Ganser Syndrome Followed by Major Depressive Episode

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A case of complete Ganser syndrome resolved after one week, but was immediately followed by a major depressive episode. The two disorders had a common cause, which is best encapsulated in a psychodynamic formulation.

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The incidence of Ganser syndrome (Ganser, 1898) depends on the strictness of the diagnostic criteria used. Enoch & Trethowan (1979) regarded the four essential features as (a) approximate answers, (b) clouding of consciousness, (c) visual or auditory pseudohallucinations, and (d) somatic conversion symptoms. By these standards, most reports are of incomplete forms, the complete syndrome being "exceedingly rare" (Lishman, 1987).

Ganser syndrome may occur during the course of a variety of organic and functional psychiatric disorders, and less commonly in isolation (Lishman, 1987). In either case onset is usually sudden and related to a stressful life event (Lishman, 1987) particularly domestic, sexual, or financial trouble (Whitlock, 1967). Despite earlier controversy, most authorities now regard the condition as a hysterical disorder; even in 'secondary' cases, functional illness and organic factors are seen as principally releasing hysterical mechanisms rather than directly causing the disorder (Scott, 1965; Latchman et al., 1978; Cocores et al., 1984; Lishman, 1987). The prognosis is generally good: most cases are transient, resolving suddenly, with an amnesia for events during the syndrome being the only sequela (Enoch & Trethowan, 1979).

The following case illustrates the complete syndrome, an association with mental handicap, an atypical outcome (depressive illness), and a clear aetiology.

Case report

J, a 31-year-old man, was admitted to a regional secure unit after being convicted of arson. He was known to have mild mental handicap, and to harm himself impulsively when faced with stressful life events, but had never suffered psychiatric illness. Following admission, a dementia screen (computerised tomography brain scan, electroencephalography, syphilis serology, biochemical profile, full blood count, thyroid function tests, serum B12 and folate levels) was normal, while psychometric assessment revealed an IQ of 65 with global impairment. Over the next 18 months he made reasonable progress with a rehabilitation programme. Throughout this period he required no psychotropic medication and was euthymic.

Eighteen months after admission, two 10-year-old boys alleged that J had indecently exposed himself to them at the perimeter of the hospital grounds. He was confined to the unit and the police were asked to investigate. For the next seven days he repeatedly denied the episode, and showed no emotional response to the allegations, behaving as if nothing had happened.

He then had a long interview with a member of the local Citizen's Advice Bureau about legal representation. At 2 a.m. the following morning he got out of bed and began fumbling about the corridor, bumping into objects. He was seen by the duty psychiatrist and complained of seeing vivid, angry, disembodied faces in colour. He was unsure whether they were real, but said they frightened him. He also described hearing voices, but was unable to give a clear description. No other psychotic symptoms were elicited. Full physical examination was normal. He denied drug abuse and had not consumed alcohol for several weeks.

On examination the next morning he appeared perplexed, but described his mood as 'OK'. He was still experiencing visual pseudohallucinations as before, and in response would often stare wildly at the ceiling. He demonstrated vorbeiren den. His responses, all given with the utmost seriousness, included: (Q) What colour is the sky? (A) Orange. (Q) What is 4 plus 4? (A) Seven. (Q) How many legs does a cow have? (A) Three. (Q) Who is the prime minister? (A) Margaret Thatcher (John Major had been for the last six months). (Q) What shape is this (shown a circle)? (A) A square.

In addition, he was disoriented in time and place: (Q) What day is it? (A) Don't know. (Q) What month is it? (A) April (it was mid-May). (Q) What year is it? (A) 1991 (correct). (Q) What is this place? (A) A guest house (a few minutes later he spontaneously mentioned 'the ward staff', but was unconcerned when this inconsistency was pointed out).

He complained of photophobia and weakness in his arms, but full physical examination revealed no consistent signs. A full blood count, biochemical profile, a porphyria screen, and a urinary drug screen were all normal. A diagnosis of Ganser syndrome was made; he was not prescribed any psychotropic medication and his symptoms were ignored as much as possible to avoid reinforcing them.

His mental state changed little over the next seven days, although his symptoms fluctuated in severity. On one occasion he dramatically fell to his knees, clutching his abdomen and complaining of pain; examination was normal. He continued to respond to visual hallucinations when he believed he was alone. Throughout this period he appeared unconcerned about his symptoms and in a daze. He remained independent in all activities of daily living, with no evidence of depressed mood or biological symptoms being noted.

One week later his mental state changed abruptly. His Ganser syndrome rapidly resolved and over the next three days he developed a severe depressive illness. He described persistent low mood, anxiety, anhedonia, poor concentration,
and lethargy, his appetite became poor, he developed insomnia, and became withdrawn, refusing all visitors and isolating himself on the ward. He became pessimistic, described plans for suicide, described himself as a "bad man" who did not deserve to live, and was observed to punch and slap himself. Dothiepin was commenced and quickly increased to 150 mg daily.

Shortly after his depressive illness began he asked to see his key nurse. He spontaneously confessed to the indecent exposure and talked about the shame that he would feel if the other patients and his family found out he was a "nonce" (sex offender). At a later session he said he needed to punish himself and could not understand why the staff were not punishing him. It was explained that the staff were there to help him and that his offence would be kept confidential. By now the police had decided not to press any charges.

He remained depressed for 4½ weeks, but then began to recover. Ten days later he returned to normal. Although able to discuss his depressive episode, he had no memory of his Ganser syndrome, commenting, "I just went into a trance. I remember nothing at all." After his recovery he worked constructively in individual sessions dealing with his sexual offence.

**Discussion**

J showed the complete Ganser syndrome (Enoch & Trethowan, 1979), followed by a major depressive episode (DSM—III—R criteria; American Psychiatric Association, 1987).

In hysteria symptoms are not under conscious control, whereas in malingering they are produced voluntarily in pursuit of a clear goal. The differentiation is important medically and legally, but in practice can be difficult. This is especially true with Ganser syndrome, where symptoms, although unconsciously produced, often appear to serve a useful purpose. J's diagnosis of Ganser syndrome, as opposed to malingering, was aided by several factors; unlike a malingerer he was not upset by inconsistencies in his symptoms, was not anxiously on his guard to avoid them, and his symptoms continued when he believed he was unobserved. Furthermore he showed belle indifference, a characteristic feature of hysteria.

Regarding the aetiology of his Ganser syndrome, the normal physical examinations, blood and urine tests tended to rule out physical factors. The fact that his depressive symptoms appeared after his Ganser syndrome had resolved excluded their releasing the hysterical mechanisms. Psychogenic factors appeared of primary importance. In the following formulation, J's Ganser syndrome and depression are regarded as separate manifestations of a common underlying conflict, that is, symptom substitution is suggested as the linking mechanism.

The allegation of indecent exposure was a major threat to J; to accept it would shame him. J tried to avoid this by using a succession of defence mechanisms. For the first week he successfully used denial, continuing to function well and remaining euthymic. His interview with the Citizen's Advice Bureau seemed to precipitate his Ganser syndrome. Presumably it brought home the seriousness of his situation and the likelihood of criminal proceedings, breaching his denial. J needed a new defence and 'chose' dissociation.

The psychological features of Ganser syndrome (pseudohallucinations, disorientation, approximate answers) can be seen as a flight from reality into a layman's impression of 'mental illness', dissociation allowing the patient to escape from an intolerable situation (primary gain). Conversion symptoms emphasise the patient's relief that he is ill. The benefits of the sick role can be regarded as the secondary gain.

After one week J's dissociative defence failed (why is not clear, although at the time his mother was telephoning him regularly to enquire why he was ill, and this may be relevant). Externally this was manifest as the resolution of his Ganser syndrome, internally it forced him to face the painful reality of his offence; that J first admitted this only days after his Ganser syndrome resolved supports this hypothesis. Accepting his offence resulted in a loss of self-esteem and consequent depression (Freud, 1917).

In a final attempt to come to terms with his shame, J employed another defence, turning on the self. This was manifest by his suicidal ideas, hitting himself, and his view that he was a bad man and should be punished. J's defences (denial, dissociation, turning on the self) were relatively primitive; presumably his low intelligence predisposed him to use them.

Two other facts support the idea that coming to terms with shame was J's underlying conflict. During his Ganser syndrome his visual pseudohallucinations took the form of angry faces; a symbolic element to hysterical symptoms is well recognised. Later, during his depressive illness he openly told his key worker about his fear of criticism from patients and his family. His recovery appeared due to several factors: the police decision to drop charges, his constructive sessions with his key worker, and his course of dothiepin.

J's progression to severe depressive illness is in sharp contrast to the complete recovery usually seen in Ganser syndrome (Enoch & Trethowan, 1979). J's case suggests that such an outcome may result from continuing intrapsychic conflict. The acute onset and severity of his depression reinforces the view that patients with Ganser syndrome should
be admitted for assessment (Enoch & Trethowan, 1979; Carney et al., 1987) and suggests the need for follow-up after apparent recovery. Further reports should help clarify the prognosis of this rare disorder.

References


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The Million Dollar Man

Resource Implications for Chronic Munchausen’s Syndrome

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Munchausen's syndrome in a man of subnormal intelligence is described. The case is unique for the extent of detailed, corroborated history. This man has been a voracious consumer of NHS and other services, and an estimate has been made of his cost to the health and prison services. The case raises various ethical, forensic, and resource issues. British Journal of Psychiatry (1993), 162, 253—256

Munchausen’s syndrome has been extensively described since Asher’s (1951) original report of patients with “acute illness supported by a plausible and dramatic history . . . made up of falsehoods”. Although he described somatic presentations (acute abdominal, haemorrhagic, and neurological), subsequent writers have reported psychological complaints. These include reaction to bereavement often accompanied by self-harm (Snowden et al., 1978), depression (Ben-Tovim, 1978), thought disorder (Cheng & Hummel, 1978), post-traumatic stress disorder (Geracioti et al., 1987), and alcohol abuse (Caradoc-Davies, 1988). DSM—III—R (American Psychiatric Association, 1987) also refers to presentations with suicidal ideation, memory loss, hallucinations, and dissociative and conversion symptoms.

The following case illustrates many of these typical features. An additional point of interest is his verified history of educational difficulty and subnormal intelligence. The case is unique, however, for the extent of corroborated, detailed biographical and medical history. Since the onset of his disorder he has been a voracious consumer of services.

Case report

The subject is an unemployed man in his 30s who lives in London. The authors have documentary evidence of 545 treatment episodes at 84 hospitals over 1977—88. As he provided an inaccurate history, information was obtained from his mother, and where direct family knowledge existed, social-service and probation reports.

He was born in the middle of a large sibship to an impoverished but stable working-class family. His father, who was often away from home due to his occupation, died prematurely of cancer during the subject’s adolescence. His mother is alive and well. Although there is no psychiatric illness in the family, three siblings had educationally subnormal schooling and one has epilepsy. There is no reported history of discord or distorted relationships within the family.

His early development was complicated by threatened miscarriage at four months, a prolonged difficult labour, and at nine months, measles requiring hospital admission. He received schooling for educational delay from 7—16 years, at which time he had no friends and was often truant.
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