Noda, 1950, reported that during the Japanese epidemic of amphetamine abuse, in a 2-month period 31 of 60 convicted murderers had some connection with the misuse of amphetamines—Rylander, 1969—reports that there had been 3 murders, 1 manslaughter, and 21 assault and battery crimes committed by the 146 stimulant addicts admitted to his Swedish Forensic Psychiatry Clinic.

There had been 109 crimes committed against property some of these crimes were associated with aggression.

In his original monograph on amphetamine psychosis—Connell, 1958—states that hostile aggressive behavior was observed in 22 percent of the subjects included in his series from England.

In a recent study by the—Kalant, 1976—examining deaths reported by the coroner in the Province of Ontario in 1972 and 1973 which were related to amphetamine use, they found that 17 of 26 were deaths of a violent nature.

Seven were due to accidental violence, usually, due to poor judgment; seven to suicide; and three to homicide.

Among the suicides, there was a high incidence of self-inflicted fatal gunshot wounds.

Two suicides followed the killing of a police officer with subsequent impending capture by the police.

One male was shot by a policeman after attacking him with a knife.

From perusal of both the reported homicide cases and those of assault, it is apparent that many drug users move through three fairly distinct phases leading to the violent act.

The three phases consist of: First, chronic amphetamine abuse; second, an acute change in the individual's state of emotional arousal; and third, a situation that triggers the specific events leading to the act of violence—Ellinwood, 1971a.

The phase of chronic abuse often sets the stage; it includes changes in the individual's frame of mind involving suspiciousness, paranoid thinking, and fearful regard of his environment.

It is during this period that he obtains and begins to carry a concealed weapon.

Armed robbery as a means of supporting the drug habit and conflicts over drug dealing also are segments of the setting that derives from chronic drug use.

The second phase, involving a sudden change in emotional arousal and/or a loss of intellectual control, is often secondary to a variety of factors, including a sudden increase in the dosage level—or acute use in a person with low tolerance—chronic loss of sleep, and the use of other drugs, especially sedatives and alcohol.

In this emotional and cognitive framework, the person often misinterprets his environment and becomes increasingly fearful.

The emotional misinterpretation may be quite subtle; for instance, a sudden and overwhelming interpretation of a minor "clue" that fits into the person's delusional system.

On the other hand, it may be a very gross misinterpretation of the entire environment; strangers suddenly becomes sources of persecution.

Often the person mistakes a stranger for a persecutor, or, alternately, for a friend—Ellinwood, 1967; 1969.

This phase of sudden misinterpretation of the environment is associated with an intense sense of reality.