PSYCHOGENIC EPISODES IN THE COURSE OF MAJOR PSYCHOSES.

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THIS paper is concerned with the occurrence in three cases of a major psychosis of more or less circumscribed and apparently psychogenic episodes similar to those described by Ganser (1897), and which form a characteristic syndrome, since called after him. Two of the cases here described were endogenous depressions, the third was a schizophrenia. All three showed depersonalization.

Ganser (1897) described a "specific hysterical twilight state," the chief symptom of which, it will be remembered, was the "talking past the point" (Vorbeireden). Answers to the simplest questions were given inaccurately, although it was evident from the response that the patient had understood the question and that the right answer was not very far from the forefront of consciousness, so much so that the possibility of simulation at once arose. This suspicion was all the greater since the syndrome was usually observed in prisoners on remand, where the value of simulation to avoid punishment was obvious. All his patients showed hallucinations, mostly visual and auditory, and the picture suggested an acute hallucinatory confusion of organic type. These hallucinations appeared to influence the patient's conduct, which was often violent. All his patients showed a generalized analgesia. The condition always subsided after a few days, and the patient regained clear consciousness together with complete disappearance of all the other symptoms and amnesia for the period of the psychosis.

Since this paper others have described this syndrome, and Flatau (1913) summarized the literature up to that date and also reported some additional cases. Since then very little appears to have been contributed to the problem, and the syndrome is now described among the prison psychoses in every adequate text-book of psychiatry. Everybody has agreed so far that the syndrome

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rests on a hysterical basis, but it is also agreed that an entirely satisfactory understanding of all its features is still not forthcoming; in particular this is the case with the symptom of "Vorbeireden," the genesis of which, in this condition, has not been satisfactorily determined.

It is hoped in this brief article to discuss this problem, and if not to solve it at least to clarify the issues for further observation and discussion. In addition to this other questions arise which demand an answer. One of these is why such episodes should occur in diverse psychoses. What role, if any, may be attributed to the existence of depersonalization in these cases? Is there a special relationship between schizophrenia and psychogenic episodes of the kind described? May they have a closer affinity to schizophrenia than has hitherto been realized?

Before describing the cases brief mention must be made of Wernicke's hysterical pseudo-dementia. This is always described in the text-books as separate from the Ganser syndrome, but it is not entirely clear from a study of the literature how far this differentiation is justified. Stress is laid (Bumke, 1936) on the associated disturbance of consciousness in Ganser states, but the central symptom, the characteristic form of "Vorbeireden," is the same in each. This will be discussed more fully later.

The three other forms into which the hysterical psychotic reactions are subdivided, twilight-states (fugues and subsequent amnesia), hysterical delirium (dramatization in a state of clouded consciousness of the traumatic determinant) and hysterical stupor, do not immediately concern us, but must inevitably be considered in passing in any inquiry into the relationship of hysteria with other psychoses, notably schizophrenia.

CASE 1.—Aged 27. Admitted December 1, 1939.

Family history.—Father has been in a mental hospital for several years; he is said to be a quiet, difficult, querulous man. Mother has always been nervous and cries a lot. Patient is one of nine children; two brothers have had depressive illnesses.

Past history.—Healthy child, not nervous. Reached the top standard at school. Joined the Navy aged 16 and made rapid progress, being promoted Yeoman of Signals at the early age of 24. Married in April, 1939; his wife is a pleasant, rather simple woman a few years younger than the patient. A baby was born and died of pneumonia shortly after birth in April, 1940, while the patient was in hospital.

Pre-psychotic personality.—A quiet, solitary, ambitious man. Very conscientious in his work as an instructor of signalling and keen on the success of his pupils. His work gave him a good deal of prominence at the training school and scope for gratifying a desire to be the centre of interest. He was always very sensitive about his small stature and liable to "moody fits" lasting three or four days. He hated being "ragged." He was nick-named "Depression" by his ship-mates at the age of 18.

Previous medical history.—Appendicectomy some years ago, otherwise negative apart from childhood complaints.

Present illness.—In October, 1938, he had intercourse with a prostitute, after which he was very remorseful, and for some weeks before his marriage in April, 1939, he was depressed and self-reproachful. After the marriage he was happier, but in August, 1939, he became depressed again and had an impulse to kill his

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wife. He was admitted to a Naval hospital for a short time and sent on sick-leave on August 22. While at home he was depressed, had difficulty in thinking, and had feelings of guilt. He slept badly, had little appetite for his food, wept a great deal and shunned company.

On admission to a Royal Naval Auxiliary Hospital, he said: "I feel worried over my work and my wife; I told her I was sorry; I felt everything had gone away . . . I thought life had gone from me. I felt like killing my wife because I love her so and hate myself . . . because I failed in my duties." He was a small man (5 ft. 5 in.), of dark colouring. His appearance was somewhat neglected. He looked depressed and was slightly retarded. He was full of self-reproach over failing in his duty: "I thought my boys weren't doing well." He showed both depersonalization and derealization; his actions seemed to him to be those of an automaton in an altered world. Ideas of reference were present; he thought that people looked at him critically and discussed his wickedness and his incompetence at work. Physical examination was negative apart from a well-healed appendicectomy scar and absent abdominal reflexes. The Wassermann reaction was negative in the blood.

Progress.—For the first two months he remained severely depressed. Retardation and depersonalization were very marked and he was continuously a suicidal risk; he felt he would be better out of the world, but wanted his life to be taken by someone else. At the end of this period he seemed much brighter; he sat on a table in the ward cracking jokes which amused the other patients and did imitations of the medical and nursing staff which were a grand success. After a few days he became more depressed than ever, and on February 20, 1940, he accused another depressed and quite innocent patient of speaking offensively about his (our patient's) mother. He threatened to assault this patient and was removed to a single room for special observation. At this time he was regarded, in addition, as actively suicidal.

On February 22, 1940, two days later, there was a dramatic change in the picture. At 10 a.m. he showed definite katatonic symptoms (e. g. he kept his arm extended in an uncomfortable and unnatural position for 27 minutes), echolalia, echopraxia and "Vorbeireden." Answers to questions were difficult to elicit and almost always beside the point. He spoke incomplete sentences relating to his mother and death. He was bewildered, self-reproachful and hopeless of the future. Topics which had previously aroused much affect evoked no response. As the day passed the katatonic signs became less marked, the "Vorbeireden" continued, but the whole impression became more histrionic. The date was given just a week wrong; his orientation for person and place remained correct. He began spitting indiscriminately, played with his saliva, grimaced incessantly, masturbated openly and was doubly incontinent. Echolalia was marked, while spontaneous speech consisted in a kind of "verbal doodling" over his mother and death. During examination he suddenly leaped from his bed and showed malicious pleasure at having startled the doctors and attendants. He showed himself throughout responsive to, and in close touch with his environment; this point, and the obviously histrionic quality of the episode, alone distinguished the clinical picture at this stage from a gross and unmistakable schizophrenia. Later in the day his mood became playfully snarling.

23.ii.40: Little change.

24.ii.40: Refused food; he was tube-fed and never subsequently was there any serious difficulty in getting him to eat.

25.ii.40: Little change.

26.ii.40: He spoke of an electrical force influencing him through the window. At 9.30 p.m. he began to behave violently, banging his legs on the bed and shouting. On the withdrawal of the attendants who were restraining him he became quiet and lay on the floor beating a "tattoo" with his feet. He then got up from the floor, picked up a chair and threw it down; on being ordered to pick it up he did so and stood it upside down. He staggered round the room as though drunk, but appeared to be careful not to hurt himself; if pushed he prevented himself falling over.

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He showed no response to pinprick, or to extreme pressure on the Achilles tendon or calf muscles. Later in the night he danced on his bed. All the furniture in the room was removed and he slept for a few hours on a mattress, then another outburst of violent behaviour occurred. Next morning he took breakfast with a little persuasion. The amount of activity and the bizarreness of his behaviour increased noticeably with the size of his audience. Frequent sound associations in his stream of talk and an apparent extreme alertness of hearing and sight seemed to add an element of mania to the total histrionic-schizophrenic picture. (On hearing a bystander gently tapping the floor with his foot he exclaimed, " Tom, Tom the piper's son.")

After about ten days this phase of the illness passed and he relapsed into his previous state of retarded depression with occasional harmless impulsive acts, e. g. gnashing his teeth and bursts of laughter.

20.iii.40 : 6 c.c. of sodium amytal were given intravenously. The retardation and depressive mood vanished. He said he felt quite normal in every way, though a little sleepy. He spoke perfectly rationally and showed a pretty wit at times. Questioned about his illness, he said that in the first place his depression had been brought on by fear of venereal disease (following the illicit intercourse mentioned above) and by his dislike of his work as instructor at the boys' training school, where he was " ragged " on account of his small stature and his youth. His depression had persisted, he felt, because he was constitutionally disposed to it as shown by his father and brothers having had similar illnesses. He considered that he was naturally a rather " hysterical " person (this use of the psychiatric term may well have been suggested to him in previous interviews by doctors), and this caused him to have " hysterical " outbursts. He said he obtained great pleasure from these outbursts, but had no intention of harming anyone " as that is not my policy." He decribed bizarre visions, e. g. he had seen black men standing on their heads in his room, adding, " I've always had a soft spot for coloured people." The nature of these visions was difficult to assess, but it is probable that they were hysterical pseudo-hallucinations. The electrical influence he ascribed to the switching on and off of an electric motor which was just audible through his window. He had been made to drink blood, and rats sent by one of the doctors had " gnawed at my vitals." When closely questioned he admitted the improbability of these ideas and remarked that he had thought that Walt Disney must be in charge of the hospital. When asked if he felt altered in any way, he replied : " Oh, I don't think I'm Julius Caesar or Lord Nelson, or anything of that sort." He said he felt different from his ordinary self, but in some way which he could not describe. He had no control over his " hysterical " outbursts. The spitting he considered disgraceful behaviour.

A few hours after the injection, after a short sleep, he relapsed once more into retarded, self-reproachful depression. It will be seen that a remarkable approach to normality occurred with considerable insight under the influence of sodium amytal. The evidence gained during this truly " lucid interval " was convincingly in favour of a pure depressive illness in an obsessional and hysterical personality. No schizoid features whatever were revealed. In the following weeks his depression remained unchanged, punctuated by impulsive and incongruous behaviour (he would suddenly get up from his chair, run his hands through his hair and laugh cynically, then quickly become tearful again). On April 4 he was invalided from the Navy. He was discharged under certificate to a mental hospital near his home.

CASE 2.—Aged 28. Admitted to the Neuro-psychiatric Unit from the Surgical Department on February 14, 1940.

Family history.—He comes of a respectable crofter family in the Outer Hebrides. His father and mother are alive and well. He is the eldest of a family of eleven, all of whom are said to be normal and healthy.

Past history.—Reached the top standard at school. On leaving, as is usual in the island, he earned his living by casual labour in the summer and fishing in the winter. He had never left his home waters until called up for the war, and was

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apparently in every way a normal member of the island population, perhaps slightly above the average in intelligence. He is unmarried.

Present illness.—He was called up in September, 1939, and served in a mine-sweeper off the coast of Wales. He settled down quite well with his messmates, and as regards enemy action had a fairly easy and lucky time. He reported sick in the middle of January, 1940, saying that he had had intercourse with a girl in port 14 days before and had recently felt sharp stabbing pains in his penis on two or three occasions while at work on deck. He also complained of a urethral discharge. He was admitted to the Surgical Dept. on February 5, 1940, and examination showed the presence of a non-specific urethritis with numerous pus-cells in the urine, but no gonococci were found. Tubercle bacilli were, however, discovered in a mid-stream specimen. He had no chest symptoms, and tubercle bacilli were absent from the sputum on the one occasion that any was obtainable. X-ray of the chest and renal areas was negative. The blood sedimentation rate was only very slightly raised. His urinary symptoms rapidly cleared up and he seemed to be physically perfectly well. Nevertheless repeated laboratory examinations of the urine (including inoculation of a guinea-pig which died within six weeks of miliary tuberculosis) established a diagnosis of tuberculosis of the urinary tract. He lost 10 lb. in weight while in hospital, but owing to his mental state he was eating relatively little and he showed no other sign of constitutional disturbance. After very full investigation in the Surgical Dept. he was reported to be tremulous and self-concerned and he was transferred to the Neuro-psychiatric Unit on February 14, 1940.

His general physical condition was very good. He was extremely tense, clasping and unclasping his hands incessantly during interviews and following every part of the physical examination with breathless interest. He denied feeling nervous or depressed, but it was clear that in fact he was very anxious. His orientation was correct and there was no evidence of hallucination or of compulsive phenomena. His general knowledge was fairly good; he could do simple calculations correctly, and recalled a short story with very fair understanding and verbal accuracy. He could, on the other hand, repeat only five digits forwards and three backwards. Memory for recent and remote events was unimpaired. Although protesting that he was no longer ill in any way, he admitted that his nerves had been upset by worrying over the risk he had run of contracting venereal disease.

He was treated with rest, sedatives and reassurance for a week.

22.ii.40: He refused his breakfast and medicines; he chanted prayers in a loud voice, and continually asked to be allowed to see another patient from his own island with whom he had been friendly while in the surgical ward. He said that he had heard officers' voices outside his room saying that his case was hopeless. He himself knew it was hopeless and begged to see his friend for an hour before he died, and for his body to be sent back to the island to be buried in the family grave. (At this time investigations were incomplete, the diagnosis of urinary tuberculosis had not been established, and no mention of tuberculosis had been made to him.)

23.ii.40: He continued to chant loudly despite the protests of other patients; he repeatedly intoned, "I want civil life." His answers to questions were always beside the point, and he never abandoned his sanctimonious sing-song even for the most ordinary remarks. He again refused his food and had to be restrained by four stewards while receiving an injection. He made a steward taste his tea in case it was poisoned, and he spat repeatedly on the floor of his room. The impression made was of feigned insanity overlying a depressive state. On being sternly accused of "playing up" he admitted that he had seen patients behaving in this way often enough when visiting his sister, who was a nurse in a mental hospital. This admission was not followed by any improvement in his behaviour. He continued to refuse almost all food and on February 26, 1940, a tube feed was given despite active resistance. After this he took his food with persuasion and gradually became quieter. He made many attempts to bargain (still in a religiose chant): "I'll take my medicine if I can have a cigarette." He was convinced he had syphilis and would not accept reassurance. By the beginning of March his behaviour

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had improved a great deal; he was quiet and obeyed all instructions scrupulously, as though anxious to please everybody. He spoke much of syphilis, of being unclean and of his wish to have his body sent home for burial. Each morning he was convinced he would die before nightfall, but next day showed no surprise at his survival. He said, " I'm filthy all over; I'm a disgrace to the whole island and I don't think it right that the medical officer leaves me here in my condition and writes to my family to tell them of my disease ; it will be known all over the village and there will be a scandal and disgrace for my family. I would rather die by my own hand than be shot." He could not be reassured that no message had been sent to his relatives. Day by day his depression deepened and gradually he became silent and inattentive to questions, answering no one save a ward sister who spoke to him in Gaelic. He lay still in bed and wept from time to time. On April 7, 1940, he was found attempting to swallow a handkerchief ; for some days he had spoken of " doing himself in." He was invalided from the Navy on May 1, 1940, and, as his family refused certification, he was escorted home by two attendants.

The main features of this case were severe depression (a primitive reaction in a simple personality), a content determined by native religiosity and nostalgia, and a violent histrionic episode with resistive behaviour, refusal of food and " Vorbeireden." The precipitating cause was an act of indiscretion followed by much self-reproach. The urinary tuberculosis appears to be incidental as far as the content of the psychosis is concerned in that the patient was ignorant of it throughout. The psychopathological implications of his foreboding of death, however, are interesting in view of the presence of grave physical disease.

CASE 3.—Aged 43. A senior officer in the Royal Naval Reserve. Admitted February 5, 1940.

Family history.—His mother, who died of cancer at the age of 73, is stated to have walked in her sleep.

Personal history.—No details of his infancy were available. Beyond septicaemia at 10 years old there was no previous serious illness. He was a stable child. He left school at 15 and after serving in a training ship he entered the Merchant Service. His employers spoke well of him and described him as an efficient officer. He survived the Great War without disability. He joined the R.N.R. and was called up for service at the outbreak of the present war. He had married 20 years before and had a daughter of 19 and a son of 14. For some little time he had been friendly with another woman with whom he had been intimate. His wife knew nothing of this affair until after the onset of the present illness. His personality was always a little odd ; he was shy and seclusive and he did not encourage the visits of friends, although he was said to have many acquaintances. His mood was stable and he had always made an impression of genuineness and sincerity. He enjoyed mechanical pursuits, e. g. taking watches to pieces, but he had few outside interests. He drank and smoked moderately.

Present illness.—On November 13, 1939, he wrote his wife and his mistress each a letter and transposed the envelopes. A week later, following a letter from the former, he realized his mistake. At this time he telephoned his wife asking her to write. This was the first intimation of his infidelity which the wife had had. She evidently condoned his lapse in part at least and they corresponded as before until towards Christmas. The patient then arranged to meet his wife and did so. He complained of " neuralgia " on one side of his face and insomnia. They discussed the sexual situation, about which the wife appears to have shown an almost pathological complacency. She stated that she did not mind giving him up, although she was very fond of him. They arranged a meeting with the mistress at which they agreed to carry on as they had been doing in order to prevent damage to his career. He was also reluctant to break up the home because of the children. In January the patient was transferred to another station. On January 15, 1940, the medical officer was summoned to him. He complained of feeling acutely depressed and unable to perform his duties. He stated that for the past three months he had become increasingly depressed. Two months before this his ship

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had been beached and, although no technical responsibility attached to the patient (he was promoted soon after to a senior rank), he appears to have felt morally to blame. He said that he had always felt escape to be preferable to facing the facts. He finally went to bed and refused to see anybody. He admitted having contemplated suicide. He was admitted to a Royal Naval Hospital on January 17, 1940. Here he continued to be depressed and developed a fear of the dark and of being alone. After a few days he became less depressed and took more interest in his surroundings. A few days later he became very worried, felt his promotion undeserved, became restless, jumped out of bed, expressed a fear of being operated upon, said his wife was in the building (which was not so), and was incontinent of urine and faeces. Later still he was described as "suspicious"; spoke of "writing on the wall"; said he was the King. Physically nothing abnormal was found except a hypoalgesia over the whole body. The Wassermann reaction was negative in the blood and the cerebro-spinal fluid was normal.

His mental state remained substantially unchanged during the next two weeks. He made frequent threats of suicide. On January 31, 1940, he developed a pyrexia of 100° with an erythematous rash on the wrists (he was having medinal at this time). Ten minutes before the doctor's morning visit he became apparently unconscious. His eyes were closed and directed upwards, but they returned to a horizontal plane when his eyelids were held open. The abdominal reflexes were absent. On attempting to open his mouth the attendants were resisted and he pursed his lips and clenched his teeth. This condition was regarded as hysterical. On February 4, 1940, he became violent again and tried to bite his attendant.

He was admitted to a Royal Naval Auxiliary Hospital on February 5, 1940. He then presented the clinical picture of a Ganser syndrome. He gave his name correctly, but said he was in the previous hospital. He professed not to know the month, but on pressing said "January." His conversation was incoherent; he made clawing gestures with his hands; he spoke in whispers at times. He said $2 + 2 = 1$. To the question 4×3 he replied, "I want my chance minus." Asked to name a cigarette case he replied "Bird." Told firmly to answer correctly he replied "Silver," and on pressing again, "A case." The whole stamp was ungenuine and histrionic. Physically nothing abnormal was found. On February 9, 1940, his condition was essentially unchanged, but he showed echopraxia and the "Vorbeireden" was as marked as before. A few days later the picture began to change somewhat; he spoke of "electrical" sensations produced, he thought, by treatment for a "venereal complaint." He showed one or two depressive features still, e. g. he felt that there was something he must do to make himself clear, but did not know what; he spoke of a key which would unravel the whole thing. He showed thought disorder of the so-called paralogical kind, e. g. asked to interpret the proverb "A stitch in time," he replied that it referred to an operation and went on to speak of the hypodermic needle. He was now much clearer, knew the date, and on February 18, 1940, was completely in touch, although the ungenuine impression made by the total picture persisted. A few days before he had been told of his mother's death and received it with apparent indifference, making such comments as would have been appropriate perhaps to a distant relative. He had a certain degree of insight; said he had had a nervous breakdown and looked forward to recovery. The self-reproach remained.

On February 22, 1940, he began to have auditory hallucinations and jumped out of bed saying his son was calling him. He wanted to make a systematic search of the block. He began to look and also to feel bewildered; said the medal ribbons of a member of the staff were wrong. He said his entourage was changed in some way. All of this puzzled him. The ungenuine impression made by these symptoms persisted. Early in March he began to say that his thoughts were relayed by the radio, and the derealization persisted. He said he did not wish to go into the day room as all the patients there were dying. He said that at night he smelled scents of flowers and fruit. (No flowers were in the room, but there was some fruit.) He complained of lack of energy and inability to make decisions. "Things around did not seem true"; he also spoke of being unable to convince himself of things. Later

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he felt that certain hardly visible marks on the wall of his room had a message for him. He spoke of the influence on him of a " ray " which he saw and felt and which he thought might have a therapeutic purpose. He said " People are controlling me." He thought someone was going to kill him. He had ideas of poverty also (" I've lost all my money and my clothes "). He spoke of having been a " worm " ; it is not entirely clear whether this was meant in a metaphorical sense or referred to an actual experience, perhaps in the hypnagogic state. Later, when those around him performed ordinary actions, e. g. sitting down, he felt they had a significance for him. He did not know whether to imitate them " to make himself right."

On March 13, 1940, he was given 7.5 gr. sodium amytal intravenously. At first attempts to give the drug produced a state of panic. He asked if it was " 606 " in the syringe. He eventually agreed to its administration. When under the influence of the drug he said the movements of his arms on admission indicated the painting of a rose. He shed maudlin tears and discussed his domestic problems, saying that he wanted to return to his wife. Otherwise nothing significant emerged. He improved during the next month very slightly, but the symptoms persisted accompanied by a noticeable dreaminess and remoteness. He was vague, and efforts to induce him to elaborate his experiences were futile. On April 9, 1940, he had an attack in which he became pale, trembled and looked distressed. It may be there was a transient loss of consciousness, but this was not confirmed. He did not wish to wear the stripes of his rank as he felt he had no right to them. A week or two later he seemed more sensible and all trace of " Vorbeireden " had gone. The thought disorder and passivity feelings remained ; his affect was superficial and insufficient ; rapport was negligible ; his answers were curt and uninformative. He complained constantly of being tired. Told of his impending invaliding from the Navy and consequent damage to his career, he showed little interest. On discharge he presented the typical picture of a post-acute schizophrenic state. His affect was flat, his actions and conversation polite, conventional and stereotyped. The hallucinations and thought-disorder persisted, as also the derealization. The total impression was that of an almost burnt out fire. He was discharged to a mental hospital on August 19, 1940.

Commentary.

Before discussing the questions raised at the outset, certain diagnostic and psychopathological aspects of the cases will be mentioned.

The first case is essentially a depression with now and then a hint of manic features (e. g. transient, but definite flight of ideas) and hysterical and obsessional features. As clearly emerges from the history this man showed a hysterical personality, by his love of the limelight and the selection of a job in which this tendency could be gratified. He had in fact projected a brittle idealization of himself, but one which was both controlled and fortified by his obsessional tendencies and directed into socially useful channels. These latter tendencies stressed the moral values, and contributed an element of priggishness and self-righteousness to his more or less unreal projection of himself. A moral lapse in such a person was likely to be followed by a ready reaction of depression and self-reproach. It was difficult to resist the impression that the Ganser episode served not so much to deceive others as to deceive himself. Ricklin (1904) has made the same observation and found it commoner in non-criminal cases. He proposes a so-called " dynamic " explanation, a repression of the painful experience.

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The second case appears simpler. The psychogenic episode must be regarded as the response of a primitive personality to a strange, unpleasant situation with which he was unable to cope. A strongly Celtic colouring of the psychosis was evident. How far the illness was released or influenced by the concomitant tuberculosis is uncertain.

The third case presents the greatest difficulties diagnostically. No other diagnosis than schizophrenia was permissible as soon as the apparently more psychogenic symptoms subsided. But taking the psychosis as a whole, i. e. including the period during which the patient was not observed by us, the question arises whether this was not one of those late schizophrenias which in the beginning bear the stamp of a so-called involutional depression and ultimately develop into a florid schizophrenic psychosis. The presence of obvious depressive features throughout must not be lost sight of. Such cases are not uncommon, and one of us (E. W. A.) has described similar psychoses which ran a benign course and ended in full social recovery. The depressive elaboration of many of his symptoms is interesting, e. g. the not uncommon belief that the "electrical sensations" were directed to the treatment of his illness, which he supposed to be venereal—the usual symbolism of hypochondriacal delusions after sexual lapses. The extreme anxiety, the fear that someone was going to kill him and the ideas of poverty are the typical "involutional" stock-in-trade. The hysterical disposition as evidenced by the mother's tendency to dissociative episodes is to be noted.

Depersonalization was present in all three cases. It would be interesting to know how far, if at all, this symptom is more frequent in depression showing hysterical features. It is possible that this remarkable disturbance of consciousness forms a suitable soil for the development of a Ganser syndrome. In the literature no mention is made of its occurrence in Ganser syndromes, but most of the work was done at a time when this symptom had not received as much study and attention as it has done in recent years.

As has been said, the "Vorbeireden" is the symptom which has attracted most attention from the psychological aspect. It is perhaps as well to define here the word "Vorbeireden," a term which is used ambiguously. Jaspers, after stating that this symptom has a very diverse genesis, identifies it with the term "paralogy," which is even more ambiguous. As it is understood here, however, "Vorbeireden" is that false response of a patient to the examiner's question where the answer, although wrong, is never far wrong and bears a definite and obvious relation to the question, indicating clearly that the question has been grasped by the patient. This is shown by such answers as $2 + 2 = 5$, and the classical question and answer, "How many legs has a cow?"—"Five." It is for this reason that the Ganser syndrome has been called "the syndrome of approximate answers." The term is, however, often used for any random answer which may appear to have little bearing on the question. This may be an extreme form based usually on a severe schizo-

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phrenic thought-disorder. In the interests of a precise terminology the term "Vorbeireden" is best reserved for the former. The question at once arises why patients who have never seen a psychiatric case, nor read a text-book of psychiatry, patients of different origin all over the world, should independently develop this symptom. It may be said that patients 1 and 3 never saw each other. The answer might lie in part, at least in the hysterical cases, in the popular view that insane people talk nonsense and this is the simplest and quickest way of doing it. The difficulty in sustained talking at random will be evident to anyone who tries it. It is difficult, and this is true of both hysterical and schizophrenic "Vorbeireden," not least in the latter, to resist the impression that the patient is having a joke at the examiner's expense.

It is at this point that very fundamental issues regarding "Vorbeireden" in schizophrenia and hysteria arise. It is not proposed in this brief contribution to go into this in detail as it would form the basis of a separate study. A few observations may be made in passing. The term "paralogy" has already been mentioned ; it is used to describe certain peculiarities of schizophrenic thought-disorder. A good example is shown by the third patient, who, when asked to interpret the proverb "a stitch in time," showed that "derailment into a side thought" (Kleist) which bore no inner logical relationship to the symbolic statement of the proverb, the interpretation given being perhaps partly determined by his prevailing preoccupation with sickness at the time. Nor was the derailment *en bloc*, i. e. within the framework of one group of concepts (stitching needle and suture material), but the needle mentioned was a hypodermic. This is characteristically schizophrenic. Such a response seems closely akin to the other typically Ganser responses; there is the same failure to make question and answer completely complementary, to form a fresh whole, the same slipping past. It seems impossible, formally at least, to separate them. May the symptoms not rest on a similar thinking disorder in each case? Bleuler (1937) comments on the difficulty of distinguishing the "buffoonery syndrome" (Faxensyndrom) occurring in katatonic states, and thinks that it is always, like the Ganser, a reaction to a situation. He does not mention, however, if there was a hysterical component in those cases where it occurred. Elsewhere, in another edition of his text-book, he states that Ganser reactions are acute syndromes based on a chronic schizophrenia. Mayer-Gross has seen a number of cases of Ganser syndrome in prisoners after sentence, and says that a proportion of these developed a chronic schizophrenia without a clear line of demarcation between the two pictures. He adds that differential diagnosis was extremely difficult in these cases, and believes that they were cases of schizophrenia coloured in the initial stages by the prison environment. He also saw a number of Ganser syndromes among soldiers in the last war which were acute hysterical reactions to the military situation.

It is a question whether some, perhaps many, Ganser states are not the

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product of an affective activation in whole or in part of a schizophrenic apparatus, i. e. that they are schizoid reaction psychoses. This view tends to have further support from many of the reported cases, though the disposition to such activation may be hysterical, i. e. both constitutional tendencies are present. The whole question is intimately bound up with the relationship of schizophrenia to hysteria, as evidenced by those other borderline states between the two whose significance baffles the most experienced psychiatrists. This is clearly a side of clinical psychiatry calling for detailed investigation and study.

Bumke (1936), in discussing hysterical and schizophrenic " Vorbeireden," lays stress diagnostically on the setting in which it occurs, in the latter instance on the presence of other schizophrenic symptoms, e. g. negativism. While from the practical clinical diagnostic standpoint this is of course helpful in at least the clear-cut cases on each side, psychopathologically it tells us nothing. In Case 3 it was not possible to say with certainty whether this was a " hysterical " or a schizophrenic manifestation. The patient presented, after a few days of evidently hysterical behaviour, typical schizophrenic symptoms. The only means of differentiation and, in the present lack of its exact analysis, the unscientific one, was the rapport. All through this man's illness the hall-mark of the hysteric, the ungenuineness was evident, and indeed right up to the end there was always this faint surrounding tinge to the picture. But a certain appearance of ungenuineness is not so uncommon in schizophrenia, based perhaps on the peculiarity of the affect. In one striking case which one of us remembers clearly it is true this was also associated with strong hysterical features, and it is possible that in Case 3 the interweaving of hysterical features was throughout responsible. Perhaps the most striking difference between the symptoms in schizophrenic and hysterical cases is that in the latter it is possible to obtain the correct answer if the question is firmly pressed. The material on which the present study is based is too small to permit even tentative conclusions. So far as these three cases go they tend to confirm the belief of the earlier psychiatrists, Ganser and others, that the syndrome always rests on a hysterical basis.

Ganser States and Hysterical Pseudo-dementia.

It will be generally conceded that outside prison practice the Ganser syndrome is uncommon. It is not known how common it may be, even in prison practice, in this country. So far as our limited experience went it had always been found associated with an unpleasant external situation—in one case an impending charge of embezzlement—and the impression had been that its occurrence in a depressive setting is not unusual. The latter impression has been confirmed by all three of the cases. Since the above commentary was written this impression has been further supported by another case of Ganser syndrome which occurred in the depressive phase of a cyclothymic illness.

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With regard to Case 1 and also in Case 3 the situation was really an internal one. No threat of disgrace hung over them from without, only wrathful conscience. In short the occurrence of the syndrome seemed largely a personal matter involving self-deception only. This accorded entirely with the pattern of their pre-morbid personalities.

It is to be noted that the allied syndrome of hysterical pseudo-dementia, on the other hand, is by no means uncommon in Service practice, and we have together seen perhaps a dozen cases in twelve months. Here is an illustrative case :

A stoker, aged 42, was admitted to the hospital on November 6, 1940. He had been referred because of his " low mentality " and consequent unsuitability for the Service. He had made numerous complaints of physical disorders of which no physical signs were found. On admission he complained of " wind," bad eyesight and poor sleep. He was examined by the ophthalmologist, who reported that his vision was better than he made out. In a psychiatric examination he gave a fair account of his past life. He said he had been perfectly well until he joined the Navy for the second time in April, 1940. His early life was uneventful. He reached Standard III at 11 years and evidently left then to work on a farm. He joined the Army during the 1914–18 war and served in France. He sustained no serious disability and was demobilized in February, 1919. He joined the Navy for the first time in 1919 and was invalided in 1924 owing, according to his own statement, to " rheumatism." Since that time he did general labouring until he rejoined. In 1922, while in the Service, he had contracted gonorrhoea. He was unmarried, an odd, solitary person who preferred to be on his own. He was always afraid of other people. Since his gonorrhoea he had felt he was " wasting away," and he believed that others were talking about his venereal infection and accordingly shunned his company. When seen he was somewhat morose, sullen and depressed. He was unco-operative, and it was impossible to apply an intelligence test. It seemed, however, that his intelligence was below normal. He said his spirits were " low." He complained of the various symptoms already mentioned. He was vague as to the date, but said it was " about Armistice time " (in fact it was November 14, 1940). Asked to add 8 and 7, he replied " 16." He professed to be unable to say where the sun rose and set. He said the Prime Minister was " Fisher " and the King " Teddie." Asked what money was made of he said he couldn't say, as he " had never been in a mint." He gave the number of days in a week as eight and said there were 30 minutes in an hour, and so on. He failed to give the most elementary information, and in short professed a degree of such failure that had it been genuine he could not have lived an independent life, far less have served in the Forces. It seemed clear that he was out to exploit his symptoms to the utmost with a view to getting out of the Service and also to gaining compensation. He was eventually invalided as unsuitable.

This was in many ways a typical case. The patient gave characteristically the approximate answers to questions calling for a definite answer. He also showed clearly how very difficult it sometimes is to separate sickness from malingering, a difficulty more acute perhaps in this form of hysterical reaction than any other. All the cases so far seen have represented a more or less crude attempt to escape Naval service. It is of interest to note co-existent with the hysterical reaction a much more chronic and possibly slowly developing sensitive paranoid depressive reaction which in itself would probably have made him a difficult person to work with. It seemed evident that he had never

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been of even average intellectual level, and scientifically he might he regarded as a high-grade defective. It is on such a basis that hysterical pseudo-dementia frequently arises, the intellectual failure being often hysterically exaggerated and exploited. Often, too, in our experience it is engrafted on mild symptoms of true dementia resulting from a head injury. The differentiation of the two groups of symptoms is nevertheless easier than might appear. The classical symptom, common to pseudo-dementia and the Ganser syndrome, is failure in the most elementary knowledge, and a second the usually obvious exploitation of symptoms in pseudo-dementia. This latter is not so uncommon in civilian medico-legal practice.

The difference between such a case and the Ganser syndrome is obvious. There is not such an evident disorder of consciousness, and the classical differentiation is thus confirmed (Bumke, 1936). The whole reaction appears more on the conscious level and, as stated, in these cases the element of malingering seems more often in evidence. Despite the playfulness and joking of Ganser patients, they do not leave the examiner with the impression that they are malingering.

The second of the three cases is less typically a Ganser, perhaps, and represented such a desire to escape from Naval service. In none of the three could malingering be justly suspected. In brief, the Ganser syndrome represents a subtler mode of reaction and one apparently much less susceptible to conscious control. It might be described crudely as the last card of the intelligent hysteric, but not a card possessed constitutionally by every hysteric; the disposition to it is possibly quite special. The standard of intelligence in all three cases was above average—two were highly intelligent men.

With regard to the prognosis of Ganser states it must be recorded that two of the patients (Cases 1 and 3) have recovered, the first after a course of convulsion therapy at the mental hospital to which he was sent, the second, as far as our information goes, spontaneously. The first patient was interviewed personally and appeared to have made an excellent social recovery. The second (Case 3) was not seen, but wrote to the hospital authorities about some of his property. The case of Ganser syndrome mentioned above in the commentary has shown a great lability in his mental state and, in view of this capacity for change, and in the light of the two cases already mentioned, a good prognosis with recovery fairly soon seems justifiable. Siefert (1907) mentions the poor response to institutional treatment of Ganser states, and notes the relative improvement which takes place with change of environment.

The course of a pseudo-dementia is otherwise. These cases tend to run a prolonged course and to show little change. This has been remarked by Bleuler (2), who says: "Recovery does not come at all or we must wait for it a long time." This is certainly borne out by the cases we have seen.

It is evident that knowledge of such conditions as those described, as of all clinical psychiatry, can only be obtained by careful clinical study. As such

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states, in ordinary clinical practice at least, are relatively rare a sufficiently large body of material cannot be collected by one or two observers to permit of any more than tentative conclusions. This article will have served its purpose if it draws attention to the problems raised and stimulates further study.

Summary.

1. Three cases of major psychosis are reported, two depressions and one schizophrenia, in which psychogenic episodes corresponding formally in all essentials to those described by Ganser occurred. An illustrative case of pseudo-dementia is also described.

2. The disorders in each of the three cases occurred on the basis of a hysterical disposition, perhaps activated and unmasked by the presence of another psychosis, but certainly bearing in all three cases a reactive, i. e. psychogenic, character in response to certain environmental problems. The psychopathology is briefly discussed.

3. No formal diagnostic difference between katatonic " Vorbeireden " and the hysterical was found. The hysterical responses appear more ungenuine and more amenable to persuasion and control by the examiner. The question is asked whether the tendency to develop this type of thought-disorder in Ganser states may not indicate an affinity with the schizophrenic " Anlage," i. e. whether it may not be a psychogenic schizoid manifestation. These states appear, from a study of the literature as well as of our cases, to show more clearly than other hysterical conditions the point where hysteria and schizophrenia come closest together.

4. The differentiation of the Ganser syndrome and pseudo-dementia and their respective prognoses are briefly discussed.

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