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Unreliable admissions to homicide

A case of misdiagnosis of amnesia and misuse of abreaction technique

GISLI H. GUDJONSSON, MICHAEL D. KOPELMAN and JAMES A. C. MacKEITH

Background The past decade has witnessed a recognition that unsafe criminal convictions may be occasioned by unreliable confessions.

Aims To present a case which illustrates the dangers of using abreaction interview techniques in a legal context and demonstrate the relevance of the memory distrust syndrome to an unsafe confession to murder.

Method We undertook a detailed assessment of a person appealing against his original murder conviction, 'the appellant', and a careful scrutiny of all the relevant papers in the case.

Results The appellant served 25 years in prison before his conviction was quashed as 'unsafe' on the basis of fresh psychological and psychiatric evidence.

Conclusions Amnesia for an offence had been misdiagnosed, and the use of repeated abreaction interviews had further confused both the appellant and the original court. At the Appeal Court, the advice was that the man had experienced a form of source amnesia which resulted in an unreliable confession.

Declaration of interest All three authors were instructed as expert witnesses at the Appeal Court. There was no further involvement of the authors in legal proceedings or advice. The appellant's signed consent to publication was obtained after he had read a longer version of this paper.

In recent years, the courts have become increasingly aware that wrongful convictions may be occasioned by psychological vulnerability which renders a confession unreliable (Gudjonsson & MacKeith, 1997). The concept of a 'memory distrust syndrome' is used to describe how people develop a fundamental distrust of their own memory, making them more susceptible to relying on external sources of information (Gudjonsson & MacKeith, 1982). This syndrome can be seen as a particular form of 'source amnesia' (Johnson *et al*, 1993). Normal subjects have difficulty in remembering the source or context in which they learned information – temporally (when?), spatially (where?), and in terms of source (from whom?) and modality (spoken or written?). This difficulty worsens with normal ageing, and it is also exacerbated in organic amnesia and frontal lobe disorders (Kopelman *et al*, 1997). It has also been suggested that confusion concerning the context or source of information is an important and possibly the most critical factor in producing 'confabulation' in brain disease (Korsakoff, 1889; Kopelman, 1999). In the memory distrust syndrome there is confusion concerning the source of information (whether a 'memory' has been generated internally or from external sources), and it can therefore be seen as a particular instance of source amnesia.

A memory distrust syndrome makes some people susceptible to developing a 'false memory' or 'confabulation'. In the context of recovered memories of childhood abuse, Brandon *et al* (1998) have defined a false memory as "the recollection of an event which did not occur but which the individual subsequently strongly believes". Although this definition was developed in a very specific context (childhood abuse recalled by adults), it can be applied to other contexts. Gudjonsson (1997*a*) makes a distinction between a false belief and a false memory in relation to confessions. A person can develop the belief that he or she has participated in a particular event (e.g. murder) without having any memory of it. On occasion, as in the case below, the false belief develops into a false memory.

PATIENT DESCRIPTION

A.E. was born in 1955. He was badly affected by asthma and bronchitis, and used an inhaler. He left school at the age of 15 without qualifications. When aged 15–17 years, his employers describe a willing worker, although forgetful and lacking in self-confidence. A.E. enlisted in the army as a private on 17 April 1972, but was discharged on medical grounds. He left on 8 June 1972, the day after a 14-year-old girl was attacked and killed when riding her bicycle about five miles from the barracks where A.E. was stationed. He went to live with his grandmother and worked as a salesman. He was unhappy with this work and disappointed about leaving the army.

A.E. saw his general practitioner (GP) on a number of occasions between July and September 1972, complaining of symptoms related to asthma. On 29 September, he complained to his GP of feeling depressed. He was prescribed 2 mg diazepam to take three times daily.

The police interviews

On 27 July 1972, A.E. filled in a form given to all soldiers who had been stationed nearby on the day of the murder. He said that he had been in the barracks all day on 7 June 1972 and that three fellow soldiers could verify this.

More than two months later, on 8 October, the police called and asked A.E. some questions about the form. They said that two of the soldiers named by A.E. had in fact left the army some weeks before 7 June, the date of the murder. They also suggested that he had been wrong in giving 8 June as the date of his discharge from the army, because his discharge documents were actually dated a week later. Subsequently, it was discovered that he had been on terminal leave between 9 and 15 June. However, he agreed incorrectly that he must have made a mistake, and he apologised for it.

The police officers noticed that A.E. became very nervous. He took a tablet of diazepam. After the officers left, he

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commented to his grandmother, "It might have been me who committed the murder".

A.E. reported later that in the middle of that night he had had a distressing recurrent 'vision' of the face of a girl. The following morning he told his grandmother that he was going to the police station because he wanted to see a photograph of the murdered girl. He appeared very worried. His grandmother tried to discourage him, but in the afternoon he arrived at the police station and asked to see a picture of the girl. The police cadet at the reception desk described him as shaking and stuttering.

> "It is this girl who was murdered . . . I keep seeing her face. I wonder if I've done it . . . I suffer from nerves. I keep dreaming about this girl . . . I can see her lying down . . . it's all confused".

After a few minutes, he said, "After I saw you [the police who had visited him], I was thinking, I don't know if I killed her or not". When asked what he saw, he replied, "this field", and then proceeded to draw it. (His drawing bore some resemblance to the field, but the body and bicycle were misplaced in it.) He then described the victim's dress and face (inaccurately).

From the police documents, it is clear that A.E. was extremely agitated during the interview. The police recorded that "throughout this interview [he] was crying more or less continuously". He stated: "I must be going mad. I can see her all the time". He admitted to having had treatment for depression, and to having to take tablets every day for his asthma. Police reports stated that "he was having difficulty due to his asthmatical condition". A solicitor was not requested by him; neither was a police surgeon obtained by the police.

Later that evening he said, "I must have done it because I can see a picture of her. I can see her lying by the hedge". Shortly afterwards, he described a small youth with dark hair as having done the killing, but he said he did not know what instrument had been used. He also said, "I don't know where I've been. That is why I keep wondering if it's me that's done this murder . . .". About an hour later he said, "I keep seeing her face all the time . . . she is wearing a dress. It's white with something like flowers on it. I must be going mad . . .". He repeated several times, "I must have killed her".

On the next day (10 October 1972), A.E. was interviewed, again without a caution. He said, "I remember dragging her off her bike. It was a very rough field . . .". By 15.20 that day he stated, "I am sure I killed her . . . I know I did it".

The following day, he was taken to the site of the offence, where he appeared to recognise certain houses, but he identified the location of the body and the bicycle incorrectly. Between 16.20 and 17.50 that day (over 48 hours after his arrival at the police station), he provided a statement under caution, transcribed by a police officer. It was a confession to murder. He stated that he had left the barracks on the day of the murder in full uniform, had got a lift in a car, remembered seeing the girl, and that he had pulled her off the bicycle, dragged her across the field, and hit her on the head with something.

On 12 October, A.E. told the police, "I told you. I killed her, I don't want it to happen again. I'll help you all I can, you must believe me now. I've told you what I did".

Pre-trial assessments

Shortly after being remanded in custody, A.E. described to a prison medical officer how he had always seen himself as "second rate". It had been a tremendous disappointment to him when during a cross-country run in the army he experienced an attack of asthma. He said that when the police challenged the answers he had given in the original form, he had felt a sense of self-importance. He told the doctor that he was not sure whether or not he had committed the murder, but that he needed to know. He said, "I want to know the truth . . . will you help me to get the truth?". The doctor concluded that A.E. had a defect in his memory concerning the murder, which probably reflected a hysterical amnesia. However, the doctor also raised the possibility that nothing significant had happened on the day of the murder, and that A.E. could not in fact remember what he had been doing. If so, the interrogation by the police had triggered off a series of "psychic reactions" in a vulnerable personality, resulting in the production of false memories, the only apparent motive being a wish to be in the limelight.

Accounts by other expert witnesses for the defence before the trial suggested that A.E. did not seem to know whether or not his 'memories' of the crime scene were true, and he appeared to keep testing his 'memories' against the objective evidence put before him. He told a probation officer that he was not able to inform him whether he would plead guilty or not guilty. At some stage during the court hearing he would decide for himself whether or not he was guilty.

A.E. was also seen by a prison psychologist. He obtained a full-scale IQ score of 100. The psychologist stated that A.E. had "a predisposition toward neurotic–hysterical type reactions. Strong impressions of hysterical features". A psychiatric evaluation mentioned that A.E. had problems in everyday memory. This conclusion seems to have been based on reports from informants.

A consultant psychiatrist, instructed by the defence, recommended an abreaction for the purpose of revealing "more accurately the areas in which [A.E.] claims he has forgotten what occurred and [this] might produce evidence that would be valid in respect of the girl, who was tragically murdered".

Abreaction interviews

Three abreaction sessions were carried out. The first two were agreed upon by three medical experts, although the prison doctor for the prosecution made a written protest before the third. The first abreaction session took place just five days before the trial commenced. Methohexitone was injected intravenously. A.E. then said that he had been at the barracks all day. He repeated continually, "I don't know, I don't know, I didn't do it, I didn't do it, who did? Who did? I must find out, who did?". However, later during the session, he said that he could vaguely remember "pictures . . . like snapshots" of a man standing over a body.

Just two days before the trial commenced, there was a second abreaction session, performed with an initial injection of methohexitone followed by methylamphetamine. The latter was intended to cause a general arousal of thoughts and recall and "to relieve psychic blockage and resistance". A.E. was said by the doctor to be able to talk more freely than during the first abreaction session, and he required less prompting. A.E. again stated that he had not left the barracks that day and that he had not murdered the victim.

Three days *after* the trial commenced, the third abreaction session took place. Methohexitone was administered. A.E. denied having committed the murder, but

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stated that he recalled leaving the barracks and standing by the gate of the field where the murder took place. He heard a cry, and watched a struggle going on. "I did not kill [the victim], I have not known [the victim], I have never seen [the victim])". Of the struggle, he said, "I was fascinated . . .", and he spoke again of a man standing over the body of a girl. The transcript of this abreaction material was passed to the prosecution the following day (a Sunday), and it was reported in court on the Monday.

Trial and conviction

Two days after the last abreaction session, A.E. went into the witness box and testified. Initially, he stated that he had not left the barracks on the day of the murder, but he stated later that he might have been at the field when the murder was committed. Two doctors who had examined him, and one who had not, then gave evidence arguing that he was amnesic, or at least partially amnesic, in connection with the homicide, owing to a form of "psychogenic" amnesia. It is noteworthy that one of the medical experts was asked by the prosecution whether, on the basis of what A.E. had reported, he (the doctor) was convinced that A.E. had been in the field when the murder took place. This doctor appeared reluctant to answer, but eventually did so at the request of the judge. He was of the opinion that A.E. had been there. On 13 April 1973, A.E. was convicted of murder.

The case against A.E. depended almost entirely upon his self-incriminating statements. The psychiatric view that A.E. had amnesia in connection with the offence prevailed at the trial. The expert witnesses implied that A.E. had either committed the murder or witnessed it. This was fatal to his defence.

Post-conviction behaviour

A.E. was assessed over many years by a number of prison medical officers, psychiatrists, psychologists and probation officers. They noted equivocations and uncertainty about whether he had committed the offence. However, after a period of leave in the summer of 1991, A.E. became more convinced that he had not committed the murder, and said so. This resulted in his transfer to a high-security prison and discontinuation of his release plan. Despite this, A.E. now consistently protested his innocence.

Assessment for Appeal Court hearing

A.E. completed a number of psychological tests in 1994 and 1995. The assessment revealed the following results.

First, A.E. was of average intellectual abilities, but had problems with memory processing. His concentration and verbal memory recall were poor, his memory deteriorated unusually rapidly over time, and the number of intrusion errors or confabulatory responses he produced was very high. It is relevant to point out that significant confabulatory responding on the Gudjonsson Suggestibility Scale (GSS–1; Gudjonsson, 1997*b*) has previously been found in people who make internalised false confessions (Sigurdsson & Gudjonsson, 1996).

Second, A.E.'s suggestibility scores were only modestly elevated. He was unusually hesitant and vague in providing his answers to the test questions. This suggested that he lacked confidence in his answers and had a major problem in discriminating between true recollections and the erroneous material introduced within the test. This problem with discrepancy detection has also been noted in other cases of internalised false confessions (Gudjonsson, 1992).

Third, A.E. was abnormally compliant and acquiescent on testing. His scores on compliance and acquiescence scales fell well outside the normal limits. His personality profile was that of an unstable (emotionally labile) extrovert. The scores on the Minnesota Multiphasic Personality Inventory–2 (MMPI–2; Hathaway & McKinley, 1991) were interesting. The validity scales fell well within normal limits. There were distinct elevations on scales 3 ('hysteria', t=76) and 8 ('schizophrenia', t=70). According to Graham (1987), such a profile suggests disturbed thinking, strong need for attention, and problems with concentration and memory.

Fourth, A.E. reported feeling distressed when matters concerning his sexuality were discussed with the police during the interviews, which is something which has been noted in cases of proven false confessions (Gudjonsson & MacKeith, 1990, 1994).

It must be borne in mind that the testing was conducted more than 20 years after A.E.'s arrest. However, the documents from the original case, including medical reports, indicate that the psychological vulnerabilities identified recently were present at the time of the police interviews in 1972.

The appeal hearing

Two psychiatrists and a psychologist instructed by the defence and a psychiatrist instructed by the prosecution were all in agreement about the misdiagnosis of amnesia by the original psychiatrists and testified at the appeal hearing, held 18–19 November 1997.

On 3 December 1997, A.E.'s conviction was quashed by the Lord Chief Justice, who concluded:

> "We must also accept that the appellant's confessions were, as confessions, entirely unreliable. Such was the consensus among four very distinguished experts called to give evidence before us. While these experts did not enjoy the advantage enjoyed by the doctors who testified at the [original] trial of examining the appellant within months of this offence, they were at one in regarding the diagnosis of amnesia unsound".

DISCUSSION

It was apparent to the police from the outset that A.E. was in a vulnerable physical and psychological state. The documentation suggests that they did not initially take A.E.'s 'confession' very seriously. In the light of what followed, the failure to involve a police surgeon or a solicitor was unfortunate.

The use of pharmacological abreactions in a legal setting cannot be justified, first because the nature of informed consent must be very tenuous, and second because the patient is vulnerable to suggestion or confabulations which may profoundly influence his or her testimony as to the historical fact in court. With the benefit of hindsight the successive abreaction interviewing was the seedbed in which false memories could easily be provoked or elaborated in someone of A.E.'s personality.

Recent research into offenders who are amnesic in connection with their crime, particularly violent crime, indicates that such memory loss can occur in four types of circumstance: (a) the presence of a small number of organic disorders, such as epileptic automatism or hypoglycaemia; (b) a psychotic paramnesia, such as a delusional memory; (c) severe intoxication resulting in an 'alcoholic blackout'; and (d) so-called 'crimes of passion' (Kopelman, 1995). The first three do not apply in the present case. With regard to the fourth, the offence is usually unpremeditated and unplanned homicide. It takes place in a state of extreme emotional arousal, and the victim is usually a cohabitee, relative or close

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friend. There is usually a brief period of memory loss, lasting a few minutes to an hour at most, and this memory loss has a fairly abrupt beginning and end. The offender is aware of the memory loss and often gives himself up – or at least does nothing to cover his tracks (Kopelman, 1995). Although there is scanty follow-up literature on these cases, the memory seldom recovers.

In this case, amnesia was apparently absent until months after the offence. It was not complained of by A.E., but inferred by the psychiatrists involved. The extent of the amnesic gap was vague. Although A.E. appeared to recover some 'memories', in fact he kept testing himself out, often changing his mind. This pattern is not the one expected in true amnesia for a crime.

There is, of course, the possibility that A.E. knew all the time what had happened on the day in question, but was reluctant to admit it, and that he feigned an amnesia. The strongest evidence for this is that A.E. appeared to recognise the field and local houses when taken to the scene of the crime. Moreover, he reported the confessions to various parties, even on occasion years later. However, a number of witnesses commented on how A.E. did not seem really to know whether his apparent 'memories' were true or not, but seemed to be testing them against the evidence put before him. This is not consistent with the behaviour expected of a man who was deliberately feigning memory loss for something he knew had happened.

The final possibility is that he remained in his barracks on 7 June, the day of the offence, and that nothing memorable happened. It is likely that he knew something about the murder, either from gossip or from the media. Following his initial uncertainty, the various interviews, and subsequently the pharmacological abreactions, more difficulties were created in his mind until he became completely uncertain about what was a true memory and what he had been told or inferred. This was then not amnesia for an offence, but *source* forgetting. The memory distrust syndrome is a particular instance of source forgetting. Over 24 hours, his statements in the police station evolved from "I don't know if I killed her or not", through "I must have killed her", to "I am sure I killed her . . . I know I did it". A.E.'s depression and low self-esteem helped to make him vulnerable to this process at the time.

In summary, although amnesia for offences is a relatively common situation in homicide, it was, in our view, misdiagnosed in this case. The Appeal Court accepted that this was an unsafe conviction. We suggest that important factors which facilitated errors were: first, the failure to call a police surgeon and solicitor to the police station; second, the failure to consider possibilities other than amnesia for an offence; and third, the misuse of pharmacological abreaction sessions in a legal setting. Finally, the case illustrates the hazards for psychiatrists of assuming the defendant's guilt if the defendant is pleading 'not guilty'.

CLINICAL IMPLICATIONS

- There are risks of eliciting unreliable statements in psychologically vulnerable individuals.
- Understanding memory processes is relevant to the assessment of internalised false confessions.
- The misuse of pharmacological abreaction sessions in a legal setting can have serious consequences.
- Psychiatrists and psychologists face ethical and legal dilemmas when asked to prepare advice which assume a defendant's guilt when he or she is pleading not guilty to an offence.

LIMITATIONS

- The paper is largely based on an individual case study, although a wider review of the literature and the investigations into other cases are alluded to.
- This paper does not discuss, owing to lack of space, the research base used in the investigation of cases of disputed confessions.

GISLI H. GUDJONSSON, PhD, Department of Psychology, Institute of Psychiatry, King's College, London; MICHAEL D. KOPELMAN, PhD, Neuropsychiatry and Memory Disorders Clinic, Division of Psychiatry and Psychology, St Thomas's Hospital, London; JAMES A. C. MacKEITH, MB, Denis Hill Unit, Bethlem Royal Hospital, Beckenham, Kent

Correspondence: Dr G. H. Gudjonsson, Department of Psychiatry, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF

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