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Ganser syndrome: the aetiological argument

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SUMMARY In this case history, which shows the clinical features of the Ganser syndrome, there was abundant evidence to support both an organic and an hysterical aetiology. The aetiological dilemma is discussed, and the case illustrates some of the problems of nosology, clinical presentation, and psychopathology that this syndrome raises.

In his original paper, Ganser (1898) described four criminals who showed: (i) "Vorbeigehen" (approximate answers); (ii) clouding of consciousness with disorientation; (iii) "hysterical" stigmata; (iv) recent history of head injury, typhus, or severe emotional stress; (v) "hallucinations"—auditory and visual; and (vi) amnesia for the period during which the above symptoms were manifest.

After the original description of the condition, there has been argument over the aetiological primacy of either hysteria or psychosis (including organic states) Ganser (1898), Enoch and Irving (1962), Mayer-Gross *et al.* (1969), and Tsoi (1973) have adhered to the hysterical explanation while Goldin and MacDonald (1955), Whitlock (1967), and Stern and Whiles (1942) have preferred the psychotic.

Approximate answers have been reported in a variety of psychiatric states ranging from trauma (Ganser, 1898), to organic brain disease (Sim, 1974), alcoholism with Korsakow's psychosis (Whitlock, 1967), acute schizophrenia (Tsoi, 1973), depressive states (Anderson and Mallinson, 1941; Enoch *et al.*, 1967), neurosyphilis (Tsoi, 1973), and as "motivated by" possible compensation neurosis (Tsoi, 1973). Authors tend to agree with Ganser in his statement, "I must say that I never had the impression that these patients sought to deceive me." He recognises the reality of "hysteria" as a pathological state, distinct from, and without basis in malingering.

Given that malingering does not play a part in the syndrome, a definition of hysteria must be sought. Scottowe's (1964) criteria for hysteria are: (i) the symptoms are an imperfect representation of the condition they resemble; (ii) the symptoms correspond to the mental image that the patient might be expected to have of the illness or emotional state or role in life which is resembled; (iii) the immediate syndrome, or the long-term general attitude and behaviour of the patient, can be seen to serve some gainful purpose for him; and (iv) careful history taking will generally show a previous hysterical attack, though not necessarily in the same form, and hysterical traits of personality.

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Case report

Miss A, aged 20 years, was seen by a psychiatrist on an accident ward where she had been admitted after a road accident in Italy two weeks before and transferred to a psychiatric hospital.

Her father was a kind, well-meaning man of strict morals and high standards. Her mother acted as secretary to a countess. Miss A described her mother as "volatile, extravagant, and needing attention." The patient was an only child in a family without psychiatric history.

Her childhood had been disturbed by bitter arguments between her parents who separated and reunited several times. The patient usually lived with her mother. At the age of 8 years, Miss A was put on probation for shoplifting, but before this time there were no neurotic traits or illness. She passed the 11+ examination and attended grammar school after her parents' eventual divorce. At this time her mother became considerably in debt. Creditors visited the house, and Miss A was sent to dismiss them using lies. Disliking this, she developed a complete inability to walk (aged 13 years), was admitted to hospital, and was seen by a psychiatrist after organic illness was excluded. Complete recovery was made without any specific treatment, but it was thought

advisable for her to attend boarding school, where she remained well until the age of 16 years. She then developed amenorrhoea and anorexia lasting for six months, which ended when her father treated her at his home by refusing to let her out of the house until she reached what he considered a reasonable weight. By the age of 18 years she had gained four A levels at grades, A, A, D, and C, and a place at university to read psychology. Before going on holiday she had completed her second year with results that indicated at least an upper second class degree.

Her relationships had always tended to be shallow, exuberant, and transitory, and, more recently, with men, promiscuous. This was her father's account. He also described her dishonesty and the similarity to her mother in her flamboyant and extravagant nature. She had, in her flat, for instance, five pairs of boots almost unworn, large numbers of books, many of them duplicate copies, and piles of notepads and boxes of pens, mostly new. He suspected that some of these may have been stolen, and indeed she had been given a conditional discharge for shoplifting a pair of sunglasses before going on holiday.

A friend described her as "trying to get too much of the limelight" which was beginning to tire others. Miss A described herself as deeply interested in psychology and as "extroverted."

PRESENT ILLNESS

In her vacation she had hitchhiked with a friend in a reportedly stolen car. Reckless driving had ended with Miss A's ejection from the car with a resultant closed head injury and concussion. She had not known that the car was stolen at the time. She had been admitted to hospital and, on recovery of consciousness, "talked rubbish," was disorientated in time and space, and was drowsy. After what can only be assumed to be partial recovery, she was flown back to the United Kingdom.

On her return, her father found her conversation indistinct, repetitive, slow, and, at times, nonsensical. She was drowsy and slept for large parts of the day. She was admitted to an accident ward where skull x-ray and neurological examination were normal. There was a change in her behaviour in that she became flirtatious with all men, and "a nuisance" to the nursing staff. She wore nightdresses of which the decolletage was only matched by their shortness, and psychiatric assistance was sought forthwith. Examined for the first time, her mental state was normal, except for frivolity and amorousness with the giving of approximate answers, thus: Q. What is the capital of Italy? A. Naples; Q. What is the capital of Scotland? A. Aberdeen; Q. How many legs has a centipede? A. Seven. She also showed emotional lability and a period of total amnesia. She did not show perseveration.

She was transferred to a psychiatric hospital where a similar state was found. It was interesting that approximate answers were accompanied, usually, by explanations or expletives, and accurate answers by nothing, thus: Q. 14+15? A. 37—"Oh I'm sorry"; Q. 9+8? A. 17; Q. 4×13? A. 53—"Jeepers, I've never been very good at arithmetic"; Q. Capital of Spain? A. "Dunno"; Q. Capital of Japan? A. Tokyo; Q. Capital of Scotland? A. "Blimey, Aberdeen"; Q. How many of each suit in a pack of cards? A. "14 . . . 13, sorry my maths is bad, . . . 13 . . . 14, jeepers creepers."

With the test of serial sevens she counted on her fingers and made occasional small mistakes. This was accompanied by "It's not an attention getting thing—I'm just trying to answer your questions."

Questions directed towards orientation were answered with varying degrees of accuracy, thus: "Where are you?" "The nerve part of the hospital."

During the lengthy interview she at no time expressed surprise at such questions as "How many legs has a centipede," and did not contradict herself. She dissolved in tears with anxiety about her ability to continue her course at one moment and was flirting with the examiner the next. There was no evidence at any time of hallucinations or delusions.

Physical examination was normal other than a healing occipital laceration, as were clinical investigations. The results of serial psychological testing are summarised in the Table. There was an initial discrepancy between verbal and performance scores as expected with organic damage. This was seen to resolve with a steady improvement in Full Scale Score, which did not, however, reach the standard expected of an above average psychology student.

During her stay in hospital (day 11 to day 59 after the accident) Miss A interfered with the treatment of other patients, played staff off against patients and vice versa, and made frank declarations of love to one of the authors in daily lengthy letters, written more in the style of a young schoolgirl than an intelligent student. However, without medication or other specific treatment, her mental state improved in parallel with her WAIS test. She became fully orientated, and her amorous approaches became less blatant. In out-

Table *Serial psychological testing on days after accident*

Test results	*Number of days after accident*			
	12	26	53	222
Full scale WAIS	Test	92	117	120
Verbal	aban-	97	116	119
Performance	doned	87	115	119
Information		10	10	13
Comprehension		11	17	17
Arithmetic		10	11	11
Similarities		12	15	13
Digit span		9	9	11
Vocabulary		13	14	14
Digit symbol		8	10	11
Picture completion		8	12	11
Block design		8	15	16
Picture arrangement		9	10	13
Object assembly		8	15	Omitted

patient follow-up, she showed a continued improvement in psychometric testing, and she returned to university. Even five months after the accident she still gave approximate answers, thus: "How many legs has a centipede?"—"sixteen" (at least an even number), and "What is the capital of Italy?"—"Naples." However, seven months after the accident she gave no such answers and had gained the highest mark on her university course for an essay.

Her comparatively poor final WAIS result could be explained by a certain residual flippancy towards such tests. It was felt by her father that she had returned to her normal self, both in terms of intellect and personality. She expressed surprise at having answered questions as she had done, and claimed to have no memory for her approximations.

Discussion

This case illustrates some of the problems of nosology, clinical presentation, and psychopathology of Ganser syndrome. The patient gave approximate answers, showed clouding of consciousness, and had had a head injury. She did not show hallucinations and neither was she a criminal. The latter is generally not required for diagnosis of the syndrome (Curran and Partridge, 1969; Enoch and Irving, 1962; Whitlock, 1967; Tsoi, 1973; and Sim, 1974). Hallucinations are not described in precise phenomenological detail in the literature, and even Ganser's original reports are doubtfully hallucinatory. For instance, his first patient was inferred to be hallucinated "because he spoke a great deal about war with Cossacks, about hunting and so forth . . . it was clear that this behaviour was completely his response to hallucinations." The second "confirmed that he had hallucinations as his anxious staring behaviour allowed one to guess. Black figures floated about him and threatened him, whistling and beckoning." The third had "complained very strongly about black men who had often visited him and forced themselves upon him." It would seem more appropriate to regard these experiences as alterations of visual perception associated with clouding of consciousness.

Miss A showed both a previous history of hysterical neurosis (ICD 300.1, World Health Organisation, 1965) and a premorbid personality of hysterical type (ICD, 301.5). She was consistently attention seeking and histrionic in her behaviour. She also had a severe head injury with prolonged alteration of consciousness. Her case demonstrates and, to some extent, resolves the hysterical/psychotic dilemma. In the event of her severe organic illness, hysterical features were unmasked. To quote Scott (1965) "Why should defences and deceptions be the prerogative of the sane? It is the whole man, along with his tried defences who becomes mentally ill; it would be odd if they did not colour that illness." The physical assault with alteration of brain function and the capacity to react in an hysterical manner were both present and necessary aetiologically in her presentation of the features of the Ganser syndrome.

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