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Ganser syndrome: review and case report

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The nosological conception of Ganser syndrome (GS) has evolved as the hysterical etiopathogenesis has been examined against psychosis, malingering, factitious disorders and/or organic lesions. Few articles and little scientific research and theory are available supporting the complicated diagnosis of GS. The similarities and differences between GS and factitious disorders and malingering are examined in depth here.

More publications are needed on GS to clarify its nature and investigate its treatment and uncertain prognosis.

Keywords: Ganser, malingering, factitious, Münchhausen

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El síndrome de Ganser: revisión a propósito de un caso

El síndrome de Ganser (SG) ha evolucionado en la concepción nosológica, enfrentándose la etiopatogenia histérica, contra la psicosis, simulación, trastorno facticio, y/o daño orgánico.

Hay escasos artículos, investigaciones y teoría que sustenten el complicado diagnóstico del SG. Ahondamos en las similitudes y las diferencias del SG con los trastornos facticios y con la simulación.

Se precisan más publicaciones sobre esta patología, para clarificar la naturaleza del síndrome, investigar sobre su tratamiento y sobre su incierto pronóstico.

Palabras clave: Ganser, Simulación, Facticio, Münchhausen

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INTRODUCTION

Sigbert Ganser (1897) described a condition observed in three inmates that he called Ganser syndrome (GS), which was characterized by: *approximate answers to real questions* ("patients do not know how to answer the most elementary questions, although to judge from how they respond, they have understood the meaning of the questions, showing surprising ignorance and loss of the knowledge they once possessed"), *dulling of consciousness*, *hysterical neurological changes and hallucinations*.¹

The onset and remission were abrupt and complete, subsequently followed by amnesia and bewilderment, and without any conscious intent in its presentation.^{2,3}

The most representative symptom is *approximate answers*, baptized by Westphal (1903)¹ as "*vorbeireden*" ("talking around"), although Holding and MacDonald (1955)⁴ proposed another term: "*vorbeigehen*" ("going around") because patients also act *approximately* (e.g., picking up the wrong end of a fork or phone).² The problem is that this symptom is not pathognomonic because it appears in other disorders, such as dementia, schizophrenia, etc.

Fish observes "paralogy" (illogical reasoning) and schizophrenia-like formal thought disorders.²

Enoch and Trethowan (1979) extrapolated from the prison environment and designated the four key symptoms: *approximate answers*, *clouding of consciousness*,⁴ *conversion symptoms and optional visual or auditory pseudohallucinations*: similar to hysterical pseudohallucinations (Castells, 1994 and Tyer, 1992).⁶

SG has been called a "hysterical twilight state", "hypnotic state of consciousness" (Janet 1909), "semi-lucid state" (Baruk 1959), "hysterical puerilism" (Bleuler), "prisoners' psychosis", "nonsensical syndrome", "pathological malingering" (Kiehn), "catatonic negativism" (Nissl) or "hysterical pseudostupidity found almost exclusively in prisons and in old and outdated German psychiatric texts" (Wertham, 1949).⁷

Four etiological perspectives are considered: 1) hysterical origin, 2) malingering or factitious disorder, 3) psychotic origin and/or 4) organic origin.

1. Ganser described the condition as "a hysterical dissociative reaction, the result of an unconscious effort to escape an intolerable situation".⁴ According to this view, GS is a hysterical pseudodementia with the unconscious secondary benefit of avoiding having to confront a traumatic situation.⁴ Sizaret (1989) points out the volatility over time, reversibility, subsequent amnesia without a critical attitude and polymorphic sensory-sensitivity manifestations. This author hypothesizes that stress is a necessary factor in its genesis.¹ Tsoi (1973) framed GS as a type of dissociative disorder (DD) with visual hallucinations, secondary benefits, the variability of the condition in relation to environment and neurological pictures with selective amnesia.⁸
2. Ganser denies that GS is a form of malingering but considers that such absurd inconsistencies have a clear purpose.⁴ We note that what matters is whether the clinical expression is voluntary (which distinguishes GS from malingering and factitious disorder). For Mayer-Gross, malingering and hysteria are the same condition⁴: malingering (or the conscious production of disorders) induces the production (this time unconscious and amnesic) of other conditions of hysterical origin.¹ The similarities and differences between SG, malingering, factitious disorders with psychological symptoms and factitious disorders with somatic symptoms (Münchhausen syndrome) are summarized in Table 1.
3. Whitlock (1967) views GS as a psychotic disorder, with alterations in the form of thought, dull thought and sensory perceptual alterations, particularly auditory hallucinations.² GS is described in the prodromal phases of schizophrenia and cases with catatonic symptoms exist.¹ GS could be considered to be between neurosis and psychosis and between disease and malingering.⁷
4. Some authors discuss organic syndromes in the etiology of GS, such as traumatic brain injury, functional psychosis and organic confusional states secondary to carbon monoxide encephalopathy, brain damage and polysubstance abuse (Heron 1991), left cerebral hemisphere tumor (Doongaji 1975), neurosyphilis, alcohol dependence, Korsakoff syndrome, stroke and dementia; the cases described by Ganser also included head injury or typhoid fever.⁷ Organic damage might facilitate reactions to environmental stressors by means of hysterical mechanisms.⁹

Scott promotes the use of the term Ganser "symptoms" rather than "syndrome" because approximate responses and behaviors are present in other diseases, being a form of dissociative communication.⁴

Sigal et al. 1990 defined GS as a maladaptive way of handling a stressful situation in individuals with organic and/or functional disorders.⁵

GS is briefly discussed in psychiatry textbooks under different classifications:

Alonso Fernández believes that GS is a pseudodementia, Weitbrecht categorizes it as a psychogenic state of clouded consciousness, López Sánchez as malingering¹ and in the DSM-III it is classified as a factitious disorder with psychotic symptoms, in contrast with the DSM-III-R, where GS was described as a "dissociative disorder not otherwise specified" (300.15).

Hospitalization to confirm the diagnosis is recommended. Some authors advise the use of neuroleptics⁸ and others, anxiolytics, but everyone suggests psychotherapy.³

CASE REPORT

A 34-year-old woman was admitted voluntarily for "strange behavior" with a history of anxiety attacks at the age of 16 and no family history of interest.

For three months, coinciding with a marital separation, she had been nervous. The fact that she accidentally took 3 tablets a day of fluoxetine the previous month intensified her restlessness: she wore unpaired socks, opened and closed the refrigerator intermittently, slept during the day and ranted at night that she heard that her ex-husband wanted to kill her.

She showed irritability, pressured speech, incoherent speech with approximate responses ("How many years did you work at the supermarket?" to which she answered, "five by five, 25; more than 150 years my grandparents raised me... I have three daughters: my mother, my aunt and I"), sadness, lability, anxiety, auditory hallucinations, unstructured mild delusional ideation, cognitive difficulties, medium-to-low IQ, altered sleep-wake rhythm and anorexia.

The impression was of an episode of psychosis or mania caused by switching antidepressants.

Memory gaps were observed, with difficulties in abstract thinking, increased response latency and approximate answers (mathematical operations and repetition of the words "happiness" or "doubt").

She showed striking emotional indifference with scant reactivity to her environment. Her speech was operational and alexithymic. She denied that the separation affected her and showed inconsistency in the development of activities

Table 1		Comparison of Ganser syndrome, malingering and factitious disorders			
Ganser syndrome	Malingering	Factitious disorder with psychological symptoms	Factitious disorder with somatic symptoms: Münchausen syndrome		
Involuntary production	Voluntary production	Voluntary production	Voluntary production		
Internal Benefit (in the sense of avoiding traumatic confrontation) and optional external benefit	External Benefit	Internal Benefit (in the sense of acquiring the role of patient)	Internal Benefit (in the sense of acquiring the role of patient)		
NON-controllable symptoms	Controllable symptoms	NON-controllable symptoms	NON-controllable symptoms		
Selective amnesia	Lying	Fantastic pseudology	Fantastic pseudology		
Optional underlying personality disorder (a)	NO	Underlying personality disorder	Underlying personality disorder		
Strange, with extravagant behavior, incomprehensible, tries to be submissive, although the patients are impenetrable (b)	Uncooperative during diagnostic evaluation or for adjusting prescribed treatment	Highly suggestive, they admit to having most of the additional symptoms suggested by the interviewer. They seek psychiatric treatment.	They reject psychiatric treatment and seek somatic treatment		
Spectacular remission and onset	Spectacular remission and onset	Hospitalization may be a lifestyle	Hospitalization may be a lifestyle		
Low IQ	Medium-to-high IQ	Medium-to-high IQ	Medium-to-high IQ		
NO	NO	Imitates a family member or acquaintance with mental illness, characteristic wandering through hospitals or clinics	Patients related with healthcare profession, characteristic wandering through hospitals or clinics		
Fatigue due to the duration of the interview worsens responses	Fatigue due to the duration of the interview elicits progressively more "normal" responses	No influence	No influence		
<i>Belle indifférence</i>	Gives profuse detail about condition and how it affects the patient, but little information about symptoms	Anxiety and concern	Anxiety and concern		
Symptoms persist when not observed	Symptoms disappear	Symptoms disappear	Symptoms disappear		
NO	NO	Use of psychoactive substances	Use of medications or self-induced illness		
Defense mechanism: dissociation (traumatic material in parallel consciousness)	No "trauma"	Mechanism of defense: (traumatic material in the unconscious), identification and symbolization	Mechanism of defense: repression (traumatic material in the unconscious), identification and symbolization		

^a In a study by Sigal et al., 1992, of 15 patients with Ganser syndrome, all were diagnosed with personality disorder: especially group B (antisocial and histrionic disorder) and group A (paranoid, schizoid and schizotypal disorders), finding a correlation between the deficient development of personality organization and increased risk of developing Ganser syndrome.

^b Henry Ey (1965) spoke of the evident conscious complacency of these patients (3)

with relative disease awareness (she recognized her cognitive difficulties).

We ruled out a structural brain origin (CT, MRI and EEG showed no related abnormalities) and found that she had been seen at the age of 23 for a hypochondriac delusion and "neurotic traits."

Prescription of sulpiride, 800 mg/24 h, produced full recovery within two weeks.

DISCUSSION

The patient was diagnosed as GS due to the abrupt appearance of pseudodemential symptoms, the characteristic approximate answers, *restitutio ad integrum*, *la belle indifférence* and the temporal association with a familial stressor.

The published information is still contradictory: In the Synopsis of Psychiatry of Kaplan and Sadock,¹¹ GS is classified as dissociative disorder, but it is defined as the "voluntary production of severe psychiatric symptoms," the diagnosis of dissociative disorder being incompatible with the voluntary nature of the symptoms. It is stated that "it may occur in patients with other mental disorders, such as schizophrenia, depressive disorders, states of intoxication, paresis and *factitious disorders* ..." (if GS occurs within the context of a factitious disorder, it is inconsistent to consider GS an *unintentional* syndrome).

It is thought that "an important predisposing factor is the existence of a serious *personality disorder*," which is an unproven relation, and the explanation is given that "the differential diagnosis is extremely complex unless the patient admits to the *factitious nature* of the symptoms or evidence is obtained from objective psychological tests indicating that the symptoms are *false*": however, the symptoms are not false, they are the manifestation of an involuntary exteriorization of scant psychological processing of trauma.

They add that GS "can be recognized by the fact that the symptoms are more severe when the patient believes that he is being watched," which is an unconfirmed finding.

We believe that these patients, due to their limited intellectual capacity, experience difficulties in the emotional and cognitive processing of conflict, and thus react to psychological trauma with dissociative symptoms.

We recommend a psycho-pharmacological approach: sulpiride and psychotherapy with the aim of restoring the severed emotional content to the descriptive-rational content of the trauma that has occurred.

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