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The Ganser Syndrome

By F. A. WHITLOCK

In 1897 Ganser delivered a paper entitled "Concerning an Unusual Hysterical Confusional State" in which he described three prisoners who developed transitory symptoms of mental illness. The main features were disturbances of consciousness with subsequent amnesia for the episode, prominent hallucinations, sensory changes of an hysterical kind and, on questioning, peculiar verbal responses which have come to be regarded as the hallmark of the Ganser state. The illness terminated abruptly with full restoration of normal mental function. Despite Ganser's designation of the condition as hysterical, controversy over its precise nosological status has persisted over the past sixty-odd years. Is it in fact a form of hysteria, or is it a psychotic illness of brief duration? Is the hysterical pseudo-dementia described by Wernicke (1906) identical with or distinct from the Ganser syndrome? What is the relationship, if any, of the symptomatology of the Ganser state —the often-described "vorbeireden" and "approximate answers"—to the disordered thought of the schizophrenic and the dysphasia of the patient suffering from organic brain disease? Is it a fact that the Ganser syndrome occurs most frequently in patients in military or civil prisons and is rare in the non-delinquent population? To these and other problems the standard textbooks of psychiatry return conflicting answers.

Current Textbook Descriptions

Traditionally the Ganser syndrome is described in the majority of English textbooks of psychiatry under the heading of "Hysterical Disorders". Mayer-Gross and his colleagues (1960), Henderson and Batchelor (1962), Curran and Partridge (1963), Sim (1963), Skottowe (1964) and Anderson (1964), to name but a proportion of the authors of current textbooks, all subscribe to this tradition. By contrast, American textbooks seem somewhat less certain, for Arieti and his co-authors (1959) list the Ganser syndrome under the heading of "Rare, Unclassifiable, Collective and Exotic Psychotic Syndromes". The writers in this book tend to regard the Ganser syndrome as essentially a transient psychosis, although they admit the difficulty in deciding whether or not hysteria is the more correct diagnosis. Noyes and Kolb (1963) and Gregory (1961) both adhere to the usual placement of Ganser states in the portion of their books devoted to Hysterical Neuroses. Szasz (1961) dogmatically regards the Ganser syndrome as a variant of either malingering or hysteria. He quotes, with some approval, Wertham's (1949) comment that "a Ganser reaction is a hysterical pseudo-stupidity which occurs almost exclusively in jails and in old fashioned German textbooks. It is now known to be almost always due more to conscious malingering than to unconscious stupefaction." In his anxiety to equate the symptoms of the Ganser syndrome with the alleged impersonation of the sick role in hysteria, Szasz, along with others, overlooks the fact that Ganser was quite certain that his patients were not malingering.

Associated Psychiatric Disorders

The persistence of the opinion that the Ganser syndrome is an hysterical disorder is all the more remarkable in the light of the number of reports of this condition occurring in settings of organic brain disease or functional psychosis. Admittedly Mayer-Gross and his colleagues have advised caution in the diagnosis of this condition, for, as they mention, "Many of these patients have been found subsequently to be epileptic, or the subjects of an unsuspected schizophrenia, or organic cerebral disease." Similarly, Sim comments that "organic brain disease can also present a picture with certain features of the Ganser syndrome". He goes on to describe a

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case in which the symptoms of the syndrome disappeared after the removal of a large sagittal meningioma. Henderson and Batchelor mention the development of the Ganser syndrome in a case of acute hallucinatory paranoid state, and Curran and Partridge also mention the concurrence of the syndrome with schizophrenia. By contrast, Arieti claims that "an organic condition that might lead to these symptoms (Ganser syndrome) would have to be at a very advanced stage; . . . there would be no difficulty in making the diagnosis." Noyes and Kolb regard the Ganser syndrome as "an alteration of consciousness allied both to simulation and the dissociative dream state".

Functional and Organic Syndromes

Despite the main consensus of opinion in psychiatric textbooks that the Ganser syndrome is predominantly an hysterical disorder, reports in English and American medical journals are mainly concerned with pointing out the incidence of the syndrome in a wide variety of psychiatric settings. Ganser states have been described in settings of functional and organic psychoses, after head injuries and in alcoholics. Bender (1934) described a 29-year-old woman who developed a Ganser syndrome during the course of a post-partum schizophreniform illness. The features of the Ganser state developed after a suicidal attempt by coal-gas poisoning. This author also described another patient who died shortly after admission for treatment of an acute schizophreniform illness developing during the puerperium. The evidence for the Ganser syndrome in this second case is somewhat equivocal, and the death of the patient shortly after admission leaves one in doubt about her true state at the time. The cause of the death was not given. Anderson and Mallinson (1941), after stating that "everyone has agreed so far that the syndrome rests on an hysterical basis", go on to describe three cases of their own occurring during the course of functional psychoses. The first patient was diagnosed as suffering from depression, as was the second, who perhaps would today be given a diagnosis of psychogenic psychosis. The third case was a schizophrenic with strong psychogenic features at the time of onset.

Goldin and MacDonald (1955) provide a useful review of the literature on the subject, and mention among other cases one described by Lieberman (1945) who suffered from "hysteriform, epileptiform, alcoholic and diffuse organic disorder", symptoms indicative of a fairly advanced organic brain syndrome. These authors stress the symptom of disturbance of consciousness in the Ganser syndrome and go on to describe a case of their own. This was a man of 62 who presented as a classic, agitated depression; nevertheless, the onset of the Ganser symptoms was preceded by a sudden loss of consciousness associated with double incontinence; these and other findings suggested the possibility of organic cerebral disease. Weiner and Braiman (1955) remark, "We have not been able to find any reports of patients suffering of the Ganser syndrome who were demented as well", but they mention a case of the syndrome in an alcoholic described by Voss (1908), and a further case following head injury described by Baumann (1906). They give clinical details of three of the six cases they had examined, remarking that the other three were "typically hysterical". Of the three patients described, one was a case of paretic neurosyphilis, another was a schizophrenic whose illness developed after an unsuccessful suicidal attempt, and the third had had a preceding loss of consciousness considered to be hysterical. In one of these cases at least, there was unequivocal evidence of organic brain disease. Tyndal (1956) also commented on the possible organic basis for some cases of the Ganser syndrome.

Stern and Whiles (1942) support the theory that the Ganser syndrome is a psychotic illness, giving details of three cases of their own in support of this opinion. The first of these was a woman suffering from recurrent mania or hypomania who had sustained a head injury shortly before admission. The second was a 35-year-old male schizophrenic, an alcoholic often involved in brawls, who had recently been in prison. The third case, a probable schizophrenic, showed features more strongly suggestive of pseudo-dementia or the so-called "buffoonery syndrome" than of a true Ganser state. In the first two cases there seemed to be

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some possibility of organic brain disorder, either traumatic or toxic, existing before the onset of the Ganser syndrome. McGrath and McKenna (1961) review the literature, pointing out that the syndrome has been described as occurring in schizophrenia, depression, G.P.I., alcoholic psychosis and following head injury. In their opinion, Ganser states are not to be equated with malingering, but these authors prefer to avoid committing themselves to either the hysterical or the psychotic hypothesis. Instead, they back both possibilities by calling the condition "an hysterical psychosis after Fenichel". Their own case was a 29-year-old male who developed a Ganser syndrome some eight months after head injury with concussion. It is not easy to say what part, if any, the head injury played in the production of the illness, and the authors themselves felt that the compensation issue was of greater importance. May and his colleagues (1960) describe three cases developing after severe emotional stress. All three would qualify as psychogenic psychoses with schizophrenic features and all showed acute onset of illness with clouding of consciousness. Finally, Enoch and Irving (1962) describe a case of the syndrome in a 55-year-old man admitted for what was originally diagnosed as an organic confusional state. At the time of admission he showed equivocal plantar responses, and an X-ray of the skull showed a vascular defect in the upper part of the parietal region. Despite these findings, the authors concluded that the patient manifested a pure hysterical reaction.

In summary, therefore, although a good many authors support the belief that the Ganser syndrome is an hysterical disorder, it is pertinent to point out the high incidence of organic brain disease in the cases described. In this context it is worth recalling that, of the three cases originally described by Ganser, two had suffered serious head injuries, and the third was recovering from a severe bout of typhus with prolonged convalescence and psychic alterations. If one adheres to Ganser's original description, it must be wrong to emphasize the features of clouding of consciousness, paralogia and hallucinations while ignoring the evident organic brain disturbance which appeared to be an essential feature in his cases. However, when the syndrome appears in the course of a functional psychosis, one is faced by the problem of deciding whether the Ganser-like symptoms are part of the presenting illness or are hysterical symptoms grafted on to the underlying psychotic process. The former possibility certainly seems simpler, and obviates the need for a double diagnostic description of symptoms.

Hysterical Pseudo-Dementia

The question of whether the Ganser syndrome and Hysterical Pseudo-Dementia are one and the same condition appears to be an open one. Mayer-Gross and his colleagues, Henderson and Batchelor, Sim, Fish (1962) and Szasz all maintain with varying degrees of certainty that pseudo-dementia and the Ganser syndrome are two names for the same condition. In opposition to these authorities, Curran and Partridge and also Anderson maintain that pseudo-dementia is to be differentiated from the Ganser syndrome principally on the basis that patients diagnosed as suffering from hysterical pseudo-dementia show no disturbance of consciousness. This differential point was emphasized by Bumke (1936), by Anderson and Mallinson (1941), by Anderson and his colleagues (1959) and by other authorities. All three of Ganser's original cases had shown clouding of consciousness in association with the onset of their symptoms, and it seems generally to be agreed that the absence of clouding makes the diagnosis of a Ganser state somewhat dubious. Ganser's original description of the condition as an hysterical twilight state also emphasized the associated disturbance of consciousness. Accounts of patients suffering from pseudo-dementia certainly note the absence of any disturbance of consciousness, at the same time emphasizing the qualities of simulation or malingering which are more apparent in this class of condition. Anderson regards pseudo-dementia as a disorder developing in mentally dull persons who are usually in trouble with authority. The differential diagnosis between hysterical pseudo-dementia and straight malingering is not always an easy one to make, whereas the question of malingering in the Ganser syndrome should not arise. Kiloh (1961) also supports the opinion

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that the Ganser syndrome and pseudo-dementia are not one and the same condition. Nevertheless, he tends to the opinion that the Ganser syndrome itself is an hysterical disorder, since whether or not functional or organic psychosis co-exists with the syndrome, "hysterical mechanisms" are employed by the patient, Unfortunately, Kiloh somewhat confuses the issue, as he uses the term "pseudo-dementia" to describe an apparent organic dementia occurring in a setting of severe melancholia. This, of course, is wholly different from the hysterical pseudo-dementia which usually develops, as already indicated, in persons of low intelligence who do not manifest affective changes and who are devoid of any evidence of disturbance of consciousness.

Speech Disorder

Much consideration has been given to the precise meaning of the terms "vorbeireden" and "approximate answers". The similarity between the verbal statements of Ganser patients and patients suffering from schizophrenic thought disorder or organic dysphasia has been pointed out on more than one occasion. Anderson and Mallinson mention the close similarity of the Ganser response to schizophrenic thought disorder, and Fish comments that the symptoms of vorbeireden or paralogia are by no means uncommon in schizophrenia. In some instances he feels that the nonsensical nature of the replies can be explained in terms of the patients adopting a childish, playful attitude, a condition which presumably is closely related to Bleuler's buffoonery syndrome. Alternatively, a Ganser type of response can occur as a catatonic phenomenon, explicable in terms of the symptom of forced responsiveness. It is within the experience of most psychiatrists to be puzzled by a patient's apparently inconsequential replies, and to some extent it is a matter of judgment and interpretation to decide whether a patient is giving a Ganser-type response, has a schizophrenic thought disorder, a nominal dysphasia, or is disoriented on account of a toxic-confusional psychosis.

As far as dysphasia is concerned, Critchley (1964) has commented upon the similarity between what he terms "regressive metonymy" and the vorbeireden symptom of the Ganser syndrome. In his opinion, this phenomenon, occurring in the course of an organic dementia, is the first symptom of a sensory or jargon aphasia. Some of these problems will be considered again after describing the symptomatology of patients who had shown features suggesting Ganser states, but who on later consideration turned out to have an organic or schizophrenic diagnosis. As far as the symptom of approximate answers is concerned, it is not easy to assess, from the descriptions given in the papers already cited, how approximate an answer needs to be before it is placed in this category. Pick (1917) felt that only by forcing the meaning of the term could some of the answers be regarded as approximate, and with this view the present writer whole-heartedly concurs. Even in Ganser's original description, by no means all the answers are approximate. For example, on being asked to add 2 and 1, one patient gave the answer "Three", but when asked to add 3 and 2, he gave the answer "Seven". When asked to add 5 and 2, the answer was "Four" and when required to subtract 1 from 4, he gave the answer "Five" but corrected this to "Three". It seems, therefore, that it is not the approximation of answers but their random nature which is so striking. Furthermore, not all the replies carry the implication that the patients must have had an underlying understanding of the correct answer.

Prison Psychosis

There has been considerable discussion on whether or not the Ganser syndrome arises only or predominantly in patients in prison awaiting trial. No doubt the fact that Ganser's three cases were prisoners, and the belief in the minds of some writers that the Ganser syndrome is closely related to malingering, have contributed to the opinion that the syndrome is rare outside a prison setting. Indeed, in a sense it could be said that, along with the other presenting features in the cases described by Ganser, the development of the illness in the prison setting is an essential part of the syndrome. Opinion amongst the authorities already quoted is divided on the issue, but the majority of authors

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maintain that the syndrome is most likely to develop in prisoners. However, Sim, and Henderson and Batchelor, remark on its occurrence in law-abiding patients, while Goldin and McDonald, Curran and Partridge, and Scott (1965) all support the view that it is rare in prison practice today. Of the eighteen cases recently described in the English literature (1934–1962) in which clinical details are adequate, only four developed their illness while in prison, although a number of the others had received prison sentences in the past. What is particularly striking is the high incidence of symptoms following some kind of trouble, either of a domestic, sexual or financial kind. However, as a considerable proportion of psychiatric illnesses of all kinds develop in somewhat similar circumstances, there is no reason to believe that situational stress of this kind is necessarily a specific feature of the Ganser syndrome.

Sex Incidence

Tyndal (1956) comments on the rarity of the condition in female patients. Without giving any clinical details, he mentions 25 cases of his own, all males, in which he felt the issue of compensation and pension played a prominent part in the pathogenesis. However, it is likely that a proportion of these cases could have been instances of hysterical pseudo-dementia rather than true examples of the Ganser syndrome. Five of the eighteen recently reported cases (1934-1962) were women, and a past impression of male preponderance may have been due more to the reported incidence in military and civil prisoners than to any definite sex differentiation.

Summary of Previous Accounts

It seems clear that many traditional textbook accounts of the Ganser syndrome conflict with the case reports published in the psychiatric journals. Further consideration will be given later to the nosological status of the condition, but it is evident that the Ganser syndrome can occur in a variety of psychiatric illnesses, the majority of which are due to injury or organic disease affecting the central nervous system. The relationship of the syndrome to hysterical pseudo-dementia and malingering has also been discussed, and from the evidence so far presented it is clear that those suffering from Ganser syndrome are not malingerers, and that a distinction can be drawn between hysterical pseudo-dementia and the syndrome itself; the main differentiating feature, in the opinion of some authors, is the absence of clouding of consciousness in cases suffering from hysterical pseudo-dementia. The similarity of some of the verbal responses to those of aphasics and schizophrenics has been emphasized by a number of authors, and at times difficulty is experienced in deciding on the correct diagnostic category to which the patient should be assigned. Finally, although a number of examples of the syndrome occurring in a prison or military setting have been described, it is by no means unusual for the condition to develop in civilian patients who are not in trouble with the law. These and other points will be further discussed following the description of a number of clinical cases, all of whom manifested features of the Ganser syndrome during the course of their illnesses.

Cases

Case 1. The patient, male, aged 26 years, a skilled plumber by trade, was admitted to a psychiatric ward three weeks after sustaining a closed head injury with concussion. Physically, he showed inequality of the pupils and an extensor left plantar response. The EEG showed diffuse slow activity, an abnormality which improved slowly throughout the period of in-patient treatment.

Mentally he was pleasant, somewhat facile, and had difficulty in concentrating on a given task. On questioning he responded as follows:

Q. "What is your name?"

A. "It may be the same as yours."

Q. "How old are you?"

A. "How should I know that?"

Later, he gave his correct age, but gave the year of his birth as 1922 instead of 1933. When this inaccuracy was commented on, he replied in an offhand manner, "Well, it's nearabouts." When asked to give his address, he said "Newcastle upon Tyne, Newcastle." Asked in what street he lived, he replied, "It may be the street we have been trying to find tonight." He was then asked to state the colour of his (blue) pyjamas and he replied that it might be red. The colour of a red chair he gave as brown, but later correctly as red. He appeared to have some difficulty in naming objects correctly and was disoriented in time and place. When asked to say how long he had been in the ward, he replied "Well, I could have come in this minute, couldn't I?"; he had some difficulty in distinguishing between the words "world" and "ward". Throughout the

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interview, he was cheerful, off-hand and a little perplexed. The great majority of his answers had the approximate and paralogic quality of the Ganser symptoms.

Two days after admission, he was correctly oriented but still showed impaired powers of concentration and memory with a tendency to perseverate. He continued to give paralogic answers; for example, when asked to name the year, he said "1938", when in fact it was 1958, but he gave his age correctly as 24; he then looked at the dates on his case chart and said "Why, that makes us five, it's 1958." When asked to say what he was drawing (a test picture of a house), he replied, "It's an amalgamation of building materials." He could not give any clearer definition of what he meant by this phrase. When asked to turn over a piece of paper, he turned it round so that the head of the sheet was now at the bottom. Psychological testing, using the Raven's Matrices, 1938, and the Mill Hill Verbal Scale, revealed a marked deficit (Grade IV+). On discharge, he was correctly oriented, was able to give the correct answers to most questions, but was still decidedly euphoric. He had a post-traumatic amnesia of five weeks' duration.

Case 2. The patient, a female, aged 59, was admitted to a psychiatric ward three days after falling off a ladder. She was completely unconscious for a few minutes following the accident, but managed to walk into the admission ward. At that time she was wholly disoriented, was unable to give her name, and appeared to be confused. Shortly after her admission, she walked out of the hospital and returned home. She was then re-admitted and transferred to the psychiatric unit. At interview, she appeared somewhat distraught and untidy. Physical examination and EEG studies revealed nothing of significance. Mentally she appeared to be somewhat confused; when addressed by her name, she looked over her shoulder as if expecting to see someone of this name in another part of the room. In reply to direct questions, she said she had four legs and two heads. When a single finger was pointed at her, she said there were two. She appeared wholly disoriented in time and place, believing that she was staying in an hotel, and asked to see the manager. Her capacity to sustain a conversation fluctuated considerably, but over the subsequent ten days, there was an all-round improvement in her condition. She became correctly oriented and was finally discharged. The duration of post-traumatic amnesia was not recorded in this case.

Case 3. The patient, a married salesman, aged 42, was admitted some five days after an illness characterized by headaches, vomiting, insomnia and a subjective feeling of forced thinking. The whole episode was initiated by an epileptic convulsion. There was no previous history of physical or mental illness, but there was evidence to suggest that the patient had been under domestic and financial stress for some considerable time. At the time of admission he did not show any obvious physical abnormality, but the EEG report stated that there was a diffuse abnormality with excess slow activity, maximal over the inferior surface of the left temporal convexity and probably rising from the left-mid-temporal region. The record suggested a destructive lesion in the brain. Mentally he appeared somewhat puzzled, but claimed he did not feel in any way ill. He was disoriented in time and place, and tended to evade giving a direct answer to any given question, claiming that he was not particularly interested in the subject under discussion. He had difficulty in naming objects. However, he did not seem particularly concerned by his failures. When asked to interpret the proverb "A stitch in time saves nine", he replied "Well, a stitch is something under here, isn't it?" and pointed to his sub-costal margin. The proverb "A rolling stone gathers no moss" he interpreted as "It's generally very simple, isn't it? A rolling stone travelling along doesn't pick up any moss, which they use on modern advertising props, I think. We don't use a great deal. If they're going to send stones over to represent the miners as a committee, I know what you mean anyway." He mentioned that his wife had been ill for many years from an intractable skin disorder, and went on to say that she had been in jail for this condition; he later corrected himself and said that she had been in hospital. When asked where he was, he said he was in a Department of Education in Illness, by which, presumably, he meant a Teaching Hospital. His mood showed an overall flatness and detachment, but at times he appeared somewhat irritated by the questions. A stock response to many of the questions was "Well, we don't make much use of that in our sort of business."

On the following day he complained of an unusual odour of hot metal in the room in which he was being nursed. He still showed some degree of clouding, but after three days he was correctly oriented and his speech had returned to normal A neurological examination at this stage revealed a slight impairment of power in the right hand, and in view of this and the abnormal EEG, he was transferred to a neurological ward for further investigation. Straight X-ray of the skull was normal, and a left carotid angiogram did not reveal any obvious space-occupying lesion in the brain. Haematological and biochemical investigations did not show any abnormality. A further EEG approximately a fortnight after admission showed that activity of the right hemisphere was now almost normal; however, there had been no significant change in the slow wave abnormality in the left mid-temporal region. On discharge the patient was free of symptoms, but the precise diagnosis was uncertain. In all probability he had sustained a cerebro-vascular accident which had led to the epileptic convulsion, disturbance of consciousness and the subsequent psychiatric symptoms observed at the time of admission.

On follow-up some two months later, he had no subjective complaints, but it was noted that he still had some slight difficulty in putting a name to common objects. His speech was normal, but he showed a mild euphoria and pressure of talk which were probably features of his premorbid personality.

Case 4. This patient, a married 48-year-old prison officer, was admitted shortly after the sudden onset of an illness characterized by an inability to hold things in his hands and by odd and unusual behaviour. For example, he was said to have tried to light a cigarette, but placed

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the match in his mouth instead of the cigarette. At the time of admission, he claimed not to be able to recognize any friends, and could not remember his own age and name, but was able to give quite a lot of information about his home and family. At the time he seemed quite placid and unconcerned by his symptoms. It was recorded that he seemed able to write replies to questions correctly but could not give a spoken answer. From time to time, however, it was stated that "when caught unawares" he did in fact give correct replies. Physically, apart from a raised blood pressure of 190/110, no abnormality was discovered. In the course of history-taking from the patient and his wife, it was discovered that he was greatly dissatisfied with his work and recently had been very upset by the sudden deaths of two close friends. His wife mentioned that for some two weeks before the onset of the illness he had been out of sorts and somewhat forgetful. It was felt at the time that these factors played a major part in his illness, and a diagnosis of hysteria and a differential diagnosis of Ganser syndrome or malingering was made. Two days after admission he said he was well, and he was able to give a fair account of events leading up to his illness. However, he claimed that his memory for the illness itself was vague, and he was still unable to give spoken answers to direct questions. For example, when asked to give the name of the day after Friday, he could not give the correct answer verbally, though he wrote down "Saturday" correctly. He was able to write the age of his son (20 years) but was unable to spell it out aloud.

On the third day he was still unable to carry out simple tasks, such as reciting the days of the week or the months of the year, to giving his own name or counting up to 20. However, a fortnight after admission his general capacities began to improve and he was able to give some dates and factual information correctly. It was noted that at this stage he had some features of the Gerstmann syndrome in that he manifested a right-left disorientation and finger agnosia of his right hand. An EEG at this time showed a left temporal abnormality characterized by a minor degree of asymmetry with increased slow wave activity on that side. Psychological testing using the W.A.I.S. showed a performance scale of 106, a verbal scale of 87 and a full scale of 95. The psychologist reported that in her opinion this result was compatible with an organic brain disturbance. Finally, an angiogram showed obstruction of the left internal carotid artery. There was no evidence of a space-occupying lesion, and all other arterial branches within the skull seemed normal. It was concluded that the obstruction was probably due to thrombosis, and that the features which initially had so strongly suggested an hysterical illness were in fact due to dysphasia.

Case 5. This patient, a married salesman, aged 47 and a known alcoholic, was admitted to hospital shortly after a head injury due to a fall from the steps of his house. Five days after the fall he was still partly unconscious and was described as being wholly disoriented and talking rubbish. A month after his injury he became noisy and restless, and for that reason was admitted to a psychiatric ward for further assessment and treatment. At that time it was noticed that he appeared to be confused and confabulating; he was unable to retain any piece of information for more than a minute and seemed unable to recognize people correctly. As far as one could tell, he was by now fully conscious, but was quite disoriented and unable to give any account of himself or of events of the previous day. He showed classical confabulation symptoms. A tentative diagnosis was made of Korsakoff syndrome in an alcoholic who had sustained a severe head injury. At this stage it was noted that some of his replies strongly suggested a Ganser type of response. For example, on 20 March, 1965 he said it was 21 November, 1966; on 29 March, he gave the day correctly as Monday but stated it was 25 February, 1964. Later, he corrected the month to March but still insisted that it was 1964. He appeared to have some difficulty in naming objects, and in particular, when tested for visual acuity, was unable to give the names of some of the letters on the testing chart. At this stage he was examined by the clinical psychologist; his verbal scale on the W.A.I.S. was 112, his performance scale 69 and full-scale 93. There was marked impairment of logical memory, orientation and visual memory. On the Bender-Gestalt test he had great difficulty in copying a line of dots; at one stage, instead, he gave a row of 8's and 9's, claiming that each dot looked different. When asked to draw a row of small circles, he drew them as stars. Other responses of a similar nature during his testing strongly suggested the paralogic kind of response observed in the Ganser state. At this stage an air encephalogram, angiogram, X-ray of skull, EEG and serology of the cerebro-spinal fluid were all quite normal.

Case 6. This male patient aged 16, was admitted shortly after the acute onset of a typical schizophrenic psychosis. He had been out with friends in the evening, and it was noticed that he was somewhat anxious during this time. On returning home, he believed that somebody had been in the house, and, despite parental reassurance, he spent the night roaming around looking into cupboards. On the following day he arranged some telephone apparatus belonging to his brother in a rather peculiar way. He said that everything was "wired up", that there was electricity everywhere and that his parents were charged. Later that day, being a Sunday, he went to church with his family, but during the course of the service he walked into the vestry and in a loud voice disowned his father. Later, at home, he expressed suspicion of everyone and feared that he was being poisoned. The family history and previous personal history were unremarkable. He was said to be an active lad who had recently left school after a somewhat indifferent performance there. He had a number of friends, but tended to select them from somewhat younger age groups than himself. He was employed as an apprentice carpet-layer, and it was reported that he worked well, and was cheerful and friendly.

On admission he was mute, unco-operative, suspicious and manneristic, and appeared to have some disturbance of conscious awareness. When he did reply to questions he would only say that he should not be in hospital. He refused to discuss his illness. Two days later he became more communicative, and although he said he could not clearly remember events prior to his admission, there was

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no evidence of clouding during this time. He was off-hand and casual in his manner. When asked why he had spent some time talking into an unconnected telephone, he replied, "Because I like the sound of my own voice." On the third day he was found lying on his bed gazing at a dummy figure on the floor made up of his pyjamas and underclothes. He said it meant that he was two people, one good one and one bad, and he went on to tell the doctor that if he (the doctor) took his hands out of his pockets he would understand things better. When asked how long he had been in the ward, he remarked, "About five years, how does that affect you?" When asked to name the colours of certain objects in the room, he gave some correctly, but stated that a grey filing-cabinet was brown. He appeared totally unconcerned by his errors. Although some of his replies had the quality of absurdity found in the Ganser syndrome, there could be no doubt that this patient was suffering from an acute schizophreniform psychosis, and this ceased fairly abruptly on the administration of chlorpromazine and following electroconvulsive therapy. Further enquiry disclosed that for some time the patient had been concealing considerable anxiety owing to fear of police proceedings over a shooting incident of which he had some knowledge. Fortunately, this matter was resolved satisfactorily, and on attendance as an out-patient one month after discharge, the patient was symptom-free.

Discussion

It could be argued with good reason that none of the cases described in this paper had all or even the majority of the symptoms described by Ganser in his original paper. However, the same criticism could be applied to the cases presented by other authors. Indeed, of the sixteen cases listed only one of those described by Weiner and Braiman showed the full picture of clouding of consciousness, hallucinations, paralogia, hysterical conversion symptoms and an abrupt termination to the illness with amnesia for the whole episode. Of the other two cases described by these authors, one failed to manifest hallucinations and the other showed no hysterical symptoms, but by comparison with the great majority of the cases described these three met most of the requirements for a diagnosis of Ganser syndrome. In fact, it is evident that to most authors the only essential symptom for a diagnosis of Ganser syndrome is the presence of the vorbeireden symptom, and little attention is paid to the presence or absence of the other symptoms described by Ganser. Consideration of the cases listed in this paper should be sufficient to indicate how very unreliable this symptom is, and how uncommon is its occurrence in conjunction with all the other symptoms described by Ganser. Certainly the presence of vorbeireden alone is insufficient to warrant a diagnosis of Ganser syndrome, which in the view of the present author is a condition implying an acute psychosis with at least clouding of consciousness and a sudden or fairly brisk termination with subsequent amnesia for the duration of the illness.

Six of the cases previously described did not, on the evidence presented, show clouding of consciousness, and one of those presented by Stern and Whiles did not even have very clear evidence of the usual paralogia symptoms. Much, of course, depends on the diagnosis of clouding of consciousness, a condition by no means easy to detect if the symptoms are slight or transitory. In the presence of unequivocal organic brain disease, the symptom is more often diagnosed mainly on the basis of confusion, disorientation, failure to sustain attention and subsequent amnesia. By contrast, a diagnosis of psychogenic clouding will more often be made retrospectively on the basis of amnesia, even though at the height of the illness a condition of withdrawal, bewilderment and vagueness might well make one suspect that the level of conscious awareness is disturbed.

The symptoms of hallucinations, hysterical symptoms, abrupt termination to the disorder and amnesia were for the most part absent in the majority of cases described, as indeed they were in the cases described in this paper. Only the last in the present series came reasonably close to Ganser's original description, although in this case hysterical symptoms of a conversion kind were not detected. The first two cases undoubtedly showed the characteristic features of paralogia, approximate answers and disturbance of consciousness. As far as could be discovered at the time, neither of them showed any hallucinations, but, in keeping with Ganser's original examples, both had sustained head injuries shortly before the onset of the illness. By contrast, the third case, although showing symptoms characteristic of the Ganser syndrome, also had symptoms suggesting a nominal dysphasia in association with a probable cerebrovascular accident. During his clouded phase the

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diagnosis of Ganser syndrome seemed justifiable in the light of his abnormal responses. His designation of the ward in the Teaching Hospital as "a Department of Education in Illness" was quite characteristic. In retrospect, the nominal dysphasia, persisting to a very slight degree some two months later, would justify a partial explanation of the clinical picture in terms of his central disturbance of speech. This was, in fact, a good example of a case in which it was extremely difficult to differentiate a Ganser response from an aphasic one. However, the fourth case more clearly showed a nominal dysphasia, although initially a diagnosis of Ganser syndrome and even of malingering was considered. It was known that the patient was unsettled in his job, and it was thought that he might have some reason to feign an illness in order to leave his employment.

The fifth case was an undoubted example of a Korsakoff syndrome subsequent to alcoholism and head injury. Nevertheless, he manifested Ganser-like responses in the course of his psychological testing. The relationship between this class of phenomenon and the more typical confabulation of the Korsakoff state is possibly a fairly close one; but whereas the Korsakoff symptoms can be understood in terms of a dislocation of time sense, the apparent confabulation being in some cases a truly experienced event relating to the wrong occasion, (Whitty and Lewin, 1960) the Ganser response has a quality of randomness and absurdity which is very different from the factual and circumstantial detail of the replies of a confabulating patient.

Finally, in the sixth case, an acute schizophreniform psychosis, the behaviour, though apparently absurd, could be interpreted as having some specific symbolic meaning to the patient. The vague, off-hand replies were certainly similar to the Ganser type of response, but could have been interpreted in terms of the so-called buffoonery syndrome of Bleuler. In this patient there was only slight evidence of clouding of consciousness, and at no time did he manifest any evidence of hysterical symptoms. Nevertheless, he was partially amnesic for the whole episode, which came to an abrupt termination after a short course of E.C.T. and chlorpromazine medication. His off-hand, almost contemptuous manner of replying was strongly reminiscent of the disinterest exhibited in such marked degree by the first patient in this series.

Ganser Symptoms or Ganser Syndrome?

Scott's (1965) suggestion that a differentiation should be made between Ganser *symptoms* and the Ganser *syndrome* has much to commend it. For whereas the former are comparatively common, the latter seems to be rare in the extreme. As already mentioned, very few of the cases discussed came anywhere near to meeting the full criteria of the syndrome, and similar considerations apply to the cases described in this paper. What does seem certain is that both symptoms and syndrome can occur in a wide variety of psychiatric disorders. In a good many cases previous head injury or acute functional psychosis figure prominently as settings conducive to the development of the Ganser syndrome. However, the diagnosis of the syndrome cannot rest solely on the presence of unusual verbal responses, which when examined closely have little that is specific about them. The belief that all the replies of the patients are "approximate", in the sense that there is an understandable relationship between the correct and the given answer, will not stand up to critical examination. A good many replies made do not correspond to this concept of approximation; it is the random and absurd nature of the replies which is much more striking. Hence, difficulty is encountered in deciding whether the patient has some form of dysphasia or a schizophrenic thought disorder, a difficulty which more often than not can only be resolved retrospectively after the end of the illness.

It remains to be decided how far one should continue to regard the syndrome as an hysterical disorder rather than a psychotic one. Undoubtedly one great difficulty facing anyone wishing to clarify this problem is the matter of nomenclature. Whereas a good many psychiatric symptoms can be defined with reasonable clarity, this certainly is not so with hysteria. Slater (1965) has recently commented on the problem, arguing that hysteria has no precise meaning even though he is prepared to retain

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the term "hysterical". The so-called conversion states can be defined with reasonable exactness, but dissociative states comprising fugues, amnesias and twilight states—all of which imply some disturbance of conscious awareness—lack that precise definition which would separate them from other psychogenic reactions. Where, for example, do the clouded states occurring in acute psychogenic or schizophreniform psychoses end and hysterical twilight states begin? In both conditions intense emotional upheaval precedes the onset of the symptoms; and in both, there is subsequent amnesia. Other hysterical symptoms of a conversion kind are by no means common accompaniments, and the so-called "hysterical personality" cannot be regarded as an essential predisposing factor. Hysteria, with its implications of secondary gain and malingering, is a term so loaded with value judgments that it has become useless as a clinical description. In any case, although Ganser used the term "hysterical twilight state" himself, he was quite positive that none of his patients was malingering, a consideration which applies with equal force to those described in this paper. It is concluded that hysteria and hysterical are "loaded" words implying a particular mechanism of doubtful validity.

A good many clinical descriptions subsequent to Ganser's original communication have tended to emphasize the psychotic nature of the illness rather than the hysterical one. If this is accepted, it might be best to regard the Ganser syndrome and symptoms as peculiar mental states precipitated by severe emotional stress, leading to transient psychotic illnesses usually of brief duration. Clouding of consciousness, of either an organic or a psychogenic kind, is an essential feature of the syndrome. Partial or total amnesia is an inevitable consequence of the initial disturbance of consciousness. The occurrence of Ganser-like symptoms in the absence of clouding of consciousness should lead to a consideration of malingering or near-malingering of the pseudo-dementia kind, or of the "buffoonery syndrome" arising on a basis of schizophrenia. No useful purpose is served by continuing to place the Ganser state in the category of hysteria, a term so imprecise as to defy definition. However, at this stage it would be too much to hope that hysteria will disappear from current psychiatric nomenclature. But if it has to be retained, it should certainly not include the Ganser syndrome as one of its manifestations.

Summary and Conclusions

1. The recent literature in English and American journals and psychiatric text-books dealing with a variety of aspects of the Ganser syndrome is reviewed. Consideration of Ganser's three original cases and a number of cases examined by the present writer has led to the following conclusions:

(*a*) Although the Ganser syndrome is traditionally regarded as an hysterical disorder, the evidence is strongly in support of the opinion that the condition is a psychotic one, occurring either after acute cerebral trauma or in the course of an acute psychotic illness, commonly of a schizophreniform or psychogenic kind.

(*b*) The basic essential of the condition is a disturbance of consciousness. It is maintained that this symptom separates the Ganser syndrome from hysterical pseudo-dementia, a condition occurring without clouding of consciousness in intellectually dull persons in social difficulties.

(*c*) Certain similarities between the verbal responses of the Ganser patient, the schizophrenic and the aphasic are discussed. Examples of these similarities are provided by some of the cases described.

(*d*) The belief that the Ganser syndrome occurs mainly in prisoners and male patients is not supported by the evidence provided by the present and other authors.

(*e*) It is suggested that a diagnosis of Ganser syndrome should be restricted to patients who, following cerebral trauma or in the course of an acute psychosis, develop clouding of consciousness, with characteristic verbal responses to questions, and whose illness terminates abruptly with subsequent amnesia. In a number of cases hallucinations and conversion symptoms might be detected. However, more commonly only a proportion of the features described by Ganser will be observed. In such cases, a diagnosis of Ganser-like symptoms in the course of a psychotic illness might be more appropriate.

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