MEMORY AND ITS DISORDERS IN RELATION TO CRIME.*

By HUGH A. GRIERSON, *M.C.*, M.B., B.S.Lond.,

Senior Medical Officer, H.M. Prison, Brixton, London, S.W.

OF all the problems which the medical witness has to decide, there are few which require more consideration than the question of memory in relation to crime. Before discussing disordered memory let me refer briefly to normal memory, and the processes or elements involved in its production; for disordered memory is basically disorder of one or more of these processes:

1. Perception of the stimulus, followed by—
2. Its retention or conservation.
3. Its reproduction into consciousness.
4. Its recognition as a previous experience.

Memory may be disordered as to quantity and quality, that is, it may be increased, decreased or perverted.

Hypermnesia, or abnormal increase, may be difficult to determine, for there is no standard of memory. A normal memory in one person may be superior to that of another less fortunately endowed; but the memory of the latter may improve as the result of certain mental disorders, for example, in hypomania and paranoia. In the latter disease the memory of minute details associated with delusions is very striking, and of greatest importance in distinguishing between genuine and feigned delusions.

Transient hypermnesia may be due to the action of drugs, such as opium, cocaine, etc. Although drug addiction is not common nowadays in this country, it must be remembered that a case may be received into prison at any time. My experience includes a female cocaine "sniffer", who on reception was hypomanic and hypermnesic. Although she settled down after the first day or two, she became acutely hallucinated during her menstrual period, and nursed an imaginary baby. This lasted for three days, when her mental state cleared up as rapidly as it started. Hypermnesia in itself is of no medico-legal importance except as an indicator of an underlying abnormal state of mind.

* Extracts from a paper read before the Annual Conference of Prison Medical Officers at the Home Office, April 4, 1936.

https://doi.org/10.1192/bjp.82.339.360 Published online by Cambridge University Press

Paramnesia (pseudo-memories of Kraepelin, mnemonic delusions of Mercier) is an illusion or perversion of memory with false recollection, in which patients speak of events which have never occurred, or, if they did occur, the recital is exaggerated or distorted.

Kraepelin (1), in his *Manic-Depressive Insanity*, said: "Pseudo-memories are not infrequently met with in the manic states. Occasionally they show in a pronounced manner a tendency to delusional fabulation—to descriptions of wonderful experiences out of the past, which the patient seriously believes. The patient is usually led away in his narrations to exaggerations and distortions, which arise partly from a mistaken perception, but also to subsequent misinterpretations, without the arbitrariness of it coming clearly into consciousness." Seemingly Kraepelin regarded pseudo-memories as immature hallucinations and delusions. Classical examples of fabulation are seen in pathological lying or pseudologia fantastica. It is rather interesting to study the different points of view on pathological lying. As to belief, Bernard Hart (2) says, "the belief of the pathological liar is half-way between the entire absence of belief, found in the case of ordinary day-dreaming, and the full and absolute belief accompanying delusions."

Risch thinks the patient has a genuine belief in his own fabrications. Rivers (3) regards the condition as a state of regression in which the person affected has "never learned properly to distinguish imagination from reality and has utilized this imperfection for the satisfaction of his instinctive tendencies". Divorcement of reality from imagination could well be applied to other conditions besides pathological lying. Other observers say the fault lies with the retentive and reproductive processes, and not in perception. Perhaps the psycho-pathology is still obscure.

As to disorders in which pathological lying is found, the commonest are moral deficiency, chronic alcoholism, dementia præcox and paraphrenia. A classical case is that of "Jane", quoted fully by East (4). Her delinquencies concerned all the instincts, and included bigamy, theft, arson, fraud and attempted murder. East tells her story in full, and it is unnecessary to consider it completely here. Suffice it to say that, whether she failed to distinguish imagination from reality or not, she certainly satisfied to the full her instinctive tendencies, and not one, but all of them.

Another type of case is that of the chronic alcoholic, the hard-drinking type, who seldom develops delirium tremens or insanity, but shows moral deterioration. One patient who had spent years in South Africa gave accounts of wonderful exploits there. When doubt was cast on his statements, he repeated them, in a slightly modified form, but just as incredibly. Pathological lies are usually not impossible, only incredible.

A general increase of memory cannot be assumed. Memory, however, may be false as to time. This is seen in Korsakov's psychosis, in which events are related as of recent occurrence, whereas they took place a long time before.

https://doi.org/10.1192/bjp.82.339.360 Published online by Cambridge University Press

Most commonly a sequel to chronic alcoholism, it is often associated with peripheral neuritis, although not always so. One case was that of a man, bedridden, who related walks he had just had in the park, although actually they had occurred thirty years before. A further case is that of—

T. W—, a male, æt. 62, charged with stealing a ham. He was an inmate of a mental hospital, and had been out on leave to stay with his brother for Christmas. The brother collected him, and on the way home allowed him out of his sight for a moment. He disappeared, and was arrested for having taken a ham from the front of a grocer's shop. There was a history of alcoholism. Under observation he appeared very demented, although he gave a fairly coherent account of the theft. His memory, however, was very perverted, and a report from the mental hospital said he showed pseudo-memories and mistaken identities, and that he was an undoubted case of Korsakov's syndrome.

Amnesia.

Although amnesia, in criminal practice, is more commonly alleged than any other condition, yet the defence of amnesia in the absence of any other abnormal state is practically confined to capital charges. So long as the present state of the law as to murder exists, so long will counsel attempt to get their clients within the pleasant confines of Broadmoor, irrespective of medical truth. In my experience, in only one case of murder has the prisoner pleaded guilty on the advice of his counsel, although other cases have pleaded guilty without advice. Not long ago in a murder case the Judge asked counsel if he had ever heard of insanity being raised in an attempted murder charge, and the counsel admitted he had not. This, of course, was in reference to the absence of any evidence of insanity, and so it is with amnesia. No counsel will try to get his client an indeterminate sentence in Broadmoor on a lesser charge than murder if he can help it.

In Hopwood and Snell's (5) 100 cases of amnesia, 78% were considered genuine. It would be interesting to know how many of these cases showed any evidence of mental abnormality actually associated with the amnesia. In view of the modern theories of amnesia there will probably be increasing use of this defence.

In cases of those who can remember, the fact that at the first interview they say they cannot does not, to my mind, always imply a wilful attempt to deceive. It is, I think, a reaction which is often subconsciously suggested to the patient from within. Perhaps there are but few of us who did not similarly react, in our childhood days, in an attempt to avoid the probable painful consequences of an awkward situation. To me it does not seem an altogether unnatural response. Although the denial is made and persisted in by some with intent to deceive, yet the majority recover their memory at a subsequent interview.

In studying the conditions with which amnesia may be associated, it takes but a few moments to realize that there are few in which such a condition

https://doi.org/10.1192/bjp.82.339.360 Published online by Cambridge University Press

may not be present, though the degree varies between wide limits, from mere haziness to complete amnesia. Stated briefly and only generally, if the schizophrenic and paranoid reaction types are excluded, the remaining psychoses, together with the alcoholic and epileptic states, may all be characterized by some degree of amnesia. Of these conditions the most important are melancholia, alcohol and epilepsy, for if associated with amnesia the defence of irresponsibility is strengthened.

Melancholia.—East gives melancholia as one of the most frequent causes of insane homicide and suicide, and this is still true. Of the cases sent from Brixton to Broadmoor during the past few years, depression was the emotional state in about 60%. The assessment of the depression in mild cases of melancholia may present considerable difficulty. Amongst our acquaintances we have all met people of cyclothymic or mercurial temperament: soon up and as soon down, according to circumstances. A further difficulty may be that the depression disappears as quickly as it originates, so that when the patient is received in prison there may be no observable evidence. This is especially so in cases who have been detained for some time in an outside hospital for observation, or perhaps for treatment for self-injury. Thus it may be that the only fact on which an estimate can be based is a comparison of the patient's reaction and conduct in relation to the circumstances of the crime.

In the manic-depressive psychoses exhibited in prisoners, memory, *per se*, is not usually affected. There is little doubt, however, that many in the melancholic stage show some disorder of memory in relation to crimes of impulse. Hopwood and Snell (5) lay stress on depression as a cause of impulsive crime followed by amnesia.

Although in the melancholic the state of memory at the time of the crime may be a matter of opinion, yet it is a fact that the subsequent memories of the crime vary greatly in different individuals. As to amnesia, East (4) regards repression as mainly responsible—" the exclusion from consciousness of a memory too painful to be retained ". Certainly repression is more common amongst the depressed, yet I often wonder if repression is always the sole cause. There seems to be a short and complete amnesia for the crime itself in some cases of melancholia, and this amnesia has always been so convincingly described by the patient as to lead me to believe that no impressions had been registered. On this aspect of the subject Kraepelin says: " In states of depression we encounter more or less clouding of consciousness up to almost complete oblivion. Memory is not permanently encroached on by the disease, but the patients frequently lose for a time the mastery of their range of ideas."

A case of melancholia and amnesia with repression:

M. J. C—, charged with the attempted murder of a workmate. There was nothing to note in the man's personal history. In the family history there was a sister who had committed suicide by hanging. He had served twenty years in the Royal Artillery, rising to the rank of sergeant. Discharged with an exemplary

https://doi.org/10.1192/bjp.82.339.360 Published online by Cambridge University Press

character and a service pension. He had since worked as a civilian fitter in an R.A.S.C. depot, and was so working at the time of the crime. One morning after breakfast he went into the canteen with a piece of iron shaped like a chopper and attacked a workmate. The victim received terrible injuries; one arm was nearly cut off, as was also a hand, and his nose was completely hacked off. After the attack the prisoner bashed his head against a pillar. Examination showed that his wife had died some time before, and he had become depressed, and thought that the victim had killed his wife. Actually she had died of tuberculosis. He was very deluded and depressed, and intended committing suicide that morning by throwing himself under a train. He had previously written a long account of his delusions in an exercise book. After the crime and after bashing his head against the pillar, he said, "I think I have done that s—— in; that —— —— killed my wife. I have got it all down here". At the hospital he tried to cut his throat. Repeated examination showed him to be still depressed and suicidal, and to have no memory of the crime. From his manner and from the history of the case, and the fact that there appeared to be no reason for deception, I believed him. This was a case of repression, for he said what he had done, and gave a reason, not only after the crime, but after inflicting injuries on himself.

Organic reaction types.—These are, in the main, mental diseases and disorders arising from toxins, both exogenous and endogenous, of which alcohol is the most important as far as disorder of memory is concerned. Of less importance are syphilis, Huntington's chorea, hypothyroidism, opium, cocaine and other drug addictions, etc. In these conditions the general effects on memory are variation in level of attention, impaired retention and reproduction, leading to final deterioration.

Alcoholism.—The estimation of the disorder or defect of memory resulting from alcoholism may be a difficult matter, and sometimes impossible. For not only does it depend upon the quantity and kind taken, but also on the susceptibility of the individual. In most cases this is an unknown factor. The drinker is always modest in his estimates as to the quantity consumed, and the chronic alcoholic is never reliable. In some cases the effects of the alcohol have worn off by the time the individual is received into prison. Increased susceptibility is synonymous with pathological drunkenness, but I would advise extreme caution in making such a diagnosis without knowing all the facts of the case, and being on very sure ground.

When alcohol is associated with other conditions, such as head injuries, mental disease or defect, epilepsy, or psychopathic states, then the estimation of memory defect is even more uncertain. In Hopwood and Snell's (5) cases of amnesia there is a definite history of chronic alcoholism in 38%, a suspected history in more, and in only three cases was there a history of teetotalism. Although chronic alcoholism is responsible for much certifiable insanity, yet the acute condition provides more examples in which memory is affected.

I have mentioned previously Korsakov's psychosis as a sequel to chronic alcoholism, in which memory may be perverted as to time. Although, as a rule, the defect of memory is proportionate to the degree of drunkenness, it is not always so. Ordinary drunkenness may produce complete amnesia, or may be associated with automatic action, comparable to that of the epileptic.

https://doi.org/10.1192/bjp.82.339.360 Published online by Cambridge University Press

In delirium tremens memory is always confused, but not necessarily absent. Patients can usually recollect their hallucinations. In *mania a potu* and alcoholic automatism the amnesia is usually complete.

The following case is an example:

S. F—, a male, æt. 53. Charged with setting fire to a dwelling-house (in fact the room he occupied as a lodger). His father had been a heavy drinker, and in consequence of this the home had been broken up, and the accused left it when he was 18. There was nothing in his family or personal history. He had had occasional bouts of drinking from loneliness and depression, having nothing to do in the evenings. He had been in the Royal Navy for six years. His present work was a motor driver, and he had been doing this for seven years. He was not allowed to drink at work, and was often on duty for days and nights, so might have little or no drink for long periods. As to the charge, he had delivered a car about mid-day, then went to a public-house and started drinking. He had several whiskies before dinner, and one or two afterwards. Later he amused himself by playing the piano; he remembered doing this and named the tunes he played. He subsequently lost his memory until finding himself in a padded room in a hospital, with blood all over him. He had no idea what had happened in the meantime, but it seems that he went back to his lodgings and burnt some important letters, the burning paper set fire to the waste-paper basket, and the flames spread to the curtains. When the police came he was extremely violent, and he had to be hit on the head with a truncheon to get him away. He had no memory of burning the papers, which he did not want to lose, or of any struggle, or being hit on the head. He had no grudge against his landlady; on the contrary he was good friends with all the family. He was friendly with the police, and had not come into contact with them before. His landlady gave him a good character. I considered his amnesia genuine, and that he had been so drunk as to be incapable of forming an intent.

Alcohol and attempted suicide.—East (6), in a paper on 1,000 cases of attempted suicide, gives figures showing that 391 were alcoholic, and of these 141 were with unconscious impulse and in 171 memory was retained. He states that when alcohol is acting alone it is more commonly amnesic, but when it is associated with other conditions the reverse holds good in even greater proportion. Since that paper was written conditions have changed greatly, the restrictions as to consumption and the strength of alcohol, the fact that an attempted suicide may be dealt with summarily, and the altered social conditions generally, have all been instrumental in reducing the numbers of such cases received into prison. I understand that in pre-war days such receptions averaged about 300 a year in Brixton; to-day the average is about 50, and alcohol does not play the prominent part as a cause that it did. In pre-war days delirium tremens was common. There has been one case in Brixton in the last two years.

Although the medical profession is satisfied as to the existence of states of complete amnesia from alcohol, it must be remembered that the law will not accept drunkenness as a defence of insanity; the limit to which law will go is to accept drunkennes of such degree as to prevent the accused from forming the specific intent relative to the crime.

https://doi.org/10.1192/bjp.82.339.360 Published online by Cambridge University Press

So far I have considered alcoholism alone, but perhaps of more frequency are those cases of alcohol combined with some other abnormal state, e.g., mental disease or defect, head injuries, epilepsy, psychopathic states, etc. Such cases present great difficulty in the estimation of the memory defect. In general it may be said that the underlying abnormal states cause a greater intolerance of alcohol, and in many cases alcohol exaggerates the condition from which the patient already suffers. Especially is this so in cases of depression, when the post-alcoholic depression is superadded. It is in such states that attempts at suicide are to be expected. Old head injuries of themselves I have found to have little or no effect on memory, but with alcohol, excitability and confusion of memory frequently follow.

Finally there is alcoholic dementia, which for present purposes can be compared with the senile and secondary dementias. They all result from degeneration, and in general show the same characteristic, i.e., gradual and progressive failure of memory, and differing only in the character of the offences and physical signs. It is said that the loss of recent memory is more pronounced in the alcoholic—the so-called " instantaneous amnesia ".

Epilepsy.—Of all the diseases associated with amnesia, epilepsy is the most perplexing and controversial. Our knowledge of it seems to be little further advanced than it was fifty years ago. In criminal cases most help is to be obtained from those medical officers of prisons and of Broadmoor who have published their experiences on the matter.

That epilepsy is popular with the lawyers is due to the fact that, unlike other mental states, the only direct evidence needed is that of the crime. The rest of the defence can be filled in from theory. From what one hears in the courts one would think that epileptic crime, especially in the form of the equivalent, is quite common. It is extremely rare, and East, Sullivan (7), Hopwood and Snell all confirm this.

Epileptic equivalent cannot be diagnosed in the absence of any history of previous attacks, and I doubt whether psychic epilepsy, in the absence of any other epileptic phenomena, exists. According to Sullivan all epileptics are abnormal between the attacks. This seems to be true of the reported epileptics who have committed crimes, but we have all seen epileptics who show no abnormality in the intervals between the fits. In all Sullivan's (7) and East's cases there is a definite history of epilepsy.

In the courts automatism is the condition usually alleged, for the simple reason that in most cases there has been no evidence of a fit in immediate relation to the crime, and perhaps no evidence of epilepsy at any time. As to previous losses of memory, some of them, although apparently true, sometimes supported by evidence from the police, were later proved to have been false, and to have followed such incidents as stealing from parents or employers.

It is, I think, generally agreed that epileptics may commit acts of violence in such a state of disordered consciousness, not unconsciousness, that there is

https://doi.org/10.1192/bjp.82.339.360 Published online by Cambridge University Press

no subsequent memory of the crime, not only immediately, but for all time. Recently at a trial epileptic unconsciousness and amnesia were spoken of as being the same condition; of course this is not so. Unconsciousness, being a complete cessation of mental function, must include amnesia, but amnesia does not imply unconsciousness. For all we know an epileptic may be quite conscious of what he is doing and know it is wrong; all we are certain of is that there is no subsequent memory. What are the views in this matter of amnesia in epilepsy? As a student I was taught that epileptic furor was followed by complete amnesia, but this does not seem to be universally held. As far back as 1901 John Baker (8) said, "The retention of consciousness and even of memory is perhaps most frequently seen in those cases in which there exists a pre-epileptic condition of suspicion or smouldering hatred fanned into the highest intensity in the post-epileptic stage. The degrees of the possession of the delusional thought prior to the fit, and the purpose accompanying the delusions, are such as not to efface from the memory of the epileptic the acts which he has unwittingly accomplished under the irresistible thraldom of the attack. Consciousness and memory are, therefore, not inconsistent with epileptic furor." East, in 1926 (9), mentions a patient who had post-epileptic furor who had quite a detailed recollection of what had happened, and later expresses the opinion that any epileptic crime in a state of complete amnesia is rare.

According to Muskens (10), in all the conditions of epileptic psychical disturbances, from the simple petit mal to stupor and mania, the characteristic amnesia exists. He adds an historical note that this was recognized by the early Roman physicians. As to automatism and the equivalents, as far as I can find out, all are agreed that the amnesia is complete.

Illustrative case of epileptic furor:

F. R. L—, æt. 32, male. He was a patient in a mental hospital, and was charged with attacking another patient. He had suffered from major epilepsy from an early age, and had been an inmate of a mental hospital for the past eight years. In Brixton he showed the suspicion, resentment and aggression typical of the epileptic. He was also demented, and could give no coherent account of himself or his history. His ideas were persecutory. At the mental hospital he had stated his intention of murdering someone, either a patient or one of the staff, and had actually made three attacks on different patients. One day whilst at Brixton he was sullen, and refused to get up from a chair. On being told more emphatically, he rushed at another prisoner to strike him, but before he reached him fell to the ground in a typical major fit. In the crime which formed his charge, he had hit another patient on the head with a chamber and knocked him out. He then jumped on his face, and bit his thigh. He had no memory of doing this, and it seems that after this attack he had a fit. He was sent to Broadmoor.

Although text-books describe major and minor attacks, there are intermediate forms, as in the following case: A business man, æt. about 50, served in the war, of which his epilepsy was a sequel. The seizures were suggestive of the

https://doi.org/10.1192/bjp.82.339.360 Published online by Cambridge University Press

major type, with automatism. They were fairly frequent, one or two a week. They came on at any time without warning. There was no aura. I have seen him in an attack when playing cards. He would be sitting quietly, and without any warning would stare in front of him, obviously oblivious to all his surroundings; the cards would fall from his hands, and his pipe from his mouth. This state would last a few seconds; he would then move his hands in a circular motion round each other, and at the same time his facial muscles, especially those around the mouth, would work. It would all pass off in a minute or two, and he would slowly and quietly look for his pipe and cards. This sequence of events happened several times in my presence. On another occasion he had an attack whilst standing up, his facial muscles worked, and his feet kicked against the skirting board, but there was no movement of the hands, and he did not fall. He is quite aware of his disability. He has no memory of what happens in these attacks. They supported Mercier's (11) opinion to this extent, that automatic action was present each time, and that it was nearly, if not always, of the same character; it did not appear to be a caricature of some normal act.

Probably of more frequent incidence are those cases of genuine epilepsy, not amnesic, but associated with excitement and violence, and committed in a more or less confused state, and certainly under abnormal emotional stress. These cases provide instances of epileptic insanity in which responsibility can only be judged from the ordinary standpoint, viz., character of the crime, absence or insufficiency of motive, the accused's condition at the time, and his past history.

Positive diagnosis of epilepsy can only be made from actual observation of an attack; otherwise diagnosis can be only conjectural. That evidence of epilepsy can be misleading, and wilfully so, is shown in the case which came before me recently of a man who had twice been in prison before for stealing a motor cycle and car respectively. On both occasions he alleged amnesia for the crime. His accounts sounded genuine, and appeared to be supported by the official army records, showing that he had a fit in 1916, and loss of memory each summer from 1920 to 1925. Also there were certificates from two medical practitioners to the effect that they had treated him for some time past for epileptic automatism, and the police said he had been missing on fifteen occasions in the past two years. His amnesias for his crimes were considered genuine. Nothing was heard of him for eight years—that is, until July, 1935—when he was received on a charge of wife desertion. In the meantime he had been in a Ministry of Pensions Hospital, and had escaped after six months. He had worked in hotels also. This time he alleged amnesia for six months, from January to July. His wife was interviewed, and was very anxious to impress me with the genuineness of her husband's losses of memory. I was unable to accept the amnesia as being genuine, and told the prisoner so. Finally he agreed that he had been malingering, and thanked me

https://doi.org/10.1192/bjp.82.339.360 Published online by Cambridge University Press

for exposing his deceit. It will be seen that in this case there was a good deal of evidence to support a history of genuine amnesia, including that from official records, and also from the man's own wife. As to the latter, I was quite satisfied that there had been collusion. It was probably an attempt to regain a pension which had been stopped.

Schizophrenia.—Schizophrenic states in criminals seldom appear to cause any obvious defect of memory. The majority can and do give details of their crimes, though fewer can give a reason for them. Even in states of muteness it will subsequently be found that there is quite a good memory for events during the mute period. The simple primary dement, however, may show defective memory comparable to the oligophrenic—conditions between which it is at times difficult to distinguish. Similarly confusional states differ in no way from those due to other causes. Sullivan reminds us that confusional states may be ushered in by seizures comparable to epilepsy and may be interpreted as such. Recently we had a case showing such a seizure, but the evidence of a schizophrenic state was too strong for the diagnosis to be missed.

Repression.—This mental mechanism is most frequently met with in cases of serious crime.

The extent of the amnesia from repression varies; it may cover the crime only, but more frequently it extends to periods before and since that experience. When this is so the amnesia after the crime may be considerably extended. After self-inflicted injuries, such as a cut throat, a retrograde amnesia may result. Amnesia from repression has not the medico-legal importance comparable with other amnesias, for it does not relate to the accused's state of mind at the time of the crime. This is shown in the following case:

J. C. T—, male, æt. 39. Charged with cutting the throat of his child and afterwards his own. On reception he said he did not remember cutting his own throat, and that he did *not* cut his child's throat. His history showed a certain amount of depression following unemployment. The depositions revealed a statement from the accused showing that at the time of the crime he knew what he had done, and regretted it. Repeated examinations showed amnesia from repression, and retrograde expansion to cover the first crime.

Dissociation.—Of all the states producing amnesia, dissociation provides the most interesting examples in fugues, double and multiple personalities, etc. As to extraneous causes of dissociation, it has been said that a sudden and strong emotional shock may produce immediate and complete dissociation.

The following case of a fugue has been referred to in another place, but is of sufficient interest and pertinence to be related again:

It was a case of a man who was charged with being in possession of a ring, which he was reasonably suspected of having stolen. He was picked up late at night in the country, and when brought to Brixton was unable to give his name or any account of himself. When received he had no idea of his identity, but had a faint idea that he came from Cardiff. Nothing could be got out of him for two days. On the third day he was reading a newspaper in the ward when a paragraph

https://doi.org/10.1192/bjp.82.339.360 Published online by Cambridge University Press

concerning the movements of a ship attracted his attention. This paragraph stated that owing to rough weather the ship " —— " had had to put back to port, and further stated that the " —— " was the ship from which the captain had been missing for some time, and that there was still no news of his whereabouts. Our patient at once exclaimed that this was his ship and that he was the missing captain. He was interviewed, and was able to complete his story. During the last two months of the ship's voyage sickness and storms had given him great anxiety, he had been more or less continuously on duty, and the ship's officers had even had to work as ordinary seamen. He remembered docking his ship early one morning, and going ashore to telephone to his wife that he was coming home. The next thing he could remember was being on the Embankment, with a policeman's lamp shining in his face. Between these two events there was an interval of four days of which he had no memory. He had but little money in his pocket, and after walking around London started to walk home. Beyond this suspense and worry there was no history of any abnormal state. He was identified by photographs, and the ring (which formed the charge of suspicion) was found to be his own and bore his initials. This case shows the complete absence of motive, no criminal conduct while in the dissociated state, and the clear-cut beginning and termination of the amnesia.

In considering the genuineness or otherwise of an alleged amnesia, the known facts concerning the crime with the history of the accused must be balanced against the clinical findings. In this way only can truth be determined.

References.—(1) Kraepelin, *Manic-Depressive Insanity.*—(2) Hart, Bernard, *Psychopathology.* —(3) Rivers, W. H. R., *Instinct and the Unconscious.*—(4) East, W. Norwood, *Forensic Psychiatry.* —(5) Hopwood and Snell, " Amnesia in Relation to Crime ", *Journ. Ment. Sci.*, January, 1933. —(6) East, W. Norwood, " Attempted Suicides : Analysis of 1,000 Cases ", *ibid.*, July, 1913. —(7) Sullivan, W. F., *Crime and Insanity.*—(8) Baker, John, " Epilepsy and Crime ", *Journ. Ment. Sci.*, April, 1901.—(9) East, W. Norwood, " Forensic Aspects of Epilepsy ", *ibid.*, October, 1926.—(10) Muskens, J. J., *Epilepsy.*—(11) Mercier, C., *Crime and Insanity.*

https://doi.org/10.1192/bjp.82.339.360 Published online by Cambridge University Press