the effect of ECT in our patient, acting on a previously abnormal central nervous system, was sufficient to produce the schizophrenia-like psycho-syndrome.

Weston and Whitlock (1971) described a case of the Capgras syndrome following severe head injury, and Whitlock (1967) also described cases of the Ganser syndrome occurring on an organic basis, thus emphasizing the fact that these conditions are non-specific and can occur in a wide variety of psychiatric settings. It may, therefore, be preferable to talk of the Capgras symptoms and Ganser symptoms rather than use the word 'syndrome'. Sir Aubrey Lewis (1966) has pointed out the difficulties that arise from arguments over the use of such terms as 'syndrome', 'illness' and 'clinical entity'. However, it is important that the significance of the above contributions does not get overlooked in what may become an argument over the meaning of words. What must be emphasized is the need to search carefully for a possible underlying cause in these cases.

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DEPRESSIVE ILLNESSES IN LATE LIFE

DEAR SIR,

May I register my surprise that Sir Martin Roth and Dr. Garside could advance the naïve notion (letter, *Journal*, 1973, **123**, 373–5), that researchers' biases in collecting data on symptoms would necessarily be a direct reflection of their views?

In patients over 40 I regularly find the early morning wakening, guilt, feeling worse in the morning and so on, the symptoms which characterize endogenous depression. However, when students fuss about whether a patient of under 30 suffers from this or a neurotic depression I am conscious of a growing irritation. Why, I feel, do they not merely ask, does the patient have a condition which is likely to respond to an anti-depressant? And, instead of attempting to find the list of symptoms which characterize neurotic or endogenous depression, why do they not focus on whether the patient has shown for some months a clear-cut depression or loss of interest with sleep disturbance and possible loss of appetite etc., which is different from their lifelong pattern? Again I ask myself: can endogenous depression be a clinically significant entity when so few of the symptoms which characterize it correlate with a good response to physical treatment? (Kiloh *et al.*, 1962; Mendels, 1965; McConaghy, 1968).

Clearly I am biased against the concept that these two illnesses exist as entities. Yet when I interview a patient I regularly ask whether he has difficulty in going to sleep or does he wake early; does he feel worse in the morning or at night; and so through the questions which tend to polarize the patient's symptoms to match one of these two postulated illnesses.

Roth and Garside underestimate the effect on clinicians, whether believers or non-believers, of a theory which is clear-cut and easy to grasp, particularly when there are no alternative theories available with these advantages. Yet how often must they have seen even the bitterest opponents of Freudian theory use large chunks of it when attempting to explain aspects of human behaviour. Equally I have heard the term 'double-bind' frequently used clinically by psychiatrists who in intellectual discussion obviously regard it as a meaningless cliché. Back to the drawing board?

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[This letter was shown to Sir Martin Roth, who comments:

'The point we were making was that a man's bias will not necessarily distort his perception and falsify his findings. Sometimes a clinical psychiatrist subscribes to one theory, yet his own observations may establish the opposite. In the case to which we referred, the investigators were not themselves aware that this had in fact happened.

McConaghy's point is quite different. It is that man will not necessarily practise in the clinic what he preaches in

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his scientific papers. This is understandable. The models required for experimental work and clinical practice are quite different. But that is quite another issue.'—Ed.].

THE GANSER SYNDROME

Dear Sir,

I note that Dr. Tsoi (*Journal*, 1973, **123**, 567–72) places the Ganser syndrome 'on the hysteria-malingering dimension rather than as a psychosis' and then suggests that the syndrome by itself should not constitute unsoundness of mind for criminal purposes. What does this mean to the forensic psychiatrist?

I suggest that there are three points in the criminal law process when the mental state of the accused and/or convicted man is properly in issue: (i) regarding fitness to plead; (ii) regarding the various mental state defences; and (iii) in relation to culpability for the purposes of sentencing. In my opinion the *Ganser syndrome*, as opposed to a diagnosis of *malingering*, is relevant to the issue of fitness to plead (1). If, at the time of arraignment (or at a time before the opening of the case for the defence) the accused suffered from the Ganser syndrome as described by Dr. Tsoi then I maintain that there would be a proper issue of unfitness to plead to put before a jury. This is because fitness to plead is essentially a matter of communication rather than a question of insanity or unsoundness of mind (2), as is apparent from the cases concerned with the deaf and dumb (3).

When one turns to consider the mental state defences it has to be remembered that the only concern is the mental state of the accused at the time of the commission of the alleged offence. I cannot recall any mental state defence being raised on the basis of a Ganser syndrome, but I can recollect a successful defence ('automatism') to a murder charge based upon the diagnosis of an hysterical dissociative state (R v. Ede) (4) and a successful defence to a charge of attempted murder on the same psychiatric diagnosis which led to a verdict of not guilty on the ground of insanity (R v. Davies) (5). However, I do not think it at all likely that the notion of a Ganser syndrome, as opposed to an hysterical dissociative state, will have any relevance to a mental state defence.

The major problem presented by the mental state of an individual involved in the criminal law process is found at the post-conviction–pre-sentence stage. Here one may well see variations on the Ganser syndrome theme when offenders, in many cases, have little more to seek than judicial sympathy. It is at this stage that the presence of a Ganser syndrome is relevant in that the court should be informed of the presence of the syndrome and what it may mean in itself and in terms of the personality of the offender.

There are some other more exotic matters regarding mental state and the correctional (criminal law) process, for example unsoundness of mind and capital punishment (6), but these will not be considered here. What is not appropriate is simply to state that the Ganser syndrome, however defined, is not unsoundness of the mind for the criminal law. It is suggested that if the diagnosis is 'malingering' such a proposition should be baldly stated and supported and the diagnosis not dressed up and called a Ganser syndrome, 'the simulation . . . (being) at the conscious . . . level'.

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1. *Criminal Procedure (Insanity) Act*, 1964 s.4; for Victoria see *R v. Presser* 1958 V.R. 45.
2. See *Crimes Act*, 1958 s.393 for Victoria.
3. In *Podola's* case (1959) 43 C.A.R. 220 at 238 one reads ' "shall be insane . . ." contained in section 2 of the Act of 1800 have in many cases since 1800 been construed as including persons who are not insane within the McNaughton Rules, but who, by reason of some *physical* or mental condition cannot follow the proceedings at the trial and so cannot make a proper defence in those proceedings' (my italics).
4. Not reported but briefly commented upon in Bartholomew, A. A. (1962) Time for revision of M'Naughten Rules. *Med. J. Aust.*, *i*, 382.
5. Not reported.
6. See *Re Tait*, 1963 V.R. 532; *Tait v. R*, 1963 V.R. 547.

Publication of the Journal during National Power Shortage

Because of national restrictions on working hours, the *British Journal of Psychiatry* contains fewer pages than usual. We regret this situation and hope to receive the indulgence of our readers.

The *Journal* will return to its normal size as soon as conditions permit.

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