THE GANSER STATE

By

S. GOLDIN, L.R.C.P., L.R.C.S., D.P.M.

Registrar

and

J. E. MACDONALD, M.A., Dip. Psych.

Psychologist

Runwell Hospital, near Wickford, Essex

INTRODUCTION

THE aim of this paper is threefold:

(i) To review critically the literature on the Ganser State and clarify its meaning.

(ii) To provide a case illustration with some hitherto unreported features.

(iii) To present psychological test results, which has not previously been done in a case of this kind.

REVIEW

The Ganser State is afforded a brief paragraph in most psychiatric texts; usually, these merely repeat more or less what has been stated in earlier works. The general impression conveyed is that it is a hysterical reaction not uncommon in prisoners and sometimes found elsewhere, its unconscious motivation being to make the individual appear insane and thus absolve him from responsibility. The central symptom of the cluster is frequently referred to as "Vorbeireden" which has been translated as "talking past the point" and "talking beside the point". It is difficult to trace the origin of the use of the word, "Vorbeireden", in this context: it certainly does not appear in Ganser's original article (1898), and in his second (1904) it is present only in a quotation from Nissl and in the title of a paper by Westphal ("Über hysterische Dämmerzustande und das Symptom des 'Vorbeiredens'," 1893—this may be the earliest use of the expression). In any case, the English expressions, "talking past the point" and "talking beside the point", mean two different things neither of which corresponds to the essential symptom as described by Ganser—nor does "talking at cross purposes", which is a more accurate translation. A word Ganser does employ is "vorbeigehen", and the literal translation of this conveys the meaning better than any of the afore-mentioned phrases: "to pass by"—the patient "passes by" the correct answer to a question and gives one near to it. Thus it is necessary to go back to Ganser's own words.

Ganser said that the most striking feature presented by these patients was "dass sie Fragen allereinfachster Art, die ihnen vorgelegt wurden, nicht richtig zu beantworten vermochten, obwohl sie durch die Art ihrer Antworten kundgaben, dass sie den Sinn der Fragen ziemlich erfasst hatten, und dass sie in ihren Antworten eine geradezu verblüffende Unkenntnis und einen überraschenden Ausfall von Kenntnissen verriethen, die sie ganz bestimmt besessen hatten oder noch besassen" (1898). Examples of these two types of response, (*a*) answers to the simplest questions which are incorrect but which

show that the sense of the question has been approximately understood (like answers sometimes given by children), and (*b*) answers showing an astonishing ignorance and deficit of knowledge which must definitely have been or still be in the patient's possession, are as follows:

(*a*) Asked what is 3+2, the patient replies "7"; 4—1, "5"; to count from 1 to 20, does so with several omissions; what comes after 1, "2", and then, "12, 93"; how many legs a horse has, "3", an elephant, "5"; how many fingers he has, "11".

(*b*) Asked where he is, "Berlin, in Russia"; what they are doing, "We want to go hunting"; how many eyes he has, "No eyes"; how many noses, "I don't know"; what his name is, "Fürst" (incorrect). Asked to name a key presented to him, "Revolver"; to tell the time, reads it five hours behind; to read letters, does so partly correctly; to read a paper, "Bismarck, König, Albert, Rothschild, Geld", etc., changing the order of these words as he repeats them; to name a Thaler, a Mark and a 50 Pfennig piece, calls them all a Mark. (Later, however, he read correctly and named the coins correctly.)

These answers, which may be described as "approximate" and "ridiculous" respectively, were interspersed with correct answers. The question at once arose whether they were serious or simulated responses, particularly as they occurred, in three of the four cases, in prisoners on remand. Ganser was emphatic that they were genuinely ill persons and that he, as an experienced observer, never had the impression that they were trying to deceive him.

The other symptoms common to the four cases, concurrence of which Ganser regarded as significant and simulation of which by the psychiatrically uninformed as most unlikely, were: auditory and visual hallucinations; spatial and temporal disorientation; amnesia for the actual situation (amnesia for the state when reverted to normality); hysterical analgesia or hyperaesthesia; and lack of insight—all within the setting of a more or less disturbed, "twilight" state of consciousness of fluid character and short duration. In some of the cases there were later recurrences of this twilight state. This changing state of consciousness with memory defects he viewed as characteristic of the acute, hysterical disturbance and dubbed a "hysterical twilight state". Differences among the patients lay in the degree of their general activity, alertness to surroundings, promptness in answering questions and presence or absence of anxiety and of self-blame.

In his second paper, Ganser (1904) remarks that the patients were not surprised or irritated at the stupidest questions or at the low estimate of their intelligence implied, and that they made an effort to find the answer. The errors were not always constant, i.e. there were inconsistencies of response. Other common features were headaches and difficulty in focussing attention sufficiently to answer the questions put. Ganser had by this time seen more than twenty such cases, which occurred more frequently than he had at first thought. He now takes up the question of whether these cases were a hysterical reaction or a catatonic negativism, as some writers averred. Among the catatonics he had seen were some with manifestations generally regarded as hysterical, viz. certain convulsive and sensory disturbances: Kraepelin, he thought, had not given sufficient attention to these manifestations; for Nissl, they were signs of a later psychosis only outwardly resembling hysterical signs. Ganser, however, advanced in his outlook, realized that hysteria and catatonia are independent, that hysteria may occur with another disorder, functional or organic, giving rise to complex states or superpositions, and that persons with hysterical

temperament may or may not develop a hysterical disorder. He illustrates this from his case material.

Flatau (1913), in a review some ten years later, remarks on the increasing number of non-criminal cases reported—at least a third of all cases of this type—and on the decreasing number of relevant publications appearing. The total number of cases reported by some twelve authors seems to have been just over forty at this time, in addition to Ganser's twenty-odd and Flatau's four (of which at least two were doubtful Ganser states). Flatau stated that in non-criminals the state is usually of shorter duration and less intensity.

A search through the literature in English brings to light a mere handful of cases, and of these some are doubtful and some certainly not Ganser states. Bender (1934) describes several cases of women who had murdered their children; of three who appear to have been schizophrenic, one was said to have developed "a definite Ganser Syndrome", another "a Ganser-like state" and the third "some Ganser-like features", subsequent to arrest. For none, however, are unequivocal examples of the approximate and ridiculous answers (here considered a *sine qua non* for this diagnosis) provided: the samples of talk given show disorientation, confusion and a tendency to incoherence. In a later report, Bender (1938) cites two further cases more clearly falling into this category: one was described as a combination of alcoholic-toxic, depressive, hysterical and malingering features, arrested for killing his wife, who gave such responses as that a mouse had five legs and that a green blotter was blue; the other, a schizophrenic, arrested for "panhandling", called a dictionary a Bible, gave the name of the hospital (Bellevue) as Belmont Hotel and the duration of his stay as 12 years instead of days, took out his penis and pointed to it when asked to point to his tongue, and so on. "It is as though the individual", says Bender, "having heard the question, used it as an association test and gave the association word as an answer. This requires that the actual answer must be inhibited and that a related word or idea is offered instead." She also gives examples of the performance of these two patients on her visual-motor Gestalt test, which show confusion and disorientation: these characteristics, however, seem to have been a product of the more serious disorder rather than of the Ganser state and unlike the "near misses" of the case reported below by the present writers. She also describes the drawings of physicians, students and nurses assigned the task of drawing as though they were defectives and states that they were unable to conceal the essential Gestalt principles appropriate to their maturational level. One might comment that such productions should not, *a priori*, be expected to resemble those of Ganser patients; and in any case the test has not been adequately validated as an instrument of differential diagnosis.

Anderson and Mallinson (1941), noting that very little had been contributed to the problem since Flatau's paper, report three cases. One is said to have had depressive, manic and catatonic features; his symptoms included depersonalization and derealization, ideas of reference and delusions of an electrical force, masturbating openly and being doubly incontinent, in addition to "Vorbeireden" (sic); his behaviour under sodium amytal, however, led the authors to conclude that this was "a pure depressive illness in an obsessional and hysterical personality" and that "no schizoid features whatever were revealed" . . . The second case, who appeared as "feigned insanity overlying a depressive state", gave answers always "beside the point" and sing-song fashion. The third, diagnosed as schizophrenia, said that the month (February) was "January", that two plus two was "one", that a cigarette case was a "bird"—told to answer correctly,

"silver"—again told to answer correctly, "a case". Other examples given are even less "approximate" and the authors go on to say that "the whole stamp was ungenuine"—which is quite contrary to Ganser's findings. In none of these cases does a clear relationship emerge between the advent of the alleged Ganser state and a potential gain for the patient—in one case, it meant a ruined career. None of these cases, then, has convincingly been demonstrated as a Ganser state.

Stern and Whiles (1942) announce that the concept of hysteria has changed considerably since Ganser's time and "his cases would now be regarded as psychotic" (*pace* Ganser!). Again we are told that this state is common in prisons although rare elsewhere. In this offering, concerning "Three Ganser States and Hamlet" (more than half of which is taken up with quotation from *Hamlet*), one case was a woman suffering from "mania with schizoid features", whose replies to questions about her situation were that "It was a hospital, but is not now" and that she was "knitting" there: she was claiming compensation for an accident but in the circumstances a physical would have been much more likely than a mental symptom to yield success—and, in any case, at the time of the examination she denied that she was suffering from any mental illness. The second case was a schizophrenic, reported to have given Ganser answers on admission to hospital: an example given is the statement that his age was 19 (instead of 35); motivation, too, is again questionable—this man had already been certified in prison. The third of this series developed a buffoonery syndrome (not clearly distinguished from a Ganser state by the authors) after being found wandering by the police; he gave "Black" as his name, "White" as where he lived, "Six months" as his age; he drew a straight line when told to write his name: this occurred *after* he had been discharged from the Army. Again, we have a batch of doubtful cases. With reference to the Danish prince, the fallacy of applying psychiatric methods to a fictional character is touched upon by Davie (1942) in a rejoinder. Such pursuits are more appropriate to the dilettanti delving in the No-Man's-Land between psychoanalysis and literature.

Lieberman (1945),* after the usual ascription of "Vorbeireden" to Ganser, states that "from the available literature it seems . . . evident that the classical syndrome has become less frequent in its pure form so that today it can be looked upon only as a symptom-complex engrafted upon or portending one of a variety of nervous or mental disorders". Lieberman's case is described as containing features of "the hysteriform, the epileptiform, the alcoholic and the diffuse organic disorder" and of "a chronic schizophrenic thought disorder", in the somewhat heterogeneous manner not uncommon in these cases. This, however, is clearly a patient who experienced a Ganser state, from the full account of his behaviour given. He was vague, apathetic and disoriented; amnesic and lacking insight; echolalic and perseverating in parrying questions; he gave approximate and rather fatuous responses in both language and other behaviour. The alphabet and the months were recited with omissions and repetitions; three plus two was six; he read in a manner remotely resembling the written words and could not read numbers; he wrote his name properly but did not decipher what he had written. A handkerchief was called a cloth, an electric fan a wind charger, a 5-cent piece a dime, and all the primary colours were misidentified. A matchbox presented visually was a kite ("Lite King" was printed on the box), presented tactually it was dynamite, then paper; a pencil

* A later article by Lieberman (1954) reports three further cases but has little new to contribute.

presented visually was not named but referred to as yellow, then as wood and as red (the colour of the eraser), tactually it was a pen. He did the opposite of what was required in single acts, part correctly and part reversed in component acts. Under sodium amytal, he gave correct answers to most of these questions when they were repeated but returned to the previous mode after 25 minutes. His p.g.r. showed wide fluctuations in response to leading questions suggestive of "escape" from some as yet undefined situation, and on another occasion a similar response was elicited when he was accused of simulating mental illness. In the ensuing months there was a rapid deterioration.

Laing (1953) reports a case which appears to be one of hysterical puerilism rather than Ganser state. He did give answers like "Two" for 2×2, called an orange an apple and said that leaves appeared on trees in the autumn, but in general his behaviour was infantile with reiterated screaming, "Mom, me Mom's good, me Mom's good . . . I'm only thinking of me Mom!" He acted similarly under pentothal narcosis and there were still no correct answers under hypnosis. It should also be noted that this patient "appeared both to resent and to fear being questioned", which—as previously observed—was not characteristic of Ganser's patients. This patient had been referred for an opinion on his fitness to undergo trial by court-martial for desertion.

Wertham (1949) describes a patient who had been labelled Ganser after an examination subsequent to his incarceration for indecent exposure. This man "put on a strange act", saying, "I don't feel a bit good. My head ain't right. I think I am going crazy." Later he said, "I think I should go to a State Hospital. My mind isn't just right." For days he was mute. Then he gave answers like "329" for 392; "I don't know . . . 10 or 11" for the number of fingers on his hand, after scrutinizing them; different names for the President on consecutive days. He pointed to his right ear for his left, opened his mouth when told to close his eyes, miscopied simple geometrical drawings, put a manikin figure together with the head on one shoulder and one arm wrongly placed. He did not know the date, and he was amnesic for the offence. Later, in the penitentiary, his performance on psychological tests (of which we are given no details) was inconsistent, simple items were failed and difficult ones passed and I.Q. varied from 64 to 91. Wertham regarded this as a dubious case of a Ganser reaction, rather as one of definite and conscious simulation. He saw the patient again years later in an institution for the criminal insane, just after he had made two suicidal attempts, and found him the same suspicious and guarded person as previously. This case, then, may be regarded as one displaying features of both Ganser and malingering type, somewhere along the continuum stretching between them (q.v.).

Thus, of these fourteen cases reported by various writers, most do not appear to warrant the description of Ganser state.

French and Italian contributions to this problem do not appear to be any more satisfactory. Riese and Requet (1937) report "Vorbeireden", simulation and non-recurrence of the state ("After the disappearance of the state, as such, the patient cannot relapse"), all in contradistinction to Ganser. Their case had a previous history complicated by head injury, neurotic symptoms and syphilis. He was a man of forty-three who had been arrested for indecent behaviour towards an eleven-year-old girl. A week after admission he appeared somewhat confused and gave typical "réponses à côté"; e.g. that two plus six was seven, after long thought; that the month (October) was December, then November; that a paper was a book; and when asked to close his eyes, he drew the lids down with his fingers. Features characteristic of aphasia and agnosia were also

apparent; iteration, agrammatism, paraphasia, perseveration and inability to name objects presented tactually or to repeat simple melodies and rhythms. Questions relating to his offence were met with negative replies. This man was sent to prison, and when seen by the authors four months later he performed all the tests correctly and rapidly; his amnesia for the offence had cleared up, to be replaced by amnesia for the Ganser state. The discussion about "la pensée symbolique", with its far-fetched interpretations and generalizations on the basis of unstandardized drawings and questions, is better passed over.

Daumézon, Koechlin and Paumelle (1952) confirm that relevant publications in French have been rare. They too tell us that most cases are found in prisons. They regard it as essentially an affective disturbance (outside of schizophrenia) where the patient has some interest in the situation. Their case is one of a post-menopausal depression with hysterical features in a woman of forty-eight who had recently undergone an operation for gall-stone. She had made an attempt to kill her husband and herself. She was negativistic and said she wanted to die. She inflicted injury on herself by injecting hot water into her vagina and then accused her husband—by whom she entertained ideas of being deceived—of this. She was exhibitionistic in the way she later displayed her vagina for examination. A few days after admission she showed disturbed consciousness, did not know her name or age and gave approximate answers, e.g. that snow was red, coal green and grass white; two plus two was fifteen. Under drugs, she had vivid hallucinations and talked about childhood experiences, but she parried questions concerning her present situation with ridiculous answers. The next several weeks saw variations in this pattern; when the conversation turned on her recent life her attitude changed and there was a regression to Ganser responses. With treatment of the burn, her mental condition improved. She had hallucinated a woman who told her that her husband had another woman friend, which she said was not true: this was evidently a mechanism of exculpation from her attempted homicide and suicide, which was followed by the mechanism of "mental illness" in the Ganser state.

Sarteschi (1953) cites some earlier work in Italian and tries to restrict the connotation of Ganser state to a situational psychosis on a hysterical basis with a "constitutional, pathological, oligophrenic background"; again, it is regarded as a conscious simulation, which disappears when its object has been achieved, found only in prisoners, civilian and military, and in persons seeking compensation for accident. He states that it is becoming increasingly frequent. This viewpoint is manifestly inadequate. Having dealt in a previous paper with the clinical aspects, Sarteschi is here concerned with the medico-legal aspects, in particular the vexed question of responsibility—which is dealt with by one of the present writers elsewhere (Macdonald, in preparation).

Psychopathology

If we turn to a dictionary of psychology or of medicine for information, we find that the Ganser Syndrome occurs "in hysteria or malingering" (Harriman, 1947); that Ganser's Symptom is seen "in certain psychotic conditions" yet that Ganser's Syndrome is "generally of hysterical origin" and is "called also acute hallucinatory mania" (Dorland and Miller, 1942). The latter source also refers to the "simulation" of hallucinations in hysteria and defines simulation as both "malingering" or counterfeiting a disease and the "imitation" of one disease by another. Ganser, however, stated that his patients were hysterical and not malingering, and that they may or may not have had a psychosis in addition; but it is evident that the responses in such patients

have a motivation near to the level of awareness—as evinced by both the nature of the answers and the reactions under drugs—and that a continuum may be formulated from the brazen deception of the malingerer to the helpless confusion of the psychotic. In Karpman's (1926) view, "contrary to the generally accepted popular notion, malingering should not be regarded as wilful and conscious lying on the part of a well-balanced individual, but rather as quite an unconscious defence reaction in one who, already burdened with constitutional defects and many psychogenic difficulties, is a psychically ill individual, and who, unable by reason of these defects and burdens to handle a situation in an adequate manner, seeks in malingering an avenue of escape from the situation". Whether we agree with this formulation or not, the important thing is the fact that malingering, by its very infrequency of occurrence, is abnormal behaviour demanding psychological explanation and treatment. The attitude common among both lay and medical persons towards the malingerer is one derived from the theological and metaphysical residue of "Free Will", which still clutters up discussion of deliberateness and responsibility; implicitly or explicitly, the patient's "freedom of will" is assumed in those cases where he is regarded as "deliberately" deceiving and the patient is viewed as a culpable person—the same attitude prevails, to a lesser extent, towards hysteria. Several authors have pointed up the difficulty of distinguishing between hysteria and malingering. Cameron (1947) states that "no matter what symptoms are being investigated, the differentiation between hysteria and malingering must finally rest upon the criterion of self-deception. If the patient accepts and believes in his symptom as evidence of disability or disease, we must accept and believe in him as an hysterical patient; if he does not, we must consider him a malingerer. The trouble is that, while there are many cases which are either one or the other, there are many others in which pretence and self-deception are so intermingled as to make clear distinction impossible." Hall (1949) remarks that "differentiation is apt to be influenced by the psychology of the observer, but, whatever the decision, it will be agreed that the patient's behaviour represents a departure from normal standards", and adds that "a malingerer will naturally do his utmost to conceal his intention, this is not always true of the hysteric since the latter, once his pretence has been exposed, will derive equal morbid satisfaction from at least having drawn attention to himself by that means".

The Ganser state, then, may be regarded as in a position intermediate between malingering and hysterical states of more unconscious motivation. The four general features, one or more of which are likely to be seen in the symptomatology of hysteria, whatever form it may take, according to Skottowe (1953), are: "(i) The symptoms are an imperfect representation of the condition that 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 . . . (iv) Careful history-taking will generally show a previous clearly hysterical attack, though not necessarily in the same form, and hysterical traits of personality." It will be seen how neatly these criteria apply to the Ganser patients: the symptoms are an imperfect representation of a confusional psychosis, they correspond to the patient's "notion of insanity" (Lewis, 1946), they serve him some gainful purpose in entailing diminution of responsibility and attraction of attention, and in his previous history some indication of hysterical temperament or of other hysterical symptoms is likely to appear. As

in the fugue there is evasion by getting rid of the self through massive dissociation, so in the Ganser state there is evasion by saying the self is here but it is mad. "The wish to be insane and to appear irresponsible is fulfilled *through* the Ganser state which *is* a mental disease", says Bleuler (1951). It might be postulated that in difficult situations those of hysterical bent, who have not had the opportunity to "learn" the symptoms of other patients, physical or psychological, through observation, develop a Ganser state.

Disturbances of consciousness range from the coma through the various degrees of delirium to the mildly clouded or "twilight" states and conditions bordering on full awareness. The twilight state, says Bleuler (1951), "suggests especially a *systematic* falsification of the situation"; there is sense and a more or less logical connection in the acts. Onset and termination are often most sudden and duration is rarely longer than a few days. The oriented (automatisms and fugues) are less frequent than the disoriented, which have "a certain coherence, which might be compared with a dream" although "thinking is not clear or it may even be confused"; "the connection with the outer world is altogether interrupted or falsified by illusions and hallucinations of the visual and auditory types, especially the former" and these may lead to acts such as rape and murder. Some of the twilight states, he says, have a definite purpose, e.g. the Ganser. Other syndromes he distinguishes are: the buffoonery syndrome, playing the fool in the "vulgar" sense; hysterical puerilism, a regression to the behaviour of early childhood; and hysterical pseudodementia, "knowing nothing".

Sometimes quoted as stating that the Ganser states are "acute syndromes based on a chronic schizophrenia", Bleuler, made a distinction between the hysterical and the schizophrenic states, observing that the latter might extend over a period of months and generally could not be influenced. It is not clear whether he meant here that he considered there was a schizophrenic state resembling the Ganser state or whether he meant merely that a Ganser state could co-exist with schizophrenia in the same patient. At any rate, we may now regard Ganser as distinguishable from schizophrenic phenomena; and it is evident from his discussion of disturbances of consciousness that Bleuler believed that twilight states, including the Ganser, could be produced on a neurotic, psychotic, organic or psychopathic basis. With reference to "the characteristic, evasive answers common to both diseases" (1950) he contrasts the hysteric's systematic effort consistently to avoid giving the correct answer with the hebephrenic's giving of the first answer that comes to mind; the latter may show negativism, as does the hysteric, but this will be expressed in his entire attitude. He notes, too, that it is not only the schizophrenic who can respond rapidly with evasive answers. To the present writers, it seems that the approximate answers of the Ganser are quite distinct from the "off-centre" definitions given by some schizophrenics (e.g. definitions of a young schizophrenic seen by us: cedar—"bark"; brim—"ceiling"; guillotine—"axe"; nail—"thorn—I don't care for that too much—bag": that might seem a queer association (?) the idea of a bag of nails").

Ganser responses are also distinguishable from those of organic dements. Aubrey Lewis (1946) points out that "the most characteristic thing is the disparity between the patient's alleged deficiencies and his general alertness: he says he does not know anything about his own past, he cannot read or spell or do the simplest arithmetic, and yet he may be behaving quite naturally and adapting himself to the situation in a way which would be inconceivable if he had actually so advanced a dementia". Inconsistencies of response are characteristic of this state. Contrasting "hysterical" with "affective" symptoms, Curran

and Guttmann (1949) remark of the former that "they are not typically so persistent; they are very much more modifiable by environmental changes and measures. They are not symptoms which are in any sense impersonal, and any changes in the attitude of the patient is invariably reflected in them at once. Hence their tendency to fluctuate in intensity according as to whether or not the patient pays attention to them, which accounts for their apparent inconsistency." Frequently both types of symptom co-exist (cf. case reported below).

We may end here with a note on the mystery of the incidence of this disorder. We may not agree with Wertham's (1949) pronouncement that "a 'Ganser reaction' is a hysterical pseudostupidity which occurs almost exclusively in jails and in old-fashioned German psychiatric textbooks" and that "it is now known to be almost always due more to conscious malingering than to unconscious stupefaction", but there is a discrepancy between the number of cases and estimated frequency of occurrence reported in the older German literature and those reported in the English literature since then. Further, as we have tried to demonstrate, most of the cases described have been inaccurately designated as Ganser states. Another psychiatrist much experienced in prison work, Karpman (1926), writing on prison psychoses almost thirty years ago, asserted that the reactions of prisoners awaiting trial might be more acute than those of others but that there was nothing specific to separate them from other types of prison reaction: this suggests that he had not seen any Ganser states, for the approximate and ridiculous answers constitute a quite distinctive feature. Several prison psychologists, with many years' experience in prisons and hospitals between them, have been approached by the present writers and they have been able to report only one, rather doubtful, instance of such a condition. According to Noyes (1939), "Bearing in mind its psychological purpose it will be seen that the appearance of a pseudo-dementia in an accused but as yet unconvicted person is equivalent to a confession." This, of course, is a deduction from a psychopathological hypothesis which needs further testing by reference to fact established on other evidence. Kretschmer (1934), who described the state as one "produced with scarcely any change of consciousness . . . a condition on the borderline of malingering", said that during the (1914–18) War cases were reported of "efficient, tough-fibred" soldiers reacting to terror, such as that arising from the death of their nearest comrades, with "twilight states of short duration", in which they exhibited "a kind of pseudo-dementia or Ganser syndrome"; but we are not given any more information about these: nor does the more recent war appear to have produced a crop of them.

On the problem of incidence, we can only conclude that this is a very rare condition, since frequency of occurrence is presumably correlated positively with frequency of report and since the few reports include several false ones. Another problem is whether the Ganser state ever occurs by itself or only in conjunction with some other disorder. It is scarcely tenable, as Stern and Whiles imply, that Ganser failed to see any psychosis in more (perhaps many more) than twenty psychotics; nor is it plausible, as Lieberman opines, that in Ganser's day there was a "pure" state which has become corrupted now. It will be observed, however, that all of the cases reported since the early German literature appear to have had some kind of psychosis in addition to the Ganser state.

Case Report

Previous History

The patient examined by the present writers was a dock labourer of sixty-two, admitted to hospital in January 1954, certified. There was no family history of mental illness. The patient, G., had had a normal childhood and his previous health had been excellent. At

twenty-nine he had married a woman of his own age and his relations with her had always been harmonious, although they had no children. His wife described him as being a jovial person, fond of company, moderate in his smoking, drinking and gambling; a dabbler in house decorating and gardening. For forty years he had been working in the docks where he was regarded as a conscientious worker.

In November 1953 a newly-appointed shop steward undertook to check the dock workers' union cards to see whether they were fully paid up—a duty which his predecessor had neglected to perform. This check-up was to be carried out at the dock gates one morning, and on this occasion G., having failed to pay his dues for many years, absented himself from work in the knowledge that men had been suspended from work for such pecuniary default and that such a penalty for one of his age would be disastrous. It was then that he first complained of lower abdominal pain, diagnosed by his G.P. as gastro-enteritis. This illness kept him from work for five weeks when, although his abdominal symptoms disappeared, he developed what his doctor described as "nervous debility"; he appeared to worry excessively and to be unable to concentrate. At the end of this period, when his doctor was encouraging him to go back to work, he divulged to his wife for the first time the reason for his worry: he owed his union over £15 (at the rate of 8d. per week). His wife drew from her savings and paid this amount for him at the local branch of the union, where it was duly receipted in his union book. This brought on remorse that he had to rely upon his wife, having gambled away all his spare money.

Towards the end of December G. returned to work, but he became progressively more depressed, fretted needlessly and avoided company. The following Monday he came home with his clothes soaked: he said that he had fallen into the river and admitted that he had not gone to work because that was the day when the union dues were collected and he was afraid of what his comrades would say when they heard that he had a receipt for over £15 in his book. The events of this day are not clear, but it seems likely that he had a fugue. He remembers crossing the road near his home and being seized by a fear that he was going to be run over. Then he recalls being on the bank of a stream in a park, where he had a vision that he was being hanged; he also had the taste of burning paper in his throat. He must have lost consciousness at this point for the next thing he recalls is lying on the ground and realizing that he had been doubly incontinent. He threw himself into the shallow stream but a park attendant fished him out and threatened him with the police if he ever saw him there again. He then returned home.

Next day he went back to work, paid his week's union dues and procured a new book so that nobody would see the £15 receipt. Nevertheless, his depression deepened; he lost sleep and he was unable to apply himself to things. His wife recognized that he was ill and kept him at home. The night prior to his admission he became quite distraught, roamed the house, woke up his wife and told her that she had become mad because of his misdoings. In the morning he was found in an extremely agitated condition, scribbling letters, and he gave good indication that he intended to commit suicide. At one moment he said that his wife was missing, and the next that he was going to kill her as she was "mental". He had written the following letters:

"To my wife.
She has been the best in the world and I have been the worst coward I know this will mean me to go to the gallows which is too good for cowards like me So please show this to the police if you don't I will end it all.

Coward."

"For Gods sake.
Hand me over to the police If you don't You do not understand your job as I have worry my wife she is mental If you dont I will End her life and my own."

Present State

On admission G. was observed to be a red-faced sthenic individual with arteriosclerosis and a B.P. of 180/100. His EEG was normal. He showed all the symptoms of a classical agitated depression. He was depressed, tense and preoccupied, agitated and tremulous, taking no interest in his surroundings and unable to apply himself to the simplest tasks. He slept only with heavy sedation, and he refused to eat as he considered it a waste of time for he was due to be hanged. He complained of constipation which caused him terrible headaches. He complained of vivid, frightening dreams which depicted all the wrongs committed by him during his lifetime, and he had ideas of reference, thinking that people were calling him a "dirty tyke" and other names. Once, he said that the police were after him, and another time, that he was in prison waiting to be hanged because he had killed his wife. He had symptoms of derealization: the world appeared dull and strange, his house and garden looked terrible (reported by the social worker to be the brightest in a dingy street). He had olfactory, auditory and visual hallucinations: he complained of a horrible smell of burning paper at the back of his throat; he heard men's voices saying that he was a wicked man and threatening to kill him; occasionally he saw these men, his workmates and the police, adopting malevolent attitudes towards him. He constantly worried the hospital staff to hang him right away as it would be a waste of time to give him a trial.

Psychological Testing

G. was referred to the Psychological Department not as a diagnostic problem—he was considered to be a common case of involutional depression at the time—but for purposes

of the psychologists' own research. In view of the peculiar behaviour observed, the tests first administered (five days after admission) were not carried through to their conclusion in standard fashion, but more extensive testing was carried out later.

Progressive Matrices (1938). Oral. 12.i.54. Grade IV/V.

On Set A, the first three and sixth items were correct; on B, the first two correct, discontinued after the sixth; on C, none of the first three correct, then discontinued; on D, the first incorrect, testing discontinued.

On this test, the lower 20 per cent. of the population in this age group does not appear to score at better than chance level.

Perseveration was noted: a run of three "2"s and one of three "4"s.

Mill Hill Vocabulary (2 Jr. B). Oral. 12.i.54. Grade V. Score zero.

Examples of response: rest—"past, fire, fire"; patch—"pitch, flitch, flitch"; blaze—"walk, walk, walk"; ache—"walk, I said, walk, didn't I—can't put one for that, sir"; rage—"torment"; shrivel—"burning"; schooner—"aeroplane"; squabble—"friendly, friendly"; liberty—"tightening up"; courteous—"enemy".

Note: Klang associations, "near misses" or near associations, near-opposites and tendency to perseverate.

Re-test (*Definitions 1948*). Oral. 25.i.54. Grade IV. Score 23.

Examples of response: cruel—"be kind to people"; courteous—"row with people"; dwindle—"increase in power"; disturb—"going out for a—enjoyment"; view—"go out (?) like with anybody"; mingle—"you go out for a ride, mingle with the crowd"; fascinated—"kind of pleasure (?) you only go out for pleasure, mingle with the crowd, and you get enjoyment from it".

Note: Still some near-opposites and a tendency to perseverate, but absence of the more abnormal kinds of response; thus there is inconsistency between test and re-test in both the scores and the kinds of response.

Miscellanea. 12.i.54.

Mental Arithmetic: 0 out of 4. E.g. 7+3="9, no—19".

Counting: from 1 to 20, about 12 errors.

Alphabet: 15 to 20 errors in reciting.

Days of the week: 5 errors.

Date: "Sunday today—December 29th—28th—1942—1943."

Time: unable to tell the time.

Agnosia tests: visual presentations: a fork is called a "shovel", a padlock "part of a motor bike", a shoelace "part of rope", two keys "two bells";

Tactile: comb is "part of cigarette lighter", spoon "part of motor bike horn";

Auditory: coughing is "writing a letter", whistling "humming a song", clapping "scratching paper", foot scraping "tearing paper up".

Digits: Forward, 3; Backward, 2.

Note: Again, near misses and a tendency to perseverate. Re-test, 25.i.54.

One or two errors less in each "sub-test"; similar peculiarities, e.g. 7+3="11—er 12".

Wechsler-Bellevue I. 20.i.54.

Verbal I.Q.	..	75	Full Scale I.Q.	..	68
Comprehension	..	5	Performance I.Q.	..	<63
Arithmetic	..	0	Picture Completion	..	0
Digit Span	..	3	Picture Arrangement	..	1
Similarities	..	2	Object Assembly	..	0
Vocabulary	..	5	Block Design	..	1
			Digit Symbol	..	1

Vocabulary: absence of the above-mentioned peculiarities.

Arithmetic: one near miss.

Picture Completion: near misses, e.g. No. 1 "Hair" (E: "Anything else missing?") "The neck" (E: "Here—you see, the nose is missing.") "No, the nose is here." (E: "But you see this part of the nose is missing.") "I don't think so."

Object Assembly: near misses, e.g. at one point he had all but one of the hand pieces correct, then he rearranged it and presented it with fingers all askew and only two pieces correct.

Block Design: near misses, e.g. on No. 1 he had only one piece with the wrong face up, and this he turned over a few times, but the correct face did not turn up and he presented it as it was.

Digit Symbol: near misses, 6 of the 11 entries made being wrong. (The great majority of people do not make any error on this test, which is mainly one of speed.)

Benton Visual Retention (A). Score 1 (?) Defective. 20.i.54.

Several near misses; perseveration.

On No. 3 a remark made suggested that he had seen the peripheral figure although he did not try to draw it, despite instructions.

Re-test (*B*). Score 0. Defective. 25.i.54.

Nos. 1 to 4 were near misses.

Bender-Gestalt Z. Score 119, i.e. +6·9 S.D. 20.i.54.

The Z score does not give a specific diagnostic indication but yields a probability

amounting almost to certainty that the subject is suffering from severe psychological illness, i.e. with behaviour so deviant that hospitalization is necessary.

This was administered just after the Benton (A), in which there had been perseveration of pencil strokes throughout (in addition to the perseveration of figures mentioned above); instructions in the Bender prohibit "sketching" and in this case there was no such perseveration, showing that it had been under voluntary control.

The peculiarities contributing to the abnormally high score were rather arbitrary and inconsistent with previous drawing: No. 3 showed perseveration of dots, but this did not appear in any other figure; in No. 5 the extension had an apparently arbitrary bend; in others, the right angles and hexagons copied with the design before him were worse than those drawn from memory in the Benton.

Porteus Mazes. 12.i.54.

The first maze only was given. This was traced with a rapidly oscillating hand—a quite voluntary movement, as judged by both its own character and comparison with subsequent drawing—producing a series of loops or strokes giving the effect of a shaded pathway.

Rorschach. 20.i.54.

R 31 T/R 1·5″ P 5 F+per cent. 63 A per cent. 45 Last three per cent. 51 W per cent. 16 D per cent. 78 Dd per cent. 6 1M 1FM 1Fm 1Fk 19F 3Fc 4FC 2CF.

In general, the scores are within normal limits and there is not a significant number of neurotic or organic "signs". The pattern and content suggest a fairly normal "extra-tensive" personality of average intelligence (findings consistent with previous history).

However, there is a discrepancy between the borderline-defective level on intellectual tests and the low-average level indicated by the Rorschach record (and previous history) which points to impairment. This is evidently functional in nature from the test results in general and the inconsistencies in particular.

Further, there is an anomaly reflected in the rather low form-level of the responses, which became apparent not during the administration but during the enquiry: what had seemed to be quite usual responses turned out to be usual in content for the particular card but unusual in the part of the blot selected—again, near misses. E.g. in No. III, not the large details but only part of them were seen as men, giving the effect of distorted men with arms bigger than their legs. In the case of this response, it was also apparent that what was seen was at least momentarily withheld: before stating that he had seen any men he said, "Here, like footballs here, each got a football, haven't they". These features, together with the emphasis on colour, are consistent with a diagnosis of a hysterical reaction of the Ganser type.

Course

After only three modified E.C.T.s, the patient made a rapid and complete recovery.

He appeared to be and said that he was happy, and he made himself useful in the ward. He was full of thanks for all that had been done for him and of good intentions of becoming a model husband. During the period of his improvement, when asked how much he had owed his union he said that it was £6: when it was suggested to him that the figure was in fact larger, he admitted to £8 only; a week later, he admitted to further questioning that it had been about £15. His memory of the first week or two in hospital became very vague, and he had no recollection of his Ganser responses.

Six months later he was still well.

Discussion

This case may be classified as an involutional depression partly reactive to an environmental stress, with a Ganser state reactive to a delusion. The crisis involved in the check-up on union payments, which the patient had allowed to lapse, resulted in somatic complaint, followed by psychological disturbance which developed from "nervous debility" through a fugue episode into an agitated depression. Feelings of unworthiness and guilt heralded a state of delusion, on hospitalization, when he saw himself as in prison awaiting trial for the murder of his wife. The Ganser state then blossomed forth in its brief flower, an essay at absolution, to protect self-esteem as well as self. E.C.T. may have played a part in breaking up this state as well as the depression; the speedy recovery after only three treatments underlines the hysterical element present.

In performance on psychological tests administered in the second and third weeks after admission, depression was completely obscured and the picture presented was one which would be expected in a Ganser state: "near misses" (Mill Hill Vocabulary, Wechsler-Bellevue, Benton Visual Retention, Agnosia

tests, Rorschach); inconsistencies (Mill Hill Vocabulary—between test and re-test, both quantitatively and qualitatively; between intellectual tests and Rorschach; Benton and Bender drawings—inter- and intra-test); perseveration (Progressive Matrices, Mill Hill Vocabulary, Benton Visual Retention—manifestly voluntary, Agnosia and other tests); consciously made errors (Wechsler-Bellevue, Benton Visual Retention, Porteus Mazes). The most unstructured test, the Rorschach, gave no diagnostic pattern but the picture of a fairly normal personality of low average intelligence: there were, however, "approximate" responses and an emphasis on colour consistent with a hysterical state of the Ganser type.

Summary

An attempt has been made to dispel some of the misconceptions popularly held concerning the Ganser state, particularly those of "Vorbeireden", simulation, frequency in prisons and elsewhere and relation to other disorders.

It has been defined as a very uncommon, hysterical disturbance of consciousness of short duration and fluid character, marked by approximate and ridiculous responses to question and command, corresponding to the layman's imperfect notion of madness. Disorientation, hallucinations and lack of insight are characteristic. The state may recur and is dissociated from normal memory. It is precipitated by a situation where the patient would derive benefit from a lessening of his responsibility. A hysterical element is generally apparent in the patient's previous history. (All the cases reported in English appear to have had some psychosis in addition to the Ganser state.)

It has been contended that most of the dozen or so cases reported in English do not in fact warrant the description of Ganser state.

A case with some hitherto unreported features has been described, and psychological test results have been given.

Acknowledgments

We wish to express our thanks to Dr. R. Ström-Olsen, Physician Superintendent, Runwell Hospital, and to Dr. D. W. Liddell, Consultant Psychiatrist, for permission to publish this case; and to Dr. G. A. Foulds, Director of the Psychology Department, who first observed the unusual features of the case and suggested the formulation.

References

ANDERSON, E. W., and MALLINSON, W. P., *J. Ment. Sci.*, 1941, **87**, 383.

BENDER, L., *J. Nerv. and Ment. Dis.*, 1934, **80**, 32.

Idem, *A Visual Motor Gestalt Test and its Clinical Use*, 1938. New York, American Orthopsychiatric Association.

BLEULER, E. P. (trans. Brill, A. A.), *Textbook of Psychiatry*, 1951. Reprint. U.S.A., Dover Publications.

Idem (trans. Zinkin, J.), *Dementia Praecox, or the Group of Schizophrenias*, 1950. Reprint. New York, International Universities Press.

CAMERON, N., *The Psychology of Behaviour Disorders*, 1947. U.S.A., Houghton Mifflin Co.

CURRAN, D., and GUTTMANN, E., *Psychological Medicine*, 1949. Edinburgh, Livingstone.

DAUMÉZON, G., KOECHLIN, P., and PAUMELLE, P., *Annales Médico-Psychologiques*, 1952, T.1, 110e Année, 427.

DAVIE, T. M., *J. Ment. Sci.*, 1942, **88**, 449.

DORLAND, W. A. N., and MILLER, E. C. L., *The American Illustrated Medical Dictionary*. 19th Edn. 1942. W. B. Saunders Co.

FLATAU, G., *Zeitschrift für die gesamte Neurologie und Psychiatrie*, 1913, **15**, 122.

GANSER, S. J., *Arch. f. Psychiat. u. Nervenk.*, 1898, **30**, 633.

Idem, *Ibid*, 1904, **38**, 34.

HALL, S. B., *Psychological Aspects of Clinical Medicine*, 1949. London, H. K. Lewis & Co.

HARRIMAN, P. L., *The New Dictionary of Psychology*, 1947. New York Philosophical Library.

KARPMAN, B., *J. Nerv. and Ment. Dis.*, 1926, **64**, 331 and 482.

KRETSCHMER, E. (trans. Strauss, E. B.), *Textbook of Medical Psychology*, 1934. Oxford University Press.

LAING, R. D., *J.R.A.M.C.*, 1953, **99**, 169.

LEWIS, A., *Psychological Medicine* in *Textbook of the Practice of Medicine*, 1946. Ed.: F. W. Price.

LIEBERMAN, A. A., *Illinois Medical Journal*, 1945, **88**, 302.

Idem, *J. Nerv. and Ment. Dis.*, 1954, **120**, 10.

MACDONALD, J. E., *The Concept of Responsibility* (in preparation).

NOYES, A. P., *Modern Clinical Psychiatry*, 1939. London, W. B. Saunders & Co.

RIESE, W., and REQUET, A., *L'Encéphale*, 1937, XXXII, 209.

SARTESCHI, P., *Rivista Sperimentale di Freniatria*, 1953, LXXVII, 159.

SKOTTOWE, I., *Clinical Psychiatry*, 1953. Eyre & Spottiswoode.
STERN, E. S., and WHILES, W. H., *J. Ment. Sci.*, 1942, **88**, 134.
WERTHAM, F., *The Show of Violence*, 1949. London, Gollancz.

TEST REFERENCES

BENTON, A. L., *A Visual Retention Test for Clinical Use*, 1946. New York, Psychological Corporation.
FOULDS, G. A., *Brit. J. Psych.* (Gen.), 1951, **42**, 209.
KLOPFER, B., and KELLEY, D. M., *The Rorschach Technique*, 1946. New York, World Book Co.
PASCAL, G. R., and SUTTELL, B. J., *The Bender-Gestalt Test*, 1951. New York, Grune & Stratton.
RAVEN, J. C., *Guide to Using Progressive Matrices* (1938), 1950. London, H. K. Lewis & Co.
Idem, *Guide to Using the Mill Hill Vocabulary Scale with Progressive Matrices* (1938), 1950. London, H. K. Lewis & Co.
WECHSLER, D., *The Measurement of Adult Intelligence*, 1944. Baltimore, Williams & Wilkins.