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The 'Gaslight Phenomenon' Reappears

A Modification of the Ganser Syndrome

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In 1969 Barton and Whitehead reported two cases in which there were definite plots to remove an unwanted and restricting relative by securing admission to a mental hospital, and one case of an old lady admitted to a mental hospital following induced faecal incontinence. The old lady was considered a nursing home nuisance and she was given purgatives regularly. Inevitably she had some 'accidents' and these were used as an excuse for removing her to hospital. They labelled such attempts 'The Gaslight Phenomenon', inspired by Patrick Hamilton's play *Gaslight* which was first produced in London in 1939 and later formed the basis for a film.* Their survey of the literature uncovered few recent reports of such manipulations.

Without the emphasis of Barton and Whitehead's report the following cases might have passed unnoticed. We feel that it is time to stress again the presence of this phenomenon, and, as this report shows, it is not unique to psychiatric hospitals. Some non-essential details have been altered to prevent identification of the patients or their families.

Case 1

Mrs. K., age 72, had two admissions to a general hospital in 1970 for investigations of blackouts which occurred infrequently.

Her husband, some years her junior, managed a small store and protested considerable inconvenience with his wife's 'illness'. His exaggerated history secured her admission. He claimed that she needed him in constant attendance and this jeopardized his job and the apartment that went with it. To protect his employment, and expressing concern for his wife, he arranged, through a doctor new to the case, her third admission, this time to a geriatric service in a general hospital. That service handled many similar 'social' admissions. An admission history discrepancy led to a psychiatric referral. The patient claimed that she had two sons and three daughters, all living abroad. Her husband said they had no family. The referral letter questioned whether the patient's account represented delusional material or was in fact true. This set an investigation in motion which revealed the following unhappy details.

Six months before her admission the husband befriended a younger woman, and out of sympathy for her plight, she being homeless and depressed, he offered her temporary shelter. This lady was divorced and had some experience of working in nursing homes. The patient accepted and liked her and was inclined to believe her new friend's interpretation of her symptoms. The friend seemed quite alarmed at relatively trivial symptoms, e.g. she once worried that leg pain represented a clot which could travel to the heart; and, surrounded by these alarming responses, the patient became more and more hypochondriacal and gratefully accepted the offer of a hospital bed and investigation.

The 'friend' looked after the husband, cooking, cleaning and handling the family finances. An intimate relationship was denied, but undoubtedly the opportunities for this were increased with the wife in hospital. More sinister perhaps were the reports which the husband sent to his children (the patient's claim of two sons and three daughters was true). In letters he led them to believe that mother had leukaemia, and he even hinted at making funeral arrangements. On contacting the first hospital directly, a son was informed that mother was in very good condition for her years and the only thing delaying her discharge was the husband's concern about losing their apartment. His employer when contacted later denied that this was a possibility. He had noticed no deterioration in the husband's work or his attendance at work, and since his job was not at risk his living quarters were secure.

The family, when eventually seen, attributed most

* In the play the conspiracy is of a more devilish nature; the victim is actually induced to believe that she is 'going mad', and her consequent distress goes to strengthen the impression that she is mentally ill.

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or all of the obvious scheming to the intruder. The husband was regarded as unsophisticated and unable to plot in such detail. He had been interviewed in a non-accusatory way and he showed no obvious psychiatric illness. In retrospect it seems that he was an unwitting accomplice, torn between infatuation with the younger woman and remaining loyalty to his wife. The 'friend' disappeared as the net closed in on the central character, and husband and wife were re-united. They may not live happily ever after.

Dublin has its share of social problems. It is not unusual for women with large families, an alcoholic or psychopathic husband and sub-standard housing to present at psychiatric clinics. Understandably they have mixed symptoms, they attend chronically and seldom show much response to treatment attempts.

Case 2

Mrs. O'N. is 29 and married 10 years. She has six children. Her husband is psychopathic and he uses alcohol abnormally. At the age of 20 he spent six months in prison for assault, and more recently he has been fined for stealing. Mrs. O'N's father was admitted to a psychiatric hospital for the first time at the age of 65 from a general hospital where he was being treated for a stroke. With persisting confusion and incontinence a transfer was requested. A younger brother has had three psychiatric admissions with a diagnosis of mental retardation and personality disorder.

Mrs. O'N. was admitted to the same psychiatric hospital in October 1969. During the day, without any warning, she became confused, paranoid about neighbours and tearful. Within hours of admission she was semi-comatose, with a temperature of 103·4, a pulse rate of 140 and pretty obvious signs of pneumonia. She was transferred to a general hospital where she recovered uneventfully. Psychiatric assessment there uncovered no illness and particularly schizophrenia was excluded. Her unhappy home circumstances came to light, and she was offered supportive follow-up in the psychiatric out-patient clinic of the general hospital. During her illness her children were placed in care, and shortly after her discharge an attempt was made to treat her husband's alcoholism. He urgently requested in-patient care, and this was arranged. (A year later, in drink, he admitted that he planned the admission crisis to avoid paying £25 rent arrears.) Following his discharge, a new phenomenon appeared during joint interviews by social worker and psychiatrist. He was accusing his wife of madness. During rows that were witnessed he would say: 'Tell the doctor about the apparitions you saw'; 'They (neighbours) all call her mad Mary'; 'Tell him about your father and brother in the mental (hospital)—tell him that'; 'She's sick, doctor'; 'You'll be eating your plum pudding in the mental (hospital)'. He threatened to have her certified, and using these rather sadistic tactics he was able to distress her and alarm the treatment team. She insisted in separate interviews that his allegations were false, and at no stage, despite enormous pressure from him, did she show evidence of psychotic illness. She reasoned that her husband wanted the children in care and her in hospital to allow him greater freedom to drink even more.

It was apparent to the treatment team that he was trying to induce illness in his wife. For two years she has survived his attempts. She is afraid to leave him, knowing that he would follow her, and legal separation is difficult to arrange, particularly for the poor.

Discussion

Almost certainly the Gaslight Phenomenon goes unrecognized more often than not. We feel that these case histories, while perhaps dramatic almost, are unusual only in degree. More subtle and disguised attempts to get rid of a spouse or relative by labelling him or her mentally ill or demented do occur, and hopefully this presentation will remind colleagues to believe patients' statements unless there is corroborative evidence to the contrary. Awareness of the syndrome should help towards an early diagnosis.

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