

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

The Diagnosis of Ganser Syndrome in the Practice of Forensic Psychology

Sanford L. Drob, Ph.D. and Kevin Meehan

Forensic Psychiatry Service, New York University—Bellevue Medical Center

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Abstract

Ganser syndrome, which is briefly described as a Dissociative Disorder NOS in the DSM-IV is a poorly understood and often overlooked clinical phenomenon. The authors review the literature on Ganser syndrome, offer proposed screening criteria, and propose a model for distinguishing Ganser syndrome from malingering. The “SHAM LIDO” model urges clinicians to pay close attention to Subtle symptoms, History of dissociation, Abuse in childhood, Motivation to malingering, Lying and manipulation, Injury to the brain, Diagnostic testing, and longitudinal Observations, in the assessment of forensic cases that present with approximate answers, pseudo-dementia, and absurd psychiatric symptoms. A case example illustrating the application of this model is provided.

In this paper we propose a model for diagnosing the Ganser syndrome and related dissociative/hysterical presentations and evaluating this syndrome in connection with forensic assessments. Experience on New York's Bellevue Forensic Psychiatry Service has led us to conclude that Ganser Syndrome may be far more common than is often realized and that Ganser-like symptoms frequently complicate assessments for such issues as criminal responsibility and competency to stand trial. On our 25 bed male forensic unit, with an average length of stay of approximately 20 days, there is almost always a case in which Ganser Syndrome or a related hysterical/dissociative pseudo-dementing disorder is a significant part of the differential diagnostic picture. Our goals in this paper are to present a review of Ganser syndrome, and to provide a preliminary model for distinguishing Ganser from cases of malingering and other psychiatric and/or neurological disorders.

Review of Literature

First described by S. J. Ganser in 1898 (Ganser, 1965; Allen & Postel, 1994), Ganser syndrome was originally observed in three prisoners awaiting trial. These patients presented with clinical confusion, auditory and visual hallucinations, amnesia for recent events, sensory and motor conversion, vacant or fixated gaze, and *vorbeireden*, the symptom of approximate answers (Ganser, 1965). Indeed, the symptom of approximate answers (e.g., a subject says that a horse has three legs, or that two plus two equals five) came to be so closely identified with Ganser syndrome that it was later held by many to be its equivalent, or at the very least, its defining sign. Ganser reflected that his patients'

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astonishing ignorance suggested the possibility of malingering, but he concluded that they suffered from a “twilight hysteria” and had no intention to deceive (Ganser, 1965). In recent years, as evidenced by the inclusion of Ganser Syndrome as an example of Dissociative Disorder NOS in the DSM-IV, a certain consensus has emerged that the phenomena first described by Ganser cannot be fully explained as acts of feigning and deception.

Over the years, case reports have gathered a number of symptoms under the diagnosis of Ganser syndrome. These include the following: (1) absurd, ridiculous and/or approximate answers to simple cognitive questions, (2) clouding of consciousness, (3) disorientation and confusion, (4) loss of memory (particularly in relation to the individual’s core problem and/or later for the Ganser episode itself), (5) conversion and other somatic symptoms (including disorders of balance, pseudo-seizures and other improbable neurological symptoms), (6) visual and auditory hallucinations (and/or apparent delusions often of a dramatic or absurd nature), (7) disturbance or loss in the sense of personal identity, (8) fugue, (9) regressive and at times child-like behavior, and (10) rapidly clearing symptoms (Enoch & Trethowan, 1991; Epstein, 1991; Nyiroe, 1965). Epstein (1991) found that of these ten core symptoms, seventy-nine percent of Ganser cases suffer from four or more of the symptoms, with five as the average number.

Ganser syndrome is generally considered rare, but estimates of its prevalence depend upon the strictness of the diagnostic criteria used in reporting it (Haddad, 1993). While Whitlock (1967) held that the presence of approximate answers is the essential symptom for making the diagnosis, more recently clinicians (Hampel, et al., 1996) have viewed Ganser syndrome as having a variable, rather than fixed, set of symptoms.

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

Cocores, et al. (1984) held that although approximate answers are the most frequently reported symptom, they are not pathognomonic of the disorder.

In the century since Ganser syndrome was first described, there has been considerable debate concerning its classification. The syndrome has at various times been regarded as a form of malingering, a psychotic disorder, a histrionic disorder, and an organic disorder. Ganser syndrome has also been found to be co-morbid with other mental disorders such as schizophrenia, depression, toxic states, paresis, alcoholism, and factitious disorders (Apter et al., 1993). Ganser himself felt that the phenomenon was in essence a hysterical disorder resulting from an unconscious desire by the individual to escape from an intolerable situation (Ganser, 1965; cf. Cocores et al., 1984; Miller, 1997). Goldin and MacDonald (1955) provided support for this notion, describing the syndrome as a hysterical disturbance occurring in individuals who “would derive benefit from a lessening of [their] responsibility” (Goldin & MacDonald, 1955).

Since that time the classification of the syndrome has gone through numerous changes. Ironically, this evolution of thought has come full circle, as the syndrome is now generally understood in the basic terms described by Ganser, namely that of a functional psychological disorder with a hysterical/dissociative etiology. In the DSM-II Ganser syndrome was regarded as an Adjustment Reaction of Adult Life. The DSM-III classifies the syndrome as a Factitious Disorder with Psychological Symptoms. In the third revised and fourth editions of the DSM Ganser syndrome was removed from the classification of Factitious Disorder, a recognition of the lack of volitional intent in Ganser patients, and classified as a Dissociative Disorder Not Otherwise Specified.

Cocores, et al. (1984) reviewed 43 cases of the syndrome reported in the literature

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and concluded that the dissociative symptoms of amnesia, disorientation, fugue, and conversion were all frequently present in Ganser patients. Furthermore, individuals with known dissociative pathology, or those subjected to hypnotic suggestion, frequently manifested Ganser-like symptoms. Ganser patients typically report memory loss for not only a period of their life, but also for their Ganser-like symptoms, such as approximate answers given in past interviews (Nardi et al., 1977). Such functional memory loss is further suggestive of a self-hypnotic or dissociative mechanism at work (Cocores, et al., 1986; Hampel, et al., 1996). These considerations were instrumental in the reclassification of Ganser syndrome as a dissociative disorder in DSM-III-R and DSM-IV.

It should be noted that while in DSM-III-R amnesia and fugue are viewed as associated symptoms, in DSM-IV the diagnosis of Ganser Syndrome can only be given when not associated with Dissociative Amnesia or Dissociative Fugue (Hampel et al., 1996). Presumably if Ganser like symptoms are evident in individuals with amnesia or fugue, the latter are to be entered as the Axis I diagnosis. Epstein (1991) reports several cases of well-defined Ganser syndrome in individuals suffering from Multiple Personality (Dissociative Identity) Disorder. Our experience is that while the syndrome most commonly occurs among individuals with a history of other dissociative and hysterical disorders and symptoms, the specific designation of “Ganser syndrome” is important, especially in a forensic psychological context.

Several authors see Ganser syndrome as a stress-induced dissociative disorder that serves to diminish responsibility and attract attention and sympathy. The disorder can be viewed as a regressive and maladaptive way of dealing with a stressful situation by presenting oneself with an illness (Hampel, et al., 1996; Nyiroe, 1965). Some have

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viewed the Ganser syndrome as an unconscious production of symptoms that are in accord with the patient's naïve conception of mental illness. Ganser syndrome is often the product of limited and maladaptive coping mechanisms. The lower the level of personality organization and ego resources, the higher the risk of developing Ganser syndrome (Sigal, et al., 1992). For that reason, individuals who suffer from personality disorders, psychosis or neuropsychological deficits, or whose capacity to cope with stress is otherwise compromised are at risk for developing Ganser syndrome (Hampel et al., 1996).

Epstein (1991) describes the approximate answers of Ganser patients as following the pattern of "trance logic," in which a divided consciousness can be described as both knowing and not knowing. The overwhelmed ego of the patient dissociates itself from a painful reality, thereby avoiding what would otherwise be an external stress (e.g., arrest, having committed a crime, personal or financial failure) or internal stress (e.g., depression, cognitive deterioration, impending psychosis, physical illness). Because Ganser syndrome can evolve in response to an impending psychic deterioration, its resolution may be followed by other severe psychiatric symptoms, such as schizophrenia (Lieberman, 1954) and depression (Haddad, 1993). This fact has led some authors to declare that Ganser syndrome is found in mentally ill individuals who unconsciously feign another form of psychiatric disturbance (Stern & Whiles, 1942).

Ganser originally described the syndrome in the context of a prison setting (Ganser, 1965; Mahadevappa, 1990). Although typically found in prison settings, several authors have noted that Ganser syndrome can originate in other stress-inducing or confining situations. Whitlock held that the syndrome is not limited to prisoners but does

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have a high incidence among individuals in some sort of trouble (Whitlock, 1967).

However, recognizing Ganser syndrome is especially important in forensic settings where the possibility of malingering makes accurate diagnosis a very difficult task. Because malingering is thought to be common in these settings, dissociative and hysterical disorders are often overlooked or discounted (Apter, et al., 1993).

Screening Criteria for the Ganser Syndrome

Table 1 presents a number of symptoms that should signal the possibility of Ganser syndrome, and which can be regarded as screening criteria for the syndrome. These criteria reflect symptoms that have found a large degree of consensus in the literature. The criteria are not diagnostic, as each of them can also appear in the context of both other forms of psychopathology and malingering. However, the presence of one or more symptoms from Criteria A along with symptoms from Criteria B should alert the clinician to the possibility of a hysterical/dissociative disorder such as Ganser syndrome. The process of ruling out malingering once these screening criteria have been met requires a comprehensive, second-order, evaluation/investigation that will be discussed in detail below.

Table 1: Screening Criteria for Ganser Syndrome

A. Pseudo-dementia

(1) The examinee gives approximate answers to simple cognitive questions (e.g., A horse has “3” legs, $2 + 2 = “5”$).

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(2) The examinee provides absurd or ridiculous answers to questions that are well within his or her competency (e.g., Where is the Empire State Building? “On Avenue U in Brooklyn”)

(3) Other implausible evidence of a cognitive deficit (e.g., Patient obtains a score of 52 on IQ testing that is inconsistent with his achievement history).

B. Dissociative and or hysterical symptomatology

(1) Clouding of consciousness, disorientation, and confusion inexplicable on a toxic or other organic basis.

(2) Loss of memory, particularly in relation to the individual’s core problem (e.g., The individual cannot remember his conduct on the day of his alleged offense or even what he has been arrested for).

(3) Unusual somatic symptoms, including disorders of balance, that are not readily attributable to organic cause.

(4) Pseudo-seizures and other improbable neurological symptoms (note: in some Ganser patients the syndrome is superimposed upon genuine, usually mild, neurological deficits and a history of genuine seizures may be present).

(5) Visual and auditory hallucinations, and apparent delusions, often of a dramatic or absurd nature (e.g., The patient believes he is in Russia and the year is 1991, the patient reports a flying rabbit that visits him in his room each night).

(6) Disturbance in the sense of personal identity (e.g., The patient believes his body is inhabited by a 17th century monk).

(7) Regressive and at times child-like behavior.

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

(8) High levels of suggestibility (e.g., The patient appears to take on the characteristics of his environment; when with physicians he claims to be a doctor, with attorneys claims to be an attorney).

(9) Disorders of speech (e.g., The patient takes on a foreign accent, speaking in a supposedly foreign but actually absurd tongue).

It should be emphasized that in applying the above screening criteria the clinician should be confident that the patient's symptoms are not explicable on the basis of a toxic, neurological, or non-dissociative psychiatric disorder. However, it should be noted that individuals with Ganser syndrome often have histories of pseudo, and at times genuine, neuropsychological deficits and may have histories of other mental disorders including schizophrenia. When previously diagnosed with psychotic disorders, this may either represent a misdiagnosis of underlying dissociative pathology or a genuine psychotic disorder over which Ganser symptoms have been co-morbidly produced.

Distinguishing Ganser Syndrome from Malingering

There has been considerable controversy regarding the extent to which Ganser patients have knowledge of or volitional control over their symptomatology. Heron, et al. (1991), for example, held that Ganser syndrome is a stress-induced disorder "lying intermediate between malingering and hysteria." We have found it theoretically convenient to distinguish Ganser syndrome from both factitious psychological conditions and malingering based on the level of conscious awareness in each situation. In our view, malingers are consciously aware that they are distorting their presentation as well

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as the reasons for their distortion. Individuals with factitious psychological disorders are consciously aware of their intentional distortion but do so for reasons that are outside of conscious awareness. Finally, those who suffer from Ganser syndrome are neither fully conscious of their distortions nor aware of their motives for doing so.

While theoretically useful, this schema is of limited practical utility in that the evaluator has no direct way of determining whether a particular behavioral picture is conscious and volitional, or unconscious and thus beyond the individual's control. Further, conscious awareness does not itself necessarily imply volitional control. Making the appropriate diagnostic and forensic psychological distinctions in such cases must therefore rely upon data that are at least potentially accessible to the examiner. This includes data made available in the diagnostic interview as well as data concerning the individual's legal and personal circumstances, psychiatric and trauma history, current behavior outside the clinical interview, and psychological testing profile.

To rule out malingering and, in a forensic context, make such determinations as the competency of individuals presenting with a Ganser/factitious/malingering differential, we have found it useful to consider the following eight questions. While the answers to any one of these questions cannot be considered fully probative, data pertaining to all eight are likely to lead to a reliable forensic finding.

(1) What, if anything, about the individual's current circumstances provides him/her with an incentive or motive to malingering mental illness? How advantageous, from a legal and/or personal point of view, will a finding of mental illness be for the individual in question? (Motivation)

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

- (2) Does the defendant have a history of antisocial behavior, especially lying, and manipulation for personal advantage or profit? (Lying and Manipulation)
- (3) Do longitudinal observations confirm the mental status obtained on interview? For example, does the individual exhibit the same cognitive confusion and psychological symptoms when he/she is not being interviewed or does not believe he/she is being observed? (Observation)
- (4) Is there a history of dissociative or hysterical symptoms in the absence of an extrinsic incentive to malingering such symptoms? Is such a history documented in mental health or other records? Is that information reported on by collateral sources and/or related by the defendant him or herself? (History)
- (5) Does the individual exhibit, and have a history of exhibiting, the more subtle signs and symptoms that are correlated with a dissociative disorder, signs that a malingerer is unlikely to be aware of or be able to include in his/her presentation? (Subtle Signs)
- (6) Does the individual have a history of the abuse or trauma that is typically present in individuals who develop a dissociative defensive style? (Abuse)
- (7) Is there a history of head injury or other neuropsychological insult around which Ganser syndrome appears to have crystallized? (Injury)
- (8) Does psychological testing point to the presence of a dissociative disorder? (Testing).

We will now examine each of these questions/indicators in some detail.

Motivation

Many forensic specialists consider motivation to be the key, and in some cases

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only, factor in distinguishing malingerers from defendant's with a hysterical and incompetent presentation. These experts argue that it is impossible to get inside the minds of defendants to ascertain whether their symptoms are consciously or unconsciously determined. It is thus argued that any individual who, in the face of serious criminal charges, produces absurd psychological symptoms that do not accord with standard psychiatric and neurological syndromes should be regarded as malingering if there is a clear legal advantage to be gained, e.g. by his/her being found incompetent or unfit. These clinicians argue that it is only in the relatively rare case that being found mentally ill is to the individual's legal disadvantage (and where no other motive can be ascertained for conscious malingering) that one Ganser syndrome should even be considered.

Such an approach will clearly reduce the number of cases in which a manipulative defendant fools the forensic expert. However, in our view, this approach increases to unacceptable levels the number of truly ill defendants who are classified as malingerers. A motive to mangle can readily be attributed to the vast majority of individuals being assessed in forensic criminal contexts. This does not mean that all or even most such individuals will act upon that motive. The subtle issues in the differential diagnosis of dissociative disorder versus malingering should be settled, in our view, on psychiatric and psychological grounds as opposed to simply assessing whether malingering would be to the defendant's advantage.

Still, assessing such motives and incentives is a critical first step in determining if an individual is ill or malingering. When it is expected that a defendant views being found unfit as advantageous, malingering should be viewed as an increasingly important consideration; the greater the incentive to mangle, the greater should be one's

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

suspicions. For example, in cases where it is clear that the defendant's attorney wants his client found unfit because it would be helpful in plea negotiations or in laying the groundwork for a psychiatric defense at trial, malingering should certainly be a part of the diagnostic differential.

Lying and manipulation

The DSM-IV suggests that malingering should be suspected in those psycho-legal contexts in which the individual to be evaluated presents with Antisocial Personality Disorder. Certainly, individuals being evaluated for competency who have a history of lying and manipulation for personal gain should be suspected of, or assumed to be, malingering unless proven otherwise. While such individuals are common in a forensic setting, they do not by any means constitute the majority of individuals who are examined in such contexts.

However, the issue in relation to the Ganser syndrome, is complicated, because the literature on severe dissociative disorders suggests that, especially amongst males, lying, manipulation, and antisocial behavior are frequent presenting symptoms (Putnam, 1989). There may well be a continuum between the conscious, manipulative role-playing of the psychopath and the unconscious, maladaptive role-playing of individuals who suffer from dissociative disorders. It is also likely that, at various times, individuals with true dissociative disorders will display both kinds of behavior. Further, some individuals may use their experience with and history of true dissociative symptoms to "scam" their way out of trouble when arrested.

Before judging any such individual to suffer from Ganser syndrome, the evidence

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of a bona fide dissociative disorder, ascertained through answers to questions 3-8, should be very convincing, if not overwhelming. Otherwise, individuals presenting with a Ganser-like picture who also possess a clear motivation to malingering and a clear-cut history of antisocial lying and manipulation are probably best understood as malingering. Excluded from this dictum are “pathological liars” and individuals who suffer from *pseudologia fantastica* whose “lying” and manipulation does not serve consciously adopted ends and is not primarily for material advantage.

Longitudinal Observation

The comportment of defendants being interviewed in forensic psychological contexts frequently changes once they leave the examination room. It may be possible, especially in an inpatient setting, to assess such changes in behavior with an eye to determining whether a poor mental status obtained during the competency examination carries through to other situations. Patients suffering from Ganser syndrome can be expected to deteriorate somewhat when faced with an examination of their competency. As we have already indicated, for such patients their disorder is a regressive response to arrest and incarceration and thus an unconscious effort to avoid having to cope with their legal case. However, if patients appear seriously deteriorated on examination (e.g., can't add two and two), and later are able to run a card game with other inmates, the likelihood of malingering is greatly increased, that is, unless the clinician has good reason to believe that the variable presentation has an organic basis or he/she suspects the presence of alter personality states. Conversely, behavior that is consistently confused, bizarre, disoriented and/or dissociated during a reasonably lengthy inpatient stay speaks against malingering

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

and is evidence for a finding of genuine illness.

History

Our experience suggests that while some very fragile and poorly adapted individuals undergo a dissociative decompensation in response to stress, individuals do not typically develop a full-blown Ganser syndrome or other dissociative disorder in the absence of at least some history of prior dissociative symptoms. This is also true for many, but not all, individuals whose Ganser syndrome appears to crystallize around a head trauma (see below). Evidence that dissociative symptoms were present during a period when the defendant had no motive to malingering (e.g., prior to arrest) suggests that the current dissociative picture is genuine. This is especially true if such symptoms were clearly maladaptive. Usually the best evidence of this kind is documentary; chart notes from an old hospitalization are the most common form of such evidence. (One caution: In recent years dissociative symptoms are sometimes documented by zealous practitioners who overdiagnose, and sometimes even iatrogenically produce a dissociative picture in their patients.)

Other evidence of prior dissociative symptomatology can come from retrospective reports of family members and acquaintances. The clinician garnering such reports must, however, make an assessment of their reliability and whether collusion with the defendant's efforts to malingering might affect their credibility. Typically, family members who retrospectively report serious dissociative symptoms in a relative will be genuinely distressed by their relative's behavior and convey this distress to the clinician. We should point out that the mere fact that the defendant reports dramatic dissociative symptoms

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

(e.g., feeling possessed by another being) to the clinician without ever having reported these symptoms to family members does not necessarily indicate that they are fabricated. However, reports of such “internal” dissociative experiences cannot be confirmed in the absence of familial reports of “external” dissociative behaviors, e.g., acting like “another person,” failure to recognize family members. Of more limited value are retrospective reports from the defendant him or herself. These reports are likely to be trustworthier when they are spontaneous, detailed, and vivid, than when they seem rehearsed or lack in detail.

Among the dissociative symptoms likely to be found documented in hospital records are trance-like postures, empty, vacant stares, intermittent child-like behavior or other apparent alterations in personality, bizarre cognitive deficits in the absence of criminal charges, imaginary companions, sleep-walking, time-loss and other dramatic forgetfulness, fugue states, unexplained disorientation, psychotic symptoms refractory to neuroleptics, and unexplained failure to recognize family members and other acquaintances. Symptoms less likely to be documented in hospital charts or reported by family members are elements of the patient’s own experience: the world is “not real”, one’s body is not one’s own, familiar places are uncannily unfamiliar, one can observe oneself like one observes others, a dialog between “named” internal voices has occurred in their heads, one’s soul sometimes leaves one’s body, and one feels hypnotized when performing certain acts.

Subtle symptoms

Many of the symptoms of dissociative disorders are quite dramatic. However, a

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number of subtle signs and symptoms are commonly associated with a history of dissociative disorders. Documentary, collateral, and even self-reported evidence of these subtle signs and symptoms can be supportive or counter-indicative of dissociation in a defendant with an apparent Ganser presentation. The defendant's own self-report of such symptoms is somewhat more probative than in the case where he/she reports a history of specific dissociative states, as the aspiring malingerer is less likely to be aware of them. Table 2 provides a checklist of such subtle and correlative symptoms and signs. (Note that several of these subtle symptoms are also criteria symptoms in Table 1). One must remember that it is important to assess the presence of such symptoms and concomitants both currently (on interview) and historically (through chart review and collateral interviews).

[Insert Table 2 about here]

Table 2: Subtle Symptoms and Concomitants of Dissociative Disorders

1. Imaginary companionship system in childhood
2. High capacity for fantasy, e.g., ability to project personality onto objects and situations
3. History of super-abundant neurological and medical symptomatology (history of extensive medical/neurological work-ups)
4. High suggestibility
5. Twitching
6. Seizure-like behavior or seizures, especially pseudoseizures
7. Insomnia or sleep disturbance
8. Nightmares

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

9. Terrifying hypnogogic, hypnopompic imagery
10. Time loss or amnesia
11. Substance abuse, commonly sedatives, hypnotics, and alcohol
12. Catatonia and muteness
13. Gastrointestinal symptoms, abdominal pain
14. Past psychiatric history with multiple previous diagnoses; Diagnosis of Borderline Personality Disorder
15. Frequent job changes
16. Itinerant, wandering the country
17. Vague memories of many experiences, particularly psychotic experiences
18. Difficulty providing a clear chronological life history (e.g., grade by grade in school)
19. Contradictory (but not self-serving) accounts of events and episodes
20. Reinterpretive retrospective distortions of events
21. Find oneself with clothing and possessions one cannot explain
22. Transsexualism and other perversions
23. Pseudologia Fantastica
24. Flashbacks, intrusive images, dreamlike memories
25. Somnambulism (sleepwalking)
26. Knowledge and skills in one state but not in another (sudden loss of knowledge and skills)
27. Admission and then subsequent denial of symptoms (but not self-serving)
28. Psychotic symptoms largely refractory to neuroleptics
29. Florid symptoms (likely) first appeared in 20s or 30s

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

30. Somatic memories associated with traumas
31. Sensory disturbances (hysterical in quality)
32. Victimized as an adult
33. Pretend to know more than they do regarding life history
34. Unusually diversified reservoir of “life roles”
35. Ability to spontaneously block out pain.

Abuse

Although this has not been noted specifically in the Ganser literature, the great majority of individuals who suffer from severe dissociative disorders do so incident to early childhood physical and/or sexual abuse. This finding, which originates and is substantiated in the Dissociative Identity Disorder literature, is also true, in our experience, for the majority of individuals on the Bellevue Forensic Psychiatry Service who present with (genuine) dissociative (including Ganser) symptoms. The finding makes good theoretical sense, as dissociation is posited to be a radical mechanism for coping with overwhelming trauma. Since a very high percentage of patients who have been abused do not suffer from dissociative disorders, abuse alone should not be relied upon as the sole differentiating criterion. Nevertheless, it is an important part of the work-up in differentiating malingering from true dissociative disorders.

In ideal circumstances, one can obtain confirming documentary evidence of such abuse in prior hospital charts, court records, etc. At other times, family members will confirm such abuse (However, family members may also collude to hide or deny the existence of such abuse). On occasion, one is forced to rely on the patient’s self-report.

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This can be misleading, particularly in view of the fact that the “abuse excuse” is a favorite ploy of defendants seeking sympathy from mental health professionals.

Occasionally one will uncover a history of such abuse in cases where the defendant fails to report or even denies such a history. This provides good evidence favoring a finding of dissociation as opposed to malingering.

Brain Injury

There are a significant number of case reports in the literature (including Ganser’s own) documenting the appearance of Ganser syndrome shortly after a concussion or other brain injury. Whitlock (1967) noted the presence of an organic factor in Ganser syndrome and suggested that the condition is caused by severe psychic stress in patients with cerebral injury or psychosis. According to Cocores et al. (1986-7), almost all cases of Ganser syndrome have a history of head trauma or other organic involvement, such as hydrocephalus or neurosyphilis. Bustamonte & Ford (1977) are among those who postulate that Ganser syndrome involves a combination of hysteria and organicity. About 60% of Ganser cases describe clouded senses or disorientation, symptoms frequently associated with such organicity. However, in the majority of cases, EEG data does not suggest any specific organic illness (Cocores et al., 1986-7).

Typically, the diagnosis of Ganser syndrome is made when the patient’s presentation, originally attributed to the head injury itself, fails to conform to the pattern expected of individuals suffering from genuine neurological insults. Such patients generally present with dramatic cognitive deficits, especially in memory. Theoretically, Ganser syndrome has crystallized around a mild neuropsychological deficit, such as mild

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

memory loss, in the same way that a full-blown psychosomatic illness often crystallizes around a mild medical problem or “weak organ.” Since defendants will occasionally malingering memory loss after innocuous head trauma, the presence of such trauma should only be considered among the other confirming evidence in any particular case. Still, it is important to be aware that improbable symptoms subsequent to head trauma are not necessarily a sign of malingering.

Diagnostic Testing

The use of psychological testing in diagnosing dissociative disorders, while still in its infancy, is a complex topic worthy of its own full discussion. In general, we have found the standard measures of both dissociation (DES) (Bernstein & Putnam, 1986) and malingering (MMPI-2, SIRS) to be of limited value in our assessments. However, these and other measures can be useful in eliciting material to be used in follow-up interviews and investigations. The DES (Dissociative Experiences Scale) provides a series of obviously dissociative symptoms; the test-taker is asked to rate what percentage of the time he/she experiences them. The usefulness of the test is compromised by the fact that it is not only easy to manipulate, but by presenting a list of dissociative symptoms the test may provide a potential malingerer with a wealth of information on presenting with a dissociative disorder. When the DES or a similar inventory is used, it is imperative that each dissociative item the patient endorses as significantly present is reviewed with the patient to determine his/her reason and credibility in making such endorsements.

The general personality inventories provide virtually no coverage for dissociative symptoms and disorders. In point of fact, the MMPI-2 (Minnesota Multiphasic

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

Personality Inventory-2) does contain a number of symptoms in its item pool that on their face appear dissociative, but they are not brought together in any of the clinical scales (Hansen and Gold, 1997; Phillips, 1994; Mann, 1995). Many face-valid dissociative symptoms actually appear on the F-scale; a validity scale comprised of infrequently endorsed symptoms that indicate exaggeration or malingering. It is possibly for this reason that individuals with true dissociative disorders tend to produce MMPI profiles that appear malingered (see Bliss, 19984; Coones & Sterne, 1986; Solomon, 1983). Heron, et al. (1991) reported extreme MMPI-2 elevations in a patient with Ganser syndrome. In such a case the examiner must review each dissociative item with the patient, as well as check his/her responses against the reports of collateral sources and the other available data. It is important to note that in a context where dissociation is part of the differential, a so-called “malingered” MMPI-2 is, in and of itself, not probative on the issue of dissociation vs. malingering. On the other hand, a “valid” or a “fake good” MMPI-2 does speak against malingering in this context.

With regard to the MCMI (Millon Clinical Multiaxial Inventory), Dell (1998) has provided data indicating that individuals with Dissociative Identity Disorder show pronounced elevations on Avoidant, Self-defeating, Borderline and Passive-aggressive scales, while individuals with Dissociative Disorder NOS show elevations on Avoidant and Self-defeating scales. These elevations are similar to those found amongst individuals with chronic Post-traumatic Stress Disorder, and might be expected in Ganser patients as well.

A number of studies have made use of the Rorschach in distinguishing dissociative disorders. Most of these studies have been conducted on DID patients, and

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

their applicability to other dissociative disorders remains unproven. Still, the Rorschach does provide a means of bypassing the defendant's self-report and potentially getting at his/her underlying perceptual and cognitive processes. The published data (Scroppo, et al. 1998; Leavitt & Labott, 1997) indicates a number of Rorschach features that are suggestive of dissociation. It is hypothesized that individuals who dissociate have a high propensity for fantasy, and Rorschach variables measuring such fantasy tend to be elevated in individuals with dissociative disorders. Other noted features include increased human movement, splitting responses, and form-dimensional responses (Scroppo, et al., 1998).

With respect to the Ganser syndrome, Heron, et al. (1991) have provided anecdotal data pertaining to the usefulness of neuropsychological testing with such patients, not only in documenting the presence of pseudo-dementia but in eliciting approximate answers that illustrate the remarkable "trance logic" described by Epstein (1991). In particular, it is suggested that responses on the Boston Naming Test (in which the subject is asked to name pictures of common objects) may be particularly useful in eliciting Ganser-like approximate answers, responses that malingerers would presumably be unable to consciously generate with the ease and fluency typically noted in Ganser patients.

The "SHAM LIDO" Method

We have found a useful acronym for the kind of thorough evaluation needed to distinguish Ganser syndrome from malingering. The SHAM LIDO method involves an investigation of subtle **S**ymptoms, **H**istory of dissociation, **A**buse in childhood,

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

Motivation to malingering, Lying and manipulation, Injury to the brain, Diagnostic testing, and Longitudinal Observation. This method, in concert with our provisional diagnostic criteria, should provide a comprehensive clinical and forensic evaluation of the disorder.

Case Example

The following clinical case illustrates the diagnosis of Ganser Syndrome in the context of an evaluation for competency to stand trial. The case is that of an individual whose affect and verbalizations on interview are extremely constricted, and where little, if any direct effort is made to impress the examiners with his pathology. Unlike other cases of Ganser Syndrome in which the patient makes every effort to dramatize his symptoms to the examiner, Mr. Z's presentation was initially quite subtle and required extensive interviewing to unearth his pathology.

Mr. Z is a 39-year-old Caucasian man of Russian descent referred for an evaluation of his competency to stand trial. He was arrested after allegedly having kidnapped his wife and her family and holding them at gunpoint. Mr. Z claimed to have no recollection of the events that led to his arrest. Mr. Z displayed an almost "belle indifférence" to his criminal case, stating he has no memory of the events. However, he did not protest the allegations against him.

Mr. Z initially reported a normal childhood, but family members related that a babysitter and others had sexually abused him as a small child. Both Mr. Z and his family also reported a history of depression and three prior suicide attempts, the first occurring several years previous when he suffered a serious business setback. At that time he took

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

an overdose of sleeping pills and was hospitalized overnight. On two subsequent occasions he placed a gun to his head but reports that he simply “could not pull the trigger.” The family also reported that he would at times appear to go into a trance and leave the home for days at a time or sleep outside in the backyard, during which times he was totally non-communicative. Mr. Z denied any history of alcohol or other substance abuse. A head CT revealed no gross brain abnormalities.

On initial mental status, Mr. Z showed little if any emotional expression, required prompting to speak, and remained motionless throughout the examination. While described his mood as “fine, okay,” his affect was blunted and he appeared depressed. During the course of his hospitalization he was observed in a trance-like state on several occasions, yet he would respond if his name were called. He denied current suicidal ideation. On psychological testing Mr. Z did extremely poorly on cognitive tasks, and gave approximate answers to simple arithmetic sums. When asked how many nickels are in \$1.25 Mr. Z gave varied incorrect responses. When the math was broken down for him he was still unable to give the correct answer. Considering his level of education, simple arithmetic should have been no challenge. When asked for the date he would always report it to be one month earlier than it was, despite being shown dated newspapers, and would explain the discrepancy as resulting from efforts by the staff to trick him. On Projective Testing he produced highly elaborated responses with increased human movement, splitting responses, and form-dimensional responses.

Mr. Z reported hearing two male and one female voice at night, talking about “getting me and cutting me up, locking me up in the dark basement.” On inquiry it became clear that these were the voices of his childhood babysitter and of two of her

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

friends that used to abuse him as a child. He also reported seeing the devil dressed in red and holding a stake sitting on his bed and laughing at him. He related that he is visited weekly by a talking monkey named “Marky Mark” and a talking butterfly named “Ziggy.” He stated, with a completely straight face, that the three of them are “great friends” and that they “fly in the clouds together in a small twin engine airplane.” He lights up with child-like affection when speaking about his friends, the only show of emotion throughout the interview. Mr. Z would not spontaneously convey this information; it was only explored upon inquiry.

It is apparent that Mr. Z meets the first two screening criteria we have set forth regarding Ganser syndrome. The presence of pseudo-dementia is suggested by his approximate and at times absurd answers to cognitive questions, his insistence of the wrong date despite evidence otherwise, and his inability to make simple arithmetical calculations well within his functional capacity. He showed a number of dissociative/hysterical symptoms, including loss of memory, trance-like presentation, childlike behavior, “belle-indifference,” and absurd visual hallucinations (which might also suggest malingering). There is no history of a non-dissociative or hysterical psychiatric disorder that could explain his symptom picture. On the other hand, there is a history of early childhood abuse, and the presence of dissociative symptoms both prior to and after his arrest. Psychological testing is suggestive of a dissociative disorder. While there was clearly a motive to malingering (i.e. to avoid having to face his charges) there is no history to suggest conning, lying or, manipulation. His not spontaneously reporting the more absurd symptoms supports this. Indeed prior to his first suicide attempt Mr. Z was described as a model father, husband and businessman. Mr. Z was found unfit to

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

stand trial, diagnosed by the forensic examiners as suffering from a hysterical psychosis. This was a clear case of the Ganser syndrome.

Course and Treatment

There is some debate over the course of Ganser syndrome and the appropriate methods of treatment. Traditionally, the syndrome has been viewed as acute and self-limiting, with Ganser patients recovering quickly and completely from the syndrome (Enoch et al., 1991). However, more recent reports raise the possibility of a much more chronic course due to the fact that the dissociative mechanisms responsible for the syndrome are likely to persist long after the syndrome itself is no longer present (Miller et al., 1997, Hampel et al., 1996). We have noted both acute and self-limiting forms of the disorder and more chronic Ganser states, the latter embedded in the context of severe dissociative syndromes and other psychopathology.

Epstein (1991) recommends the implementation of supportive therapy in the context of a structured protective environment in order to effect a rapid resolution of symptoms. However, Haddad (1993) reports that recovery from Ganser syndrome may be followed by “symptom substitution” with a major depressive episode. He explains this by the hypothesis that Ganser syndrome and depression are separate manifestations of a common underlying conflict. Our own experience suggests that treating these patients as if they suffer from depression (with supportive psychotherapy and anti-depressant medication) is frequently effective. We are in agreement with Epstein (1991) that accusing them of faking or browbeating them into recovery will, at best, produce pseudo-compliance and actually is likely to intensify the syndrome.

Drob, S., & Meehan, K. (2000). The diagnosis of Ganser Syndrome in the practice of forensic psychology. *American Journal of Forensic Psychology, 18*(3), 37-62.

One of the difficulties in evaluating a Ganser patient is making a recommendation to the courts once it has been determined that the individual is, in fact, suffering this syndrome. To send a patient to trial when he is unable to properly answer the simplest of questions would make it difficult, if not impossible, for the attorney to have the client assist in his/her own defense. On the other hand, to find the individual not competent to stand trial reinforces the unconsciously avoidant behavior.

Our own view of the syndrome is that while it is unconsciously generated, it can and should in due time come under the patient's volitional control. By itself, Ganser syndrome should not be a basis for a permanent finding of incompetence. The defendant's underlying illness (e.g., depression) must be acknowledged and treated, but he/she should be informed that a full recovery is expected (Feinstein et al., 1988). In a protracted case the clinician may suspect that the syndrome is being voluntarily prolonged and that the individual has passed from experiencing a dissociative disorder to producing a malingered one.

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