sodium amytal was sometimes sufficient to bring a relief of the amnesia, and one did not need to say very much to the patients. They arrived at hospital with pallid faces, drawn features and trembling hands. As soon as amytal was injected, the breathing became easier, the face relaxed, the tremor stopped, and memory often came flooding back of its own accord. Return of memory would generally coincide with return of colour to their cheeks. It was as if changes in the autonomic system and brain metabolism produced by the amytal were all that was necessary.

Many patients were glad to have their memories back; they had struggled to get them back of their own accord, and the better the personality the more horrified they were at what had happened to them. One remembered, and was warned against, trying to find psychological motives for loss of memory in all cases by the fact that thought disorder in schizophrenia used to be considered by psychological theorists to be a motivated voluntary or unconscious withdrawal to phantasy life. They even tried to flog them to reverse this motivation.

It was known from talking to the insulin-treated patients that most were only too pleased to get rid of their thought disturbance and return to normal behaviour. There were, of course, other cases of functional amnesia who showed, as Parfitt had emphasized, almost conscious unwillingess to recall what had happened, and it had to be dragged out of them. Some hysterics who had long mastered the use of this symptom of their disease were obviously employing it for their own ends. He watched a few acute cases recover their memories suddenly and quite spontaneously while in hospital. In these, interestingly enough, return of memory sometimes coincided with a change from facial vasoconstriction and pallor to facial vasodilation producing a contrasting redness of the face which was very striking.

He wished to speak about a special small group of patients who had attacks of reversible amnesia, because they might provide a clue to the mechanism of this condition in a certain number of cases and to their proper treatment. He did not believe such people wished to have attacks either consciously or subconsciously; they happened, to their infinite distress and mortification. The reason they had them laid primarily in their heredity. There was a hysterical or unstable parent. The patients themselves had shown a constitutionally determined tendency to neurotic traits in early childhood, and might have been behaviour problem children. As they had grown up they had attained a reasonable social adaptation of a shallow sort. Their hysterical personality traits of bravado, shallow, rapidly changing affect, and exhibitionism might have won them a reputation as good fellows and mixers. Suddenly they were subjected to quite unaccustomed stresses, they experienced profound autonomic disturbances, their whole metabolism was upset, including the brain metabolism, they lost weight rapidly—sometimes up to 3 st.—and gradually or suddenly all the grosser hysterical qualities which were part of their constitutional endowment rose to the surface unchecked. Among other hysterical behaviour patterns displayed they might go quite spontaneously into hysterical amnesia for the first time. One learnt a lot about aetiology when trying to treat them even when, later on, the condition had become chronic and recurrent. He would mention one case which illustrated many of the points he had raised.

The man was a policeman at Dover. He had had ten years' service in the force, with no illness and a good record. He was happily married and sexually normal. He was very keen on his work, and though not very intelligent he was sociable, kind and friendly to everybody, and not the bullying type. He was of super-excellent physique. He said that his family history was normal and there was no neurotic disease. His father had only once been ill in his life. It was a mysterious illness. After long Petty Officer service he suddenly lost the use of his legs in Malta following fever and getting run down. He had been discharged from service and for a year or two could not walk. Then he was treated by a gipsy woman and regained use of his legs dramatically and for some years afterwards ran a successful business. That might be considered evidence of a constitutional tendency to hysteria in the family.

During the Dover raids the patient had done some first-class rescue work. He got little rest, as he had to be on duty whenever the siren went, and as his wife was evacuated he did not get regular meals. He started steadily losing weight. Finally he was blown through a doorway by a shell. He had gone on duty next night in a very shaky state. That night he had to deal with a mass shelter panic when the entrance was hit and he was inside with a large number of people. He did this and collapsed himself when it was all over. His attacks of amnesia started then. He would wake up and find himself when on duty in other parts of Dover. He was off duty for a time, and then went back, hiding his symptoms successfully for a time, but two years later he was sent to Sutton. He was discharged from the police, being told by his sergeant that he was a malingerer. He was having two or three attacks a day. In these attacks he would go blank, not recognize his wife or those around him. Often he imagined himself back in the shelter dealing with the mass panic hysteria or would act the part, lifting up floor boards, etc.

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When normal he could recall these same painful experiences, but not what he did or said in his amnesic periods.

On admission this man was still over 2 st. below his normal weight. The significance of this had been overlooked by another psychiatrist. A variety of methods of bringing on attacks of dissociation in his deteriorated state were found. When shown a needle for taking blood his face blanched, he sweated slightly, his pulse altered and then, taking a few deep breaths he slipped into an attack. The same thing happened if a siren went. The attack could be rapidly stopped by restraining his breathing, which was generally deep and rapid in the attack. This combated the hyperventilation alkalosis and cerebral vasoconstriction, which he was maintaining by his overbreathing. If asked to hyperventilate voluntarily he also went into an attack, although it seemed to need more over-breathing than when he was excited. He would get an attack if he was asked to polish the floor or when he tried it of his own accord, because this, too, caused hyperventilation. If attacks were unchecked he would report gaps in his memory of up to half-an-hour when he could not recall what he had been doing. The EEG was normal and there was no question of epilepsy.

Abreaction did not work in this man's case, and other means of treatment had to be devised. The first thing to do was to improve his weight. He gained over a stone on modified insulin therapy and immediately he was better. His autonomic nervous system became less sensitive to outside stimuli, and he had to overbreathe more persistently because it had such catastrophic effects on his brain and behaviour. Autonomic disturbance was reduced still more by barbiturates and crataegus. Then he had to be taught to hold his breath when he felt excited. Gradually he began to control the attacks by attention to these physiological, rather than psychological, principles. At the same time it revealed to him the mechanism of the attack if he ever needed or wanted to use it to his own ends. But he showed no inclination that way; he wanted to get well. He had now been working for nearly a year in a factory. The attacks varied from one a week to one every three weeks, and they came on when he lifted heavy loads or became excited or tired. His wife was careful to see that his weight was kept up.

Dr. Sargant said he had seen other cases similar to this. One unfortunate soldier was discharged from a military hospital after having seen many psychiatrists and being told nothing more could be done for him. A reasonably good previous personality and army record, he had had a hysterical mother, and though initially lightly built had lost over two stone in the Abyssinian fighting before starting to develop attacks of functional loss of memory. He was now back in civil life with his deteriorated physical state quite untreated, and he was getting attacks of amnesia at his work when he had to climb two hills during the course of it, or when excited or over-tired. Before the war in the same job he had been excellent, but now he was on the point of giving up his whole career in despair.

The point Dr. Sargant wished to make was that the treatment of certain amnesic states, and speculations as to their aetiology, must take into consideration physiological alterations and constitutional weaknesses of brain metabolism as well as conscious and subconscious motivations. He ventured to suggest, in fact, that the cause and cure of hysteria in general, and with it some of the functional losses of memory, would finally become the province of the biochemist as well as of the psychotherapist and disciplinarian in a newer and better proportioned psychiatry.

Dr. PICKWORTH asked whether the cases described by Dr. Parfitt were in the same category as the short amnesias following severe injury, shock or blast in normal people. A Birmingham engineer had his arm torn off by some machinery; he remembered an urgent desire to get out of the place, but could not recollect the actual injury itself; abreaction was present as in the form of movements of the arm and legs as he recounted the story. Another case, with no obvious affective association, was that of a man who was in his house when the semi-detached neighbouring house was demolished and the roof blown off his own house by a bomb explosion. His first impression of the event was that of sand trickling on to his neck from the ceiling plaster. He insisted that he had no loss of memory, even of a short duration, but obviously did not recollect seeing or hearing the bomb explode nor the din that the scattering of debris must have caused. These two cases were understandable from the standpoint of physiogenesis as disturbances of the cerebral capillary patterns. If Dr. Parfitt's cases were of the same category they too might have had a similar physiogenesis, the cerebral vascular pattern necessary for the association of events being disrupted for a longer time.

Dr. STENGEL said that in commenting on and criticizing some of the statements made he did not want to minimize the merits of the paper. Some weeks ago he came across an article by Prof. D. K. Henderson written in 1918 on the same subject, and comparing the present paper with that article one had the impression that neither psychiatry nor psychopathology had made any progress during the last 25 years. It seemed that they could be satisfied with the statement that a phenomenal type of amnesia was entirely due to the desire to avoid unbearable situations. It was nearly 50 years since Breuer and Freud put forward their theory of repression which had been accepted by psychiatrists and the general public, and if truth was as old as that it was time that it ceased to make headlines. Not that it was not as true now as it was 50 years ago, but it was not the whole truth, and Freud was the first to be dissatisfied with that kind of explanation. It was very interesting that it was similar case material which forced him to

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admit that the pleasure-pain principle was unsatisfactory, and it caused him to replace that theory by a more comprehensive theory.

Those were cases of dormant neurosis, and he wished to draw attention to an interesting fact that a person who was subjected to traumatic experience reacted either with refusal to remember or refusal to forget. Some of these cases arising from traumatic shock were not threatened with amnesia, but the opposite, and they were more difficult to treat because it seemed that they were losing the means of self-treatment which the amnesia patients had. It would be interesting to study those two groups under the same aspect.

Dr. Stengel wished to draw attention also to certain theoretical statements and submissions which seemed to be fairly well founded. It had been said that the amnesia was symbolic, and the same applied to the state of fugue. One could see very often that before the amnesia appeared the patient was preoccupied with the thought of death or even of suicide, and it seemed that the amnesias and fugues were symbolic substitutes for death—a fact to which Henderson, Wilson and others had drawn attention.

If psychiatrists did not confine their psychopathology to the earliest discoveries of psychoanalysts or to the later and equally important discoveries, they would know more about such phenomena and could approach the symptom from quite a different angle. In recent years psychopathology had attracted great attention, and it was really based on the fundamental discoveries of Jackson and Goldstein in New York, who had founded a pathology of neurotic reactions. He would say that these were patients who avoided catastrophic situations. In the speaker's view that conception of the catastrophic situation was quite speculative, but it was a new idea.

Dr. Sargant had pointed out other ways of approach which might lead to a deepening of their knowledge. Dr. Parfitt's attempting to differentiate between the hysteric and emotional type of amnesia was open to criticism, and he did not think that that differentiation was very useful, because it gave an impression that the hysterical patient was not an emotional case at the same time.

Dr. Stengel could not refrain from expressing his criticism regarding the vague manner in which the word " fugue " was being used not only by Dr. Parfitt but throughout the literature, because it led to a great deal of misunderstanding. He thought it would be unfortunate if hysterical amnesia and phenomena of a pathological type were put together and both called fugues as if they were the same phenomenon; a revision of the terminology would be necessary.

Dr. LINDSAY said that he had already called the attention of one of the speakers to the fact that a great deal of what had been said that day was seen in the daily life of mental defectives. There was no shadow of doubt that defectives suffered from amnesia of the same type; they suffered from it much more frequently than normal people and they were much more easily brought out of it.

His first case of that kind was 30 years ago. It was a soldier in the Black Watch who was not able to hear or to speak. He had been cured two days before by Dr. William Brown, but had all the symptoms when he arrived at the speaker's hospital within 48 hours. His commanding officer told him to send the patient to England, but he cured him too. He had seen in the paper that he would only be cured when he got back to his village in Scotland and saw his old grandmother—that other cases had been sent back and cured when they saw their grandmothers! A patient of his own of the mental age of four or five was sick in the ward and was later sent back to his work. The staff in the ward did not tell the workshop that he was coming back; he was missed and found ten miles from Caterham and came back quite quietly. Another case was that of a high-grade defective, who was out on daily employment. An S.O.S. was received from his employer that he had committed an indecent act in her garden. The patient said he did not know what he had done; again—he did not know whether his method was right—the patient was told, " If you tell me what you did you will get another chance; if you don't you must come back into the institution," and the patient told Dr. Lindsay what he did.

Col. PETRIE did not think they were talking of an entirely homogeneous set of cases. Some of these cases, at any rate those of commotional shock, were a little different from those in which merely a difficult situation had arisen. All sorts of variations of post-traumatic cases were thrown in with these hysterical amnesias. The group he had been seeing had been the unfortunate group of hysterical amnesias following absence without leave, and he recognized Dr. Parfitt's descriptions rather more than Dr. Sargant's amongst that particular group. Dr. Sargant had emphasized the hyperventilating, over-anxiety cases, and those symptoms undoubtedly did occur in the more acute cases. His general impression amongst the absent-without-leave men was that they might have a period of confusion about the time when they began to wander, but they clung to it long after it had cleared away in order to try to produce an impression of amnesia which perhaps made one call them malingerers rather than hysterics.

Squadron-Leader PARFITT, in reply, was glad that Dr. Lindsay and Col. Petrie had seen cases similar to those he had described, and he did not think he need say anything further in reply to them. Col. Petrie mentioned the commotional shock of the last war, and it would be a

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pity to get tied up with the same problem again. One was tempted to deal with them in a physical way when the psychological method was insufficient.

Dr. Sargant had described a Dover policeman. This man had signs of autonomic disturbance which were extremely common in all kinds of psychoneuroses. One saw this disturbance in anxiety states, but one wondered whether the autonomic dysfunction was the cause of the amnesia which was being discussed. For that reason he was inclined to think that if the Dover policeman had been treated on purely psychological lines he might not now be having his one attack a week. There had been a preservation of the symptom, and it could become twice a week or three times a week if he were subjected to further psychological stress. He was not impressed with the theory that the autonomic change was a possible cause of amnesia.

Dr. Pickworth described rather a different thing when he mentioned the case of the man who had his arm torn off. That was not quite the subject about which he had been talking. When a person got an amnesic reaction he was rushing away from the scene of his pain; whether one could bring back the memory by persuasion or whether his shock was so great that it blotted out his ability to retain impressions he could not say.

Dr. Stengel made some criticisms which were mainly valid. His first was that the general trend of the paper was stated 48 years ago; this was perfectly right, and the only excuse for putting forward the paper was that the principles so often mentioned by Freud were forgotten. Dr. Stengel said he did not like the differentiation between emotional—or what he had called a protective amnesia, a defensive amnesia—and hysterical amnesia because it gave the impression that an amnesia was not hysterical. He was afraid he had not made himself clear; what he tried to say was that although the state in which the symptom occurred was different, the actual symptom was the same. Both types of cases were emotional and they were both reactions.

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