

1954

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### Recommended Citation

Lewis J. Siegal, *Inability to Remember--Its Analysis in Medicolegal Orientation*, 45 J. Crim. L. Criminology & Police Sci. 151 (1954-1955)

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## INABILITY TO REMEMBER—ITS ANALYSIS IN MEDICOLEGAL ORIENTATION

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Failure to retain in one's memory, or proneness to let go from one's mind something once known or learned, usually implies an inclination not to remember a case of heedlessness or thoughtlessness. Or it may signify a defective ability to remember. Forgetting may be due to want of recall founded upon conditions beyond the individual's control, or deliberately putting something out of mind, as when it is considered too trivial to remember.

The ability to recollect or to remember is the ability to retain and to reproduce images or impressions, and the want of recollection of a fact which, by due attention, might have been remembered, cannot, in law be a reasonable ground for a new trial. This is because want of recollection may be pretended and may be difficult to refute by the introduction of proof as to its unreasonableness or untruth. In a legal proceeding where one's memory becomes of factual importance to a judicial determination, retentiveness may be inquired into for a two-fold purpose: 1.) to indicate the capacity of the individual's understanding; 2.) to evaluate the power of recollection.

It is here that medical jurisprudence applies the principles and practice of medical science to make clear and to assist in the settlement of obscure questions, which frequently arise in courts of law. Among some of the situations met, are: deception, as in the feigning of disease, or where disqualifying diseases which indicate mental illness, are in issue.

When the neuropsychiatrist is called upon in medicolegal and in other settings to explain the many-sided states of lack or loss of memory, to determine whether the particular entity is constitutional or psychic in nature, and to determine the results flowing therefrom, he should begin every investigation of any state of memory loss with a complete neurological work-up in order to establish the presence, extent, or absence of structural or toxic changes in the brain centers. Of equal importance is an all-inclusive study directed toward a disclosure of the constitutional character of the person's mental assets prior to his memory loss, together with an appraisal of his present mental soundness.

From the standpoint of cause, memory derangement may follow physical or chemical damage to brain cells, or it may present itself in a neurotic individual—without his conscious direction, as a defense pattern. This latter acting-out con,

stitutes an effort to hide the truth from himself and is effected in order to reach a feeling of mental satisfaction, even though this may undo his ability to be tolerated within his own environment, or may even reach to the full extent of personality impairment.

The reception, preservation, and presentation to consciousness of previously obtained mental impressions is the domain of memory. It serves to enable the person to make an advantageous adaptation to his environment, and its operations are constantly but not awarably drawn upon to achieve combined mental and physical adjustment to external activities. It is on the basis of the mental material presented, therefore, that the neuropsychiatrist is called upon for total determination of existing memory dysfunction and the condition it identifies.

The neurotic individual's memory lapse which often is regained abruptly, is based upon the advantage he derives from selecting the situations which he wishes to blot out from his awareness. These situations, as emotional conflicts, may bear upon guilt, shame, or feelings of inferiority or insecurity. Being productive of psychological anguish the memory of such situational material acts as a threat to his sense of safety and self-esteem. When such thought associations are repressed by being driven below the limit of awareness, they are temporarily blotted out from remembrance. It is by this operation of expulsion of the agonizing experience from memory that it becomes part of the individual's mental material not available in the immediate field of awareness. Return of the unbearable emotional sensibility is thus prevented and mental solidity is maintained.

An individual whose illness is due to structural or organ defect will regain his memory by degrees, if it returns at all, or his condition will frequently end in complete memory deterioration depending upon the extent of the brain damage, as well as upon the site and/or extent of the injury within the brain substance.

The incomplete and random types of memory loss found in dementia paralytica (a disease which is the result of antecedent syphilitic infection), and also found in the senile psychoses, have their origin in organic alterations of the outer or top layer of the brain with destruction of its nerve cells. Here the quality of the memory loss is characterized by inability to remember persons previously known or their names. The same is true in respect of non-personal matters, such as the misplacing of objects and forgetting about them, or the inability to recall recent happenings of whatsoever nature.

Where the loss of memory is for definite or specific events of a particular period, it may be due to brain cell damage or may originate on the basis of psychological factors alone. I have often observed appropriate examples of this type of memory loss in my varied services past and present, within environs of the hospital bedside and in outpatient psychiatric clinics. I have met them in examinations and observations of veteran patients of both World, and Spanish Wars during my former years of neuropsychiatric service in the Veterans Administration, as well as in consultative interviews of delinquents and offenders in various criminal courts. These are usually aftermaths of unsuccessful attempts at suicide by the taking of an overdose of a drug, consequent upon epileptic convulsive attack; they may take place after electric shock treatment for nervous and mental conditions, or may follow fainting spells.

In the mentally degenerated individual whose condition is caused by brain cell damage, intelligence and cognition are the first to go and as the condition advances impairment of memory follows. Memory loss here is due to the subject's inability to bring his formerly experienced events together with present-time situations. The clinical distinguishing features of memory loss in persons found suffering from degenerative mental changes such as syphilitic dementias, arteriosclerosis of the brain, tumors of the brain, brains poisoned by virus, drugs, or infective microorganisms; and conditions which complicate nutritional deficiencies, also, such as beri beri (which, as a vitamin B1 deficiency, afflicted our imprisoned soldiers in the Pacific during World War II), or are likely to occur following head injuries or in persons afflicted with epileptic seizures—these have all intrigued me because of the forward movement and extent of the memory loss. At first, recollection fades and as the brain destruction worsens, the ability to recall past happenings also vanishes. Inasmuch as an understanding of any recognizable factual matter can be effected only through the connection of ideas with the subject of thought, any widespread memory destruction due to brain damage produces the further interrelated inability to locate oneself within one's own environment in respect of time and place, with resultant lack of capacity to correctly fix time, present location, or one's individuality.

The memory loss, suffered by one who has received a head injury, when the blow was followed by a period of unconsciousness irrespective of length of time, may be divided into two groups: 1) The patient cannot remember the occurrence of the injury nor the time of its happening, and in most instances also shows memory loss covering a variable period *before* the accident took place. Memory loss for the period just described *can never be regained* once unconsciousness had taken place. This want of recall is termed *retrograde amnesia*. 2) If, when consciousness returns after a head injury, the individual appears bewildered and confused, memory for this clouded period also becomes lost. Such blotting out of recollection is identified as *anterograde* or *post-traumatic* amnesia. I have frequently observed that during their hospitalization, patients suffering from head injuries of varying severity, demonstrate a series of symptoms which comprise inability to locate oneself within the sphere of place or time, and show memory loss for recent happenings, as well as for happenings preceding the injury, and, at times, also confabulate. The latter symptom consists of making ready answers and reciting experiences without regard to truth. As pure and inconsistent fabrications, they are employed by the individual to fill in memory gaps, which are in reality defensive falsehoods used as an avoidance of acknowledgment of memory defect. This pattern known as the amnesic-confabulatory syndrome is also called Kossakoff's syndrome.

Another type of memory loss bearing Kossakoff's name is the memory defect found in chronic long range alcoholics. They forget occurrences which may have taken place even a few minutes before the happening, such as identifying persons before them, or associating their own relation to their environment. To cover their memory gaps, these sufferers attempt to fill them in by pseudo-memories and glibly confabulate and recite fabricated imaginary accounts of their activities. This is a psychotic disorder wherein memory disorganization is the result of alcoholic brain damage, and is recognized under the term of Korsakoff's psychosis.

Now, to describe the class of individual who is suffering from anxiety neurosis: He tries to cope with his situation, and may, if the condition is severe enough, have memory loss to the extent of being unable to identify himself by name, or to account for his presence in a new environment, or identify the place wherein he finds himself. When totally overcome emotionally, because of his state of hysterical dissociation, he may lose memory both as to his own identity and as to past experiences. This is an escape which, without awareness on his part, serves as a solution to his difficulties and cushions his disturbed state by blotting out memories of situations of horror, unrequited love, embarrassment, or similar unbearable conditions. Another type of forgetting situation is met with in the peculiar state of mental flight where a memory gap may last for months and months. This state of amnesia is a type of hysteria where conscious activity is restricted, where no thought is given to the manner of action or its consequences, and where all that can be found is the individual's drive to achieve escape from a harrowing situation. Although such a person frequently knows who he is, he is unable to explain or to remember how he got to the strange place wherein he finds himself, and equally cannot remember wandering away from his usual locality. This condition is known as a *fugue or flight state*. A second and even more odd form of fugue or flight memory gap is one, not often met with, in the hysterical individual who shows a dual personality. This behavior pattern is characterized by a mutual exclusiveness of his individuality because of his inability to recall during one personality cycle what had happened during the other. From the psychological viewpoint, such person is unable to make a choice between several conflicting behavioral goals, and in this frustrating situation he takes on the more tolerable personality, while the opposing one is kept in suppression. Thus the curbed material, which originally appeared as being against the patient's mental and emotional inclinations, has found enough systematic correlation to establish a supplementary and other independent self. Axiomatically, the condition may be psychologically expressed as a double mind working to contrary purposes—the Jekyll and Hyde personality.

The topic of malingering will now be discussed because of its importance as a factor which often complicates the various facets of litigation. It is met with during examinations before trial, physical examinations before trial, and during actual trial testimony, in both their criminal and civil aspects.

Malingering has been included in this discussion primarily because it is frequently mistaken for hysteria and has often been so treated medically. It therefore merits coverage here to round out results stemming from the hysterias or mistaken hysterias, to say nothing of its importance to which I have already referred.

In considering predisposing causes for malingering our first attention is directed to the subject's feeling of a state of insecurity, defeat, perplexity, or bewilderment within his own surroundings. As to the more immediate or exciting causes, among the most usual, we find, desire for financial advantage, escape from disagreeable tasks, dread of punishment, or of bodily injury or of loss of life, or fear of exposure to financial or social ruin.

The malingerer, whose condition I consider a character disorder type with a sociopathic or abnormal personality, will imitate an illness or injury, or if he happens to suffer from any kind of mild symptoms he will magnify them beyond truth or

medical reason therefor, thereby to establish a disabling incapacity; or, he may impute causality of his bodily disorder to the acts of another for the express purpose of tacking responsibility on to some guiltless one whom he has picked out as the scapegoat.

The malingerer's motive for his activity is a designed wish to produce symptoms in order to deceive, with no desire to free himself of them. He shows an obvious fear of being examined and his reaction to answering questions is one of caution, combined with mistrust and elusiveness.

On the basis of the above criteria it is of probative value during examination, to carefully observe this class of personality, by directing him, (while he is unaware, and his attention is drawn elsewhere), to carry out an unanticipated act which employs the bodily part that is claimed by him to be incapacitated. Such a person may be subjected to a sudden distraction, also, by some startling or alarming utterance or sound, which will unwittingly cause him to make use of his supposedly immobile body or some pretendedly implicated part thereof during this moment of stress. It is well to note here, that when under close medical scrutiny for some definite period, these persons will invariably give themselves away by not continuing their symptoms when they believe they are no longer observed. Equally so, while caught off guard, the malingerer will unwarily reveal minor contemporaneous incidents, such as had taken place with, or during the particular situation of which he had alleged to have no memory. When the perilous situation sufficiently overwhelms him, the malingerer will go all out to carry through his acts of forgetfulness anticipatory to possible avoidance of cruel or threatening consequences. Inasmuch as the malingerer wishes to blot these feared memories out of his mind, he may, in certain menacing situations, even precipitately present loss of memory for his personal identity.

Differentially, the malingerer usually shows considerable concern about his symptoms, while the hysterical individual shows very little interest in his ailments. Further differentiating between true and feigned inability to remember, a sudden return of memory is strongly indicative of malingering. A further point to bear in mind is that the hysteric wants to be repeatedly examined, and does not give way to contradictions, while the malingerer indulges in discrepancies, exaggeration and simulation of symptoms, and contradictory allegations. Most of all, he both fears and resents medical examinations.

#### SUMMARY

We have analyzed the mental operation of inability to remember; the psychological and psychopathological forces which precipitate it; the compensatory and defensive acting-out which is created; memory dysfunction associated with structural brain impairment, and the extent to which this memory defect is reflective of constitutional factors. We have seen how loss of memory is associated with other bodily disturbances, or with social personality factors. Through the latter orientation we are in the position of formulating a comprehensive conception of an individual's mental and physical capacity—or rather incapacity—responsible for the inability to remember. The amnesias induced by psychoneuroses as well as those resulting from injuries have been distinguished, some representative varieties of their patterns have been

recounted, and their qualitative influences indicated. To recapitulate further, states of memory loss, as psychological phenomena not due to organ defect, are expressions or reactions of persons exposed to difficult and stressful situations. The symptoms may be reflective of psychological exposure to peril or of threat to physical or psychic integrity, or indicative of rejection from the consciousness of objectionable memories, feelings or impulses.

When not complicated by disease of the organs, the mechanism of forgetting is indicative of a significant correlation between the memory loss and the ominous situation which the person is endeavoring to avoid by way of his display of absent memory. This, in order to enable him to carry on within certain of his spheres of activity and to retain at least some measure of capability and self-esteem.

The need for analysis and interpretation of his distress symbol cannot be overestimated when considered in its contextual relation to the great number of psychoneurotic and psychophysical disorders stemming from disappointments, vacillation, tensions generated by opposing desires, unpleasant situations and ruminations over past conduct.

As to the malingering mechanism, to quote from the Russian psychiatrist Ossipov: "every malingerer is really an unstable person . . . who by imitating a psychosis merely accentuates his own latent tendencies. . . ."

Based upon case studies from the author's personal files, consultative interviews from psychiatric services of voluntary hospitals, Veterans Administration, the various courts of criminal jurisdiction, and in other situations all investigated in their respective settings, the salient features of the diverse patterns and relative extent of the amnesias have been presented in an effort to clarify the essential nature of the differentials existing in the various disorders of memory function.

The inability to remember, as a mental deviation, is frequently put forward as a defense to a criminal offense. As such defensive instrument it is often advanced when there exists no obvious basis for a conclusion that the accused is afflicted with memory loss. Nevertheless, circumstances present themselves particularly in homicidal situations, where the latter deeds have been carried out during a break-down of one's faculty of awareness, or where the aggressor's memory of the criminal act has become blotted out after its occurrence.

Manifestly therefore, from the standpoint of legal medicine, the scientific recognition and discriminative separation of actual from feigned loss of memory, becomes a matter of paramount juridical consequence in the prosecution of the matter at bar and in the statutory disposition of the individual charged with the criminal offense.

The physician's sole concern in his approach, observation, and study of the person charged with criminality, is the application of methodological scientific conclusions, and findings based upon a trained attitude of objectivity, and without entry into the feelings of the subject under neuropsychiatric scrutiny or commiseration with him.

In this area, as in many others, forensic medicine in general and forensic psychiatry in particular, can afford aid to the prosecution, bench, bar, and those who claim its benefits; and attorneys who strive to maintain the system of law on a plane of pre-eminence and to keep it abreast of scientific knowledge, will be the first to accept with favor and acknowledge with gratification the aid thus received.