hyperkinetic, and 13% were severely aggressive. Psychosis therefore appears to be a common rather than a rare manifestation of the severe effects of the TS gene.

Furthermore, a conservative estimate of the prevalence of TS, for which there is no absolute marker, is 1 in 15 400 for children under 5 (Hunt & Lindenbaum, 1984). The disorder is thus not as rare as previously thought.

Our study of TS leads us to propose that profound language delay, severe impairment of social interactions, hyperkinesis, and sleep disturbance constitute a behavioural phenotype. Although not pathognomonic, this occurs so frequently in tuberous sclerosis that we consider that it should be included among the diagnostic criteria for the disorder.

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Amnesia: Organic and Psychogenic

SIR: In his review of amnesia (*Journal*, April 1987, **150**, 428–442) Kopelman fails to deal with the questions of whether individuals who say they have lost their memory, in the absence of any organic cause, are truly amnesic, and of how genuine amnesia may be distinguished from feigned amnesia. He seems to assume that all those suffering from what are often referred to as fugues and hysterical amnesias have genuinely lost their memory.

The question of psychogenic amnesia seems to have attracted little interest in recent years, and it is significant that many of the publications quoted by Kopelman are more than 40 years old. In the Podola case (Furneaux, 1960) the genuineness of claimed amnesia was rigorously probed during several days of a highly publicised trial, on the issue of fitness to plead. Several psychiatrists and other doctors gave evidence; some of them provided the unedifying spectacle, to which psychiatry seems uniquely prone, of disagreeing with one another about the most basic symptoms of the condition about which they were giving expert testimony. Leigh stated that a patient with hysterical amnesia for the whole of his life would not be able to recognise common objects or tie his shoe laces, but Stafford-Clark said that this was entirely wrong. In fact, Podola had made a number of apparent blunders tending to show that he did remember things he claimed to have forgotten, and the jury found his amnesia to be feigned.

The views of the late Sir Charles Symonds (quoted by Merskey, 1979) are of interest:

> I suspect also that all so-called hysterical fugues are examples of malingering. Forty years ago a young man was brought to this hospital (the National Hospital, Queen Square) as an out-patient to B Room, where I was working, with loss of memory for a period of a week. I had a heavy load of patients and it was a hot afternoon. I did not want to admit him and could not face the prospect of a prolonged psychotherapeutic session. I said to him "I'm quite sure you can remember if you try: here are paper and pencil. Write me out your story, and I will do what I can to help you". With that I put him into the side room, closed the door and went on with my work. At the end of my session I had forgotten about him, but as I was about to leave there was a tap on the door of the side room and he emerged with two sheets of close written foolscap.
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> His story was this. He worked in a shop in Birmingham, had recently married, and took £10 from the till to cover the expenses of his honeymoon. He had, as he said, "borrowed" it. On his return home he found that a previous misdemeanour had been discovered, and that he had been sacked. So there he was with no prospect of repaying the £10 before his theft would be discovered. He concluded that the only way out was suicide and that the right way would be to jump off the cliffs at Lands End. So he made his way down to Lands End but there was no suitable cliff. It was dark and cold. He went to the nearest police station and declared that he had lost his memory and knew neither his name nor address. He was then transferred to hospital at Penzance and subsequently referred to Queen Square.
>
> Since then I must have seen half a dozen cases of so-called hysterical fugue in private practice and have adopted the following plan. I have said to the patient "I know from experience that your pretended loss of memory is the result of some intolerable emotional situation. If you will tell me the whole story I promise absolutely to respect your confidence, will give you all the help that I can and will say to your doctors and relatives that I cured you by hypnotism". This approach has never failed, and I have been told some dramatic stories".

It is not uncommon for loss of memory to be claimed for the period immediately surrounding the commission of an offence, such as shoplifting. In these cases it usually becomes clear that the person concerned does have some, possibly vague, recollection of events, and such clouding of memory as is present can often be explained by the effects of drugs or alcohol, or both. Classical 'hysterical amnesia' seems to be (like other dramatic 'hysterical'

symptoms) even rarer now than in the past, and I have not seen a case for many years. But was it not the case that when such patients arrived at the casualty department, all identifying articles had usually been carefully removed?

I have never been able to satisfy myself of the genuineness of claimed psychogenic amnesia and suspect that many psychiatrists share this view, even though they might not feel as confident as Symonds in dealing with such patients. Do many psychiatrists now believe that genuine psychogenic amnesia exists, and if so, is that belief sustained by anything more than credulity?

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Physical Examinations by Psychiatric Trainees

SIR: Rigby & Oswald (*Journal*, April 1987, **150**, 533–535) draw attention to the unsatisfactory physical examinations recorded by psychiatric trainees. How much such shortcomings contribute to missed physical morbidity is uncertain.

Psychiatric trainees, and maybe their seniors, also pay scant attention to aspects of the clinical method which yield more information than physical examination. Hampton *et al* looked at the relative importance of history, examination, and investigations in making a diagnosis in medical out-patients. In 87% of patients, reading the referring letter and taking a history sufficed. Examination only made a significant contribution in 7%.

I have reviewed the case notes of 20 patients randomly selected from those admitted to this hospital in 1986. In one case an incomplete systems review of physical symptoms was recorded. The biological symptoms of depression were the only physical complaints mentioned in the other notes. In all cases a physical examination and a coherent history, from patient or relative, were recorded.

Hampton *et al* state that their findings cannot be directly applied to other settings, but it seems unlikely that physical examination could produce more information than questions about physical symptoms in the patients seen by psychiatrists. The arguments of Oswald & Rigby that all relevant data should be recorded apply equally to examination and history-taking.

It may be a council of perfection, but should not psychiatrists be encouraged to ask about and record physical symptoms? The skill of taking a medical history should be as enthusiastically preserved as that of performing a physical examination.

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Depression, Dementia, and Disability in the Elderly

SIR: The studies of Good *et al* (*Journal*, April 1987, **150**, 463–470) and Griffiths *et al* (*Journal*, April 1987, **150**, 482–493) require some comment, since acceptance by the *Journal* may lead some readers to suppose that they represent a significant contribution to psychiatric epidemiology. Good epidemiological research is founded on well-defined samples, appropriate methods, and interesting questions; these studies are seriously inadequate in every respect.

Sampling: Both studies are based on data obtained from a sample of 200 old people registered with a group practice, so these subjects are not "community elderly" as asserted by Good *et al*. In the first place, elderly people registered with a GP are likely to be more alert and healthy than those who are not so registered (Murphy *et al*, in press). Secondly, although it is unclear just how the subjects were recruited, according to Griffiths *et al* only a proportion were randomly selected from the practice list. The remainder (we are not told how many) were enrolled into the study when they attended the health centre, which introduces a serious bias. Many elderly people with psychiatric disorders are unknown to the health services, and those that present usually do so with additional physical or behavioural problems. It is hardly surprising, therefore, that the authors should have found an association between their measures of dementia, depression, and disability. Thirdly, their subjects were all able to get to the health centre for assessment; this obstacle will have excluded many of those with moderate and severe depression or dementia as understood by psychogeriatricians. Findings based on this peculiar sample cannot be extended to the elderly population in general.