

Amnesia and Homicide: The Padola Case and a Study of Thirty Cases

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Historical Overview and the Padola Case

Amnesia, derived from the Greek word meaning forgetfulness,^{1,2} has come to mean a "loss or lack of memory."² The importance of this condition needs no emphasis, for it has always been associated with criminal law. St. Augustine's "*ream lingum non facit nisi mens rea*" underpins the principle of the English and most other legal systems that a forbidden act (*actus reus*) and a wicked intent (*mens rea*) are the twin cornerstones upon which rests responsibility.⁶

In the 16th century memory was recognized as a criteria for criminal responsibility. Sir Edward Coke's dicta "there must be a total deprivation of memory and understanding"⁴ established the ground rules for assessing lack of criminal responsibility. Later, Sir Matthew Hale distinguished between "frenesis" or madness,⁴ and lesser degrees of mental illness and amnesia became an important criteria in assessing criminal responsibility. The trial of Daniel McNaughten highlighted the importance of cognitive factors in insanity issues, and this emphasis has continued up until recent times. Eliciting amnesia in an offender does not, of course, solely establish a defense of insanity or reduce criminal responsibility. The simple forgetting of an act does not imply that it was committed in a state of altered consciousness, that is automatism, although it may be difficult to differentiate such cases from those with 'psychogenic' amnesia. Such was the issue in English criminal law, in the case of Guenther Padola, where the defense attempted to establish that the accused was unfit to plead on the grounds that he was unable to instruct his counsel due to amnesia for the whole of his past life.¹¹

In reviewing this case, the authors were struck by the arguments raised at trial as to what constitutes hysterical and malingered amnesia, and a review of these aspects of the case was felt to be warranted. On July 13, 1959,

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Guenter Fritz Padola shot and killed Detective Sgt. Raymond Purdy. Purdy was shot in the hall of a South Kensington apartment block while inquiring into a woman's complaint about threatening phone calls and blackmail. Padola was arrested on July 16, 1959, at 3:45 p.m. He had two previous convictions for breaking and entering and was a prime suspect in the blackmail and Purdy's murder. The police traced him to a hotel in Queensgate, London. The door of the room was shut, and the police attempted to break it in. The police heard a faint metallic click inside and thought it was a gun being loaded. They rammed the door just as Padola opened it, and without the lock being broken, it flung inwards and hit Padola's face. He staggered back, fell over a chair, and ended face up on the floor. The policeman did not check his rush and landed on top of him. Padola initially struggled and then went limp. A cut over his eye started to bleed. His nose was bathed and he appeared to respond. At 4:15 p.m. he had sufficiently recovered to be taken to the Chelsea Police Station. He went to sleep at approximately 5:45 p.m. and remained asleep until 11:00 p.m. He was admitted to St. Stephen's Hospital the following morning, July 17, 1959. During the next day he remained mute, muttering only such monosyllables as "toilet" and "smoke." He consumed only water. On July 18, 1959, he was engaged in a difficult jigsaw puzzle and playing chess.^{5,6}

He remained in hospital between July 17th and July 20, 1959. The physicians' description was that he was stuporose but able to obey simple commands after some delay. A physical examination and skull x-ray were normal. Examination of the cerebro-spinal fluid showed a slight increase in globulin and 450 RBC's. A diagnosis of post-concussional syndrome and cerebral contusion was made. On the morning of July 20, 1959, he was diagnosed as suffering from a severe retrograde amnesia.⁷

Padola came to trial in September, 1959, represented by Mr. F. H. Lawson, Q.C., who raised the issue of fitness to plead on the grounds that Padola had lost his memory for all events prior to July 17, 1959 and was not able to instruct his defense counsel. This retrograde amnesia persisted throughout his trial and raised an issue not previously heard in the English Court.

Medical and psychiatric evidence presented supported the amnesia as genuine and the result of a cerebral contusion and concussion. Evidence whether or not the amnesia was hysterical dissociation or malingered was also discussed and formed the focal point of his trial.⁸

Arguments for an organic basis for Padola's amnesia were dismissed as unlikely fairly early. Evidence then pivoted on whether Padola's amnesia was hysterical or malingered, and the physicians implied that a clinical distinction between the conditions could be made.

Padola's memory suddenly returned following a lumbar puncture within 72 hours of arrest, but several hours later diminished in capacity. The following morning his memory completely returned and was continuous from then on. He described a "patchy" type of amnesia from the time of arrest and remembered possibly being in a police station and hearing a weak remark "I am your friend, say it went off accidentally." His "patchy amnesia" was viewed by the defense as genuine in contrast to malingering, where a full and complete blackout with complete recovery following the

lumbar puncture would be the expected clinical pattern. Prior to the lumbar puncture he felt persecuted by the police, and this fear, coupled with concussion, raised the defense of a hysterical dissociation.⁵ He persisted with a severe retrograde amnesia for all events prior to his arrest on July 17, 1959.

In rebuttal evidence, psychiatrists for the Crown emphasized the absence of other signs of hysteria, including *la belle indifférence* and conversion symptoms, the presence of rapid breathing and other emotional accompaniments during the interviews, and the retention of a rudimentary knowledge of aerodynamics and other skills. They, the Crown's experts, argued that Padola's amnesia was malingered.

The issue of Padola's fitness to plead and proceed with trial were debated by the jury for three hours and twenty-three minutes. They decided that Padola was fit. He was subsequently found guilty of murder and sentenced to death.

Amnesia in relation to crime, and particularly capital crime, is problematical. As with all other clinical entities, amnesia exists on a continuum ranging from psychogenic amnesia to organic amnesia. In practice there is an attempt to align this range to legal expectations in such a way that only the opposite ends of the continuum are recognized, to the exclusion of the in-between grey area. In legal terms, amnesia is "genuine" if it is organic, but is not accepted if "psychogenic." This may be reconciled with the possible fear that acceptability of "psychogenic" amnesia could provide offenders with a ready-made defense.

In clinical practice it is often difficult to distinguish between hysterical and malingered amnesia, and the difference is now being accepted as possibly one of degree rather than one of kind.¹¹ Hysterical and malingered amnesia are seen as 'psychogenic.'

TABLE I
COMPONENTS OF MEMORY

Stages of Remembering	Features
1. Reception	The process where information is received by the five senses.
2. Registration	Is dependent on the level of attention of the organism. It can fail or be defective if there is a disturbance of consciousness. It can be facilitated by alerting the organism to the process of remembering.
3. Retention	Is dependent on laying down a permanent memory trace -- theoretically an engram or other form of imprinting. It is affected by organic brain disease.
4. Recall	Includes ability to time-sequence past experience and to recognize past experience and objects.

Amnesia may occur as a result of a failure in any of the stages of remembering. The process of remembering leading to memory is usually described as consisting of a number of stages that are summarized in Table 1. The utilization of the categories in clinically evaluating the cause of amnesia is of prime medico-legal importance. Failure of reception is usually the easiest to detect. Failure of registration usually results from conditions

causing disturbance of consciousness, examples being drug or alcohol intoxication, head injury, and epileptic phenomena, including automatism. It may also occur when attention is focused on a particular object or event with failure to register peripheral objects or experiences. Subtle defects of attention may also be associated with major psychoses. Failures of retention typically reflect organicity and are usually found among the chronic organic brain syndromes. Failure of recall is more complex and appears to be voluntary in nature. It results in psychogenic amnesia, either hysterical or malingered in type.

The medico-legal issue of hysterical versus malingered amnesia that was raised in the Padola case, the other important issue as to whether it constituted incompetence to stand trial, and the scarcity of published clinical data on this subject, lead the authors to this study.

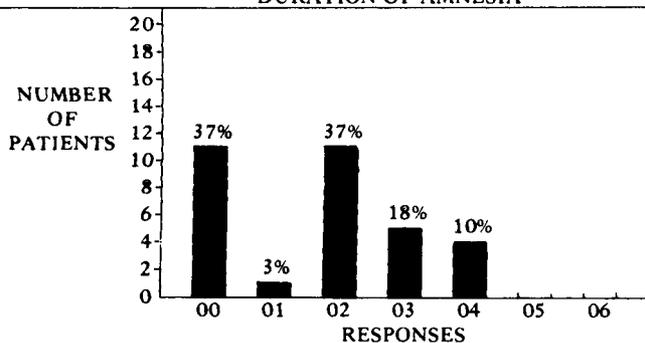
Subjects

The case histories of thirty consecutive homicides referred to the authors' Department of Forensic Psychiatry over a two and one-half year period were studied. A retrospective analysis of hospital charts and direct consultations with professional colleagues who had managed the cases were obtained. Demographic and epidemiological characteristics are the subject of another paper reported elsewhere.²⁵

The duration, characteristics, and recovery as well as factors possibly causing failure of registration or retention were studied. Amnesia was clinically classified and the results of sodium amytal interviews, polygraph examination, and the electroencephalogram were reviewed. The mean I.Q.'s and MMPI profiles from the sample were obtained but are not reported here.

Results

GRAPH NO. 1
DURATION OF AMNESIA

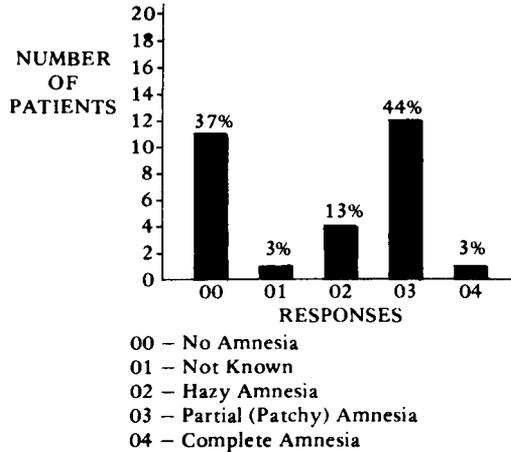


- 00 - No Amnesia
- 01 - Not Known
- 02 - Amnesia for crime only (less than 30 minutes)
- 03 - Amnesia for crime and period of 30 minutes to 6 hours
- 04 - Amnesia for crime and period of 6 hours to 24 hours
- 05 - Amnesia for crime and period greater than 24 hours
- 06 - Amnesia for crime and whole of past life

(1) Duration of amnesia: Eleven (37%) of cases showed no amnesia in relation to their crime and in one case (3%) we were unable to establish whether amnesia had been present. Eighteen (60%) showed amnesia of less

than twenty-four hours duration. Eleven (37%) reported amnesia of less than thirty minutes surrounding the alleged offense.

GRAPH NO. 2
CHARACTERISTICS OF AMNESIA



(2) Characteristics of amnesia: Attempts were made to grade amnesia according to the characteristics described by the accused.

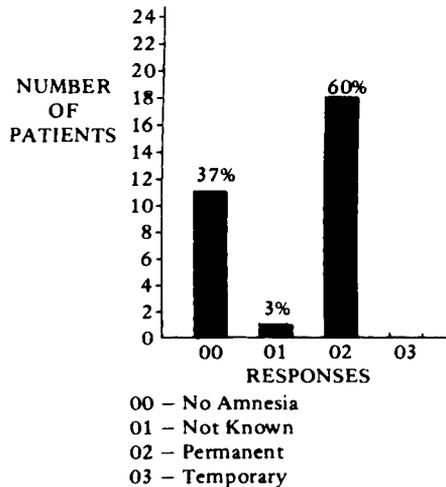
“Hazy amnesia”: No absolute amnesia either in circumscribed periods or in one complete period.

“Partial (patchy) amnesia”: Islands of memory loss with no complete period of amnesia.

“Complete amnesia”: Total memory loss for one circumscribed period.

Thirteen (44%) had a partial “patchy” amnesia for the time of the alleged offense. Only one (3%) had a complete memory blackout. Four (13%) had a hazy type of amnesia.

GRAPH NO. 3
RECOVERY OF AMNESIA

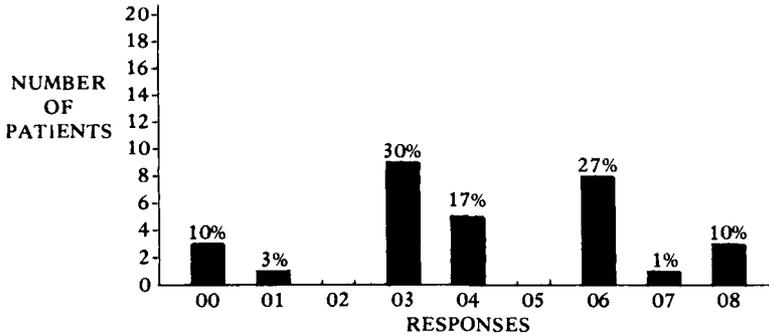


(3) Recovery of Amnesia: Attempts were made to establish improvement in amnesia during psychiatric evaluation.

“Permanent”: Amnesia that remained the same in duration and characteristics.

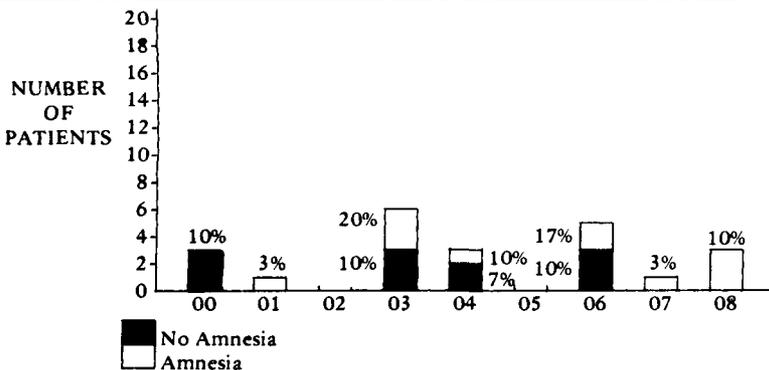
“Temporary”: Amnesia that altered in duration or characteristics, *i.e.*, duration became less or changed in characteristics, *e.g.*, alteration from complete to partial amnesia. Sixty per cent had a permanent amnesia with none showing temporary amnesia.

GRAPH NO. 4 (1)
VARIOUS FACTORS AT TIME OF CRIME THAT COULD RESULT IN AMNESIA
DUE TO A FAILURE OF REGISTRATION



- 00 – Nil
- 01 – Not Known
- 02 – Epilepsy
- 03 – Alcohol Intoxication
- 04 – Drug Intoxication
- 05 – Head Injury
- 06 – High Emotion (rage, sexual arousal)
- 07 – Hysterical Dissociation (fugue)
- 08 – Other (awaking from sleep (2), postpartum period (1))

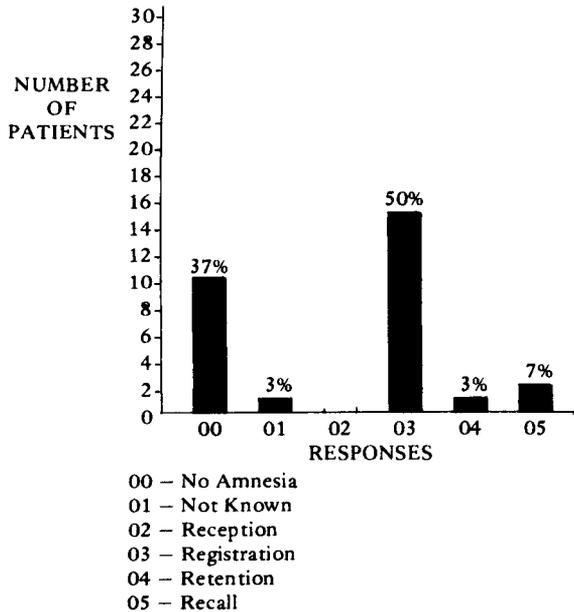
GRAPH NO. 4 (2)
PATIENTS WITH AMNESIA VS. THOSE WITHOUT
(SAME FACTORS)



(4) Failure of Registration: Alcohol and drug intoxications, or high emotional states, *e.g.*, rage and sexual arousal, were found in twenty-two (74%) of cases, the proportions being alcohol intoxication nine (30%), drug intoxication five (17%), high emotion eight (27%). Among these cases those

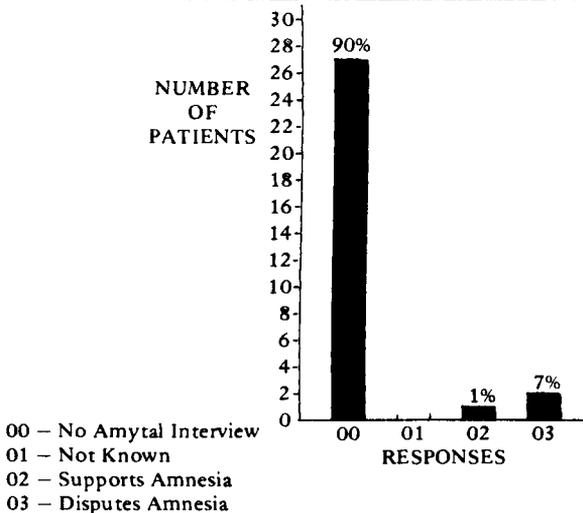
without amnesia but with alcohol intoxication were three (10%) of the total sample, drug intoxications were two cases (7%) of the total sample, and three (10%) of the total sample were high emotion.

GRAPH NO. 5
CLINICAL CLASSIFICATION OF AMNESIA DUE TO A FAILURE OF RECEPTION, REGISTRATION, RETENTION, RECALL



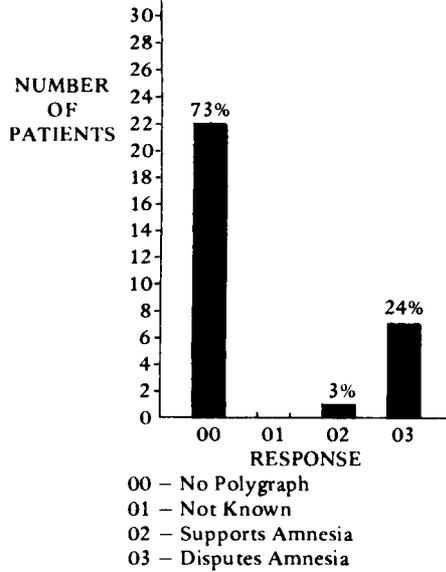
(5) Clinical Classification of Amnesia: Fifteen (50%) of cases were classified as due to a failure of registration, and two (7%) exhibited failure of recall. One (3%) showed failure of retention.

GRAPH NO. 6
SODIUM AMYTAL INTERVIEW CONDUCTED AS PART OF FORENSIC PSYCHIATRIC ASSESSMENT



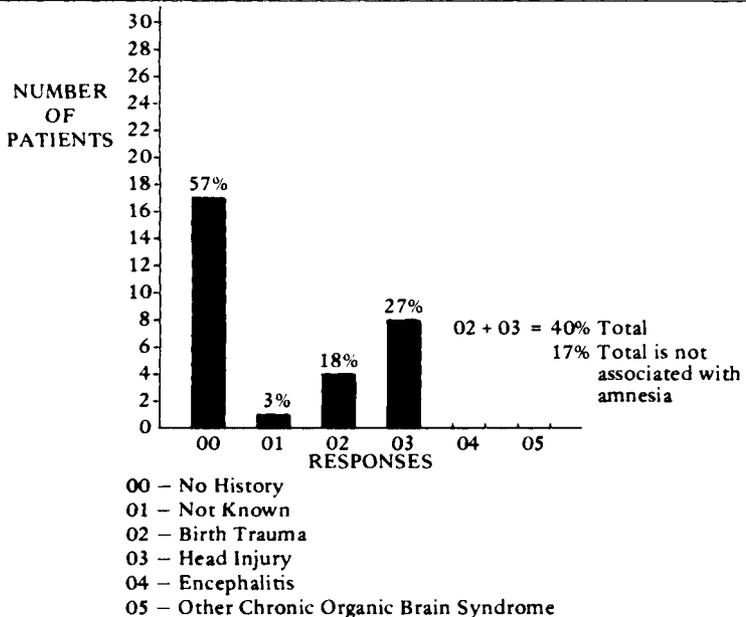
(6) Sodium Amytal Interview: Three (10%) of patients underwent amytal interviews.

GRAPH NO. 7
POLYGRAPH AS PART OF FORENSIC PSYCHIATRIC ASSESSMENT



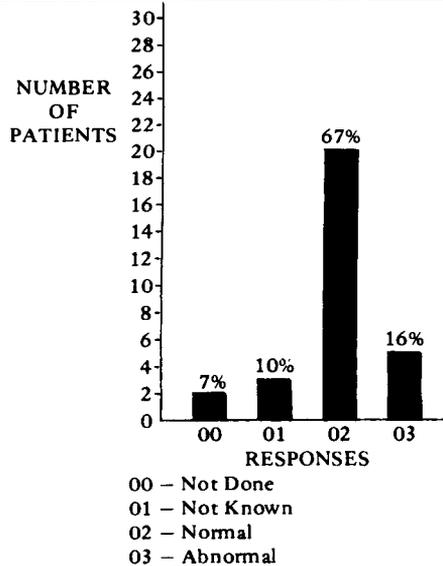
(7) Polygraph Examination and Psychological Stress Evaluation: Eight (27%) undertook the polygraph. In seven (24%) of the total sample, the polygraph result disputed the presence of amnesia. In one (3%) of the cases the polygraph supported amnesia.²⁶

GRAPH NO. 8
PAST HISTORY OF FACTORS THAT COULD CAUSE A FAILURE OF RETENTION



(8) Birth trauma and blunt head injury: A history of birth trauma and blunt head injury was obtained in four (13%) and eight (27%) of cases respectively. In 17% of the cases it was not associated with amnesia.

GRAPH NO. 9
THE ELECTROENCEPHALOGRAM



(9) The Electroencephalogram: This was accepted as being abnormal only if there was a clear and consistent abnormality. Five (16%) had an abnormal EEG. In twenty-one (67%) of cases the EEG was normal.

Discussion: Clinical Aspects

The Padola case was a landmark, for amnesia as a bar to trial had not previously been tested in the English courts. The jury took under consideration two questions: first, whether Padola's amnesia was genuine, and second, if so, whether it justified a finding of unfitness to plead. By finding his amnesia not genuine, the jury avoided the issue of competence to plead. However, notwithstanding Padola's amnesia, it is clear in retrospect that Padola was competent, for his amnesia occurred as a result of an incident after the crime and there was no permanent cerebral damage, as a result. It is interesting that portions of the medical evidence supporting the genuineness of the amnesia were well-founded, while in contrast the opposing evidence, by current clinical standards, would be considered ill-founded.

Following his arrest, Padola appeared to exhibit a genuine disturbance in consciousness consistent with severe concussion. A retrograde amnesia then appeared, caused by an organic brain syndrome, hysterical dissociation or malingering. Padola's amnesia, which spanned his previous life, and the absence of other manifestations of conversion hysteria such as la belle indifference, were given as factors against a hysterical dissociative amnesia and in support of malingering. Such arguments are ill-founded and indeed misleading, for in practice it may be very difficult, if not impossible, to

distinguish between hysterical dissociative and malingered amnesia. This issue has been studied¹⁰; among a sample of 350 admissions to St. George's Hospital in the United Kingdom, twelve patients demonstrated a persistent functional amnesia spanning their past lives. The longest duration of amnesia was approximately five weeks, a similar finding to that in the Padola case. One-third had recently committed crimes and three-quarters had displayed *la belle indifférence*. In reviewing emergency department patients with functional amnesia, one-fifth had amnesia for their past life. In two-thirds a "bang on the head" precipitated the onset of amnesia. *La belle indifférence* was noted in nearly one-half the sample of cases, but other conversion symptoms were rare. These findings are in contrast to the psychiatric evidence cited in Padola's case. Despite this, it is impractical (at the clinical level) to demarcate hysterical from malingered amnesia. Rather, these conditions are part of a continuum. Such a severe retrograde amnesia following a minor head injury like Padola's was unlikely to be of organic etiology.

Similarly, in studies conducted during the last World War,¹⁴ one-sixth of a large sample of hospitalized patients displayed hysterical amnesia, and one-third of males with psychogenic amnesia were clearly malingering. Many cases of hysterical amnesia are associated with a high incidence of personality disorder,¹⁶ usually hysterical in type.¹⁴

In the present study, nearly two-thirds of the patients (60%) claim some form of amnesia. Although the claim is slightly more frequent than in other studies,¹⁷ this figure supports the findings of other authors who quote the incidence of amnesia as ranging from 40-70%.^{18,19,20,21} It appears therefore that amnesia of varying degrees is associated with homicide, and the study confirms previous findings linking amnesia to homicide. Also, the duration of amnesia appears relevant to the dilemma in distinguishing the type of amnesia, whether hysterical or whether with an organic component. Over one-third (37%) exhibited partial "patchy" amnesia related to the offense with a duration of less than thirty minutes. The amnesia was usually of sudden onset and cessation and appears therefore to be a state of hysterical dissociation or psychogenic amnesia. The study made no attempt to try to differentiate malingered from hysterical amnesia, for the dissociative state covers both possibilities. Twenty-four per cent or one-quarter of the total sample exhibited amnesia ranging from thirty minutes to twenty-four hours, and the longer duration of amnesia is not directly related to the offense and argues against psychogenic amnesia. It suggests instead the stronger likelihood of an organic etiology. Although hysterical amnesia and fugue states, common at times of stress, can be of lengthy duration, there was only one case suggestive of a fugue.

It may be concluded from these findings that amnesia of thirty minutes' duration or less, circumscribed to the offense, is most likely malingered or hysterical, with longer durations being more clearly related to hysteria in the form of a fugue or organic factors.

The characteristics of amnesia from this study were those of the partial or "patchy" type. This is at variance with previous clinical criteria raised, claiming distinguishing features of various types of amnesia. Hopwood and Schnell¹⁵ claim that complete amnesia and sudden clearing are suggestive of feigned or

malingered amnesia. Others¹⁹ mention that most of their patients who were not malingerers had a patchy amnesia regarded by others^{15,19} as being organic in nature. Most patients in our study with memory loss of less than thirty minutes in duration, directly related to the crime, were of psychogenic dissociative amnesia, characterized by patchiness. Therefore, "patchy" amnesia is not necessarily caused by organic factors.

Previous authors¹⁵ claim that highly emotionally charged events, such as homicide, are very likely to be remembered. When amnesia occurs in association with a high emotional state, it is concluded that malingering is present. An alternative interpretation would be that a hysterical mechanism is operative and events associated with high emotion are not recalled because of repression. This would support our finding of patchy amnesia of short duration and of a psychogenic origin in relation to the homicide.

Of importance from a clinical perspective is a method of distinguishing between psychogenic and organic amnesias. Repeated psychiatric examination noting whether there has been recovery from amnesia is helpful. Such recovery signifies a failure of recall and not registration, the former supporting a psychogenic amnesia. Previous studies suggest that an organic amnesia is associated with either a complete memory loss or a patchy amnesia due to a failure of registration. Our findings are somewhat at variance with this suggestion, for as already outlined, based on the duration of amnesia (that is, less than thirty minutes), most of our cases were psychogenic. However, the characteristics of patchiness and permanency were in favor of the amnesia's being organic in etiology. In practice, organic and psychogenic factors are inter-related, and so there is some failure of registration as well as recall. Factors possibly associated with failures of registration – alcohol intoxication, drug addiction, high emotion, fugue, etc. – emerged in the study sample. These were present in amnesia cases, but were also found in some cases with no evidence of amnesia. This supports a merging of psychogenic and organic amnesia with a large grey area in between.

Other possibilities of differentiating psychogenic and organic amnesias focus upon the management of the patient. Techniques of repeated psychiatric examination, hypnosis and suggestion, drug abreaction and polygraph examination were used in our study. Repeated psychiatric examination with development of a relationship may encourage and stimulate recall and dissipate psychogenic amnesia. Inconsistencies and other characteristics of malingering may also be rated. Similarly, hypnosis and suggestion are useful techniques when in the presence of hysteria. The authors have, at times, been mildly suggestive and found that this was often sufficient to terminate the amnesia, *i.e.*, hysterical dissociative or malingered amnesia.

Drug abreaction may also be useful, through the mechanism of suggestion, the authors preferring intravenous sodium amytal or Diazepam rather than barbiturates with methedrine. Amytal results in disinhibition and relaxation, thus allowing freer communication. Suggestion and encouraging the recall of memory is helpful. Polygraphy, utilizing a multi-channel model and including voice tremor analysis, is currently an investigative technique described in detail elsewhere.²⁶ It has been our experience that it acts as a

catalyst to full recovery of memory. It is possible that polygraphy may play a useful role in differentiating organic from psychogenic amnesia. It is our view that such techniques when combined with comprehensive psychiatric examination will enhance the clinician's ability to distinguish the different forms of amnesia, so enabling us to more clearly distinguish automatism as an entity in forensic psychiatry.

Discussion: Medico-Legal Aspects

A dearth of literature surrounds the Padola case.^{5,6,7,8,9,10,11} Although Padola's amnesia occurred after the homicide and clearly was not related to his mental state at the time of the homicide, the issues emerging from this case have obstructed, in the authors' view, fruitful, resourceful discussion into the relationship between amnesia and crime among psychiatrists and lawyers alike. This has resulted in a fear that amnesia might provide a "ready-made" defense to all criminals.

The present authors are of the view that amnesia and homicide are closely related phenomena. Most cases appear on a continuum, with some cases encompassing psychogenic amnesia and others due to mixed psychogenic and organic causes, and less frequently automatisms, the results of an organic etiology. Amnesia appears to be a factor in all true cases of automatism ranging from fully developed automatic behavior, in which the individual is entirely unconscious of his actions, to partial automatism, where consciousness fluctuates. The continuum principle so fundamental to biology appears unacceptable to our legal colleagues and results in psychiatry being criticized as inconsistent and inexact. There is reluctance, for example, to accept abstract topics such as consciousness. The law regards an individual as being either conscious or unconscious. By way of contrast, psychiatry provides a range of consciousness ranging from fully conscious, clouding of consciousness, delirium, sub-acute delirium (confusional states), to stupor and coma or total unconsciousness.²²

In Canada, automatism is arbitrarily legally divided into insane and non-insane automatism.²³ This is clearly a muddled and complex dichotomy which in practice results in confusing psychiatric testimony. "Psychological blow" automatism, for example, is legally regarded as one of the non-insane automatisms. This categorization presents an enigma for the psychiatric witness, since a psychogenic amnesia may be raised as a defense. Defined as "emotional stress in the absence of other physical factors such as illness or external force, it produces what psychiatry terms a psychogenic form of automatism."²⁴ The emotional distress must be sudden and severe. From a medico-legal point of view the authors can envisage situations where a case of dissociative (psychogenic) amnesia with homicide might be interpreted as "psychological blow" automatism, allowing an acquittal of the accused. According to our study, the amnesia would most likely be psychogenic, either of hysterical or malingered origin.

Similar arguments apply when the partial defenses, such as "lack of specific intent," are raised. In other countries, but not in Canada, there is "diminished responsibility."

The future credibility of forensic psychiatry and the true carriage of justice in Canada is dependent on eliminating such inconsistencies. We

strongly hope that if clinical issues such as amnesia are linked to specific crimes such as homicide, there may be improvement in credibility of psychiatric testimony.

Acknowledgement

I would like to thank Dr. Desmond Curran for his assistance in the composition of this article and to acknowledge the late Dr. P. D. Scott for his encouragement in the past.

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