American Handbook of Psychiatry

RARE, UNCLASSIFIABLE AND COLLECTIVE PSYCHIATRIC SYNDROMES

SILVANO ARIETI
JULES R. BEMPORAD

RARE, UNCLASSIFIABLE AND COLLECTIVE PSYCHIATRIC SYNDROMES

Silvano Arieti and Jules R. Bemporad

e-Book 2016 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 3* Silvano Arieti

Table of Contents

RARE, UNCLASSIFIABLE AND COLLECTIVE PSYCHIATRIC SYNDROMES

Silvano Arieti and Jules R. Bemporad

In the first edition of the Handbook, hesitation was expressed over including a chapter on rare, unclassifiable, collective, and exotic[1] psychotic syndromes. Time has shown that the inclusion of such material was beneficial to the student and researcher, as well as the practitioner, of psychiatry in that the stated chapter has frequently been cited in the subsequent literature. While single case reports of these syndromes are occasionally reported in various journals, there appears to be a continuing need for a description of these disorders, as well as a review of the pertinent literature that is readily accessible. As stated previously, another reason for including these rare syndromes is that they pose interesting problems in terms of theory and it is hoped that by presenting them here, it may be possible to stimulate further work that may be applicable to other areas of psychiatry. The majority of these syndromes are of especial interest in that although they are not psychoses in the usual sense, peculiar distortions of reality are manifested, as well as a rigidity of the symptomatology that is reminiscent of psychotic disorders.

Rare and Unclassifiable Syndromes

Ganser's Syndrome

The essence of this disorder consists of the patient giving approximate or inexact answers to the simplest questions imaginable. The answers are not totally random but bear some relationship to the question asked; they are slightly off the mark. Although Moeli first described the symptom of *vorbeireden,* or "talking past the point" (i.e., giving slightly incorrect responses) in 1888, Ganser fully described the syndrome ten years later.[2] Ganser specified four major features of this syndrome: (1) the giving of approximate answers, (2) a clouding of consciousness, (3) somatic or conversion symptoms, and (4) hallucinations. While all features are occasionally found, the first symptom is considered essential to the Ganser syndrome. It may be of interest that this syndrome has been more frequently reported in the European than the American literature.

Although relatively rare, the Ganser syndrome is interesting from psychopathological and legal points of view. It is generally encountered in prisoners who have to face trial but also, occasionally, in patients in the general population who have to face unpleasant conditions. Jolly reported that one third of his cases were noncriminal civilians. Of the six cases reported by Weiner and Braiman, only one was a prisoner. Dogliani reported one case occurring after a relatively minor automobile accident. It has also

been reported as not infrequent among Negro soldiers in Africa.

One finds in the Ganser syndrome a more or less acute loss of the capacity to reason normally. Many cases present total or partial amnesia. The patient is disoriented as to time and space and gives absurd answers to questions. Often, he claims he does not know who he is, where he comes from, or where he is. When he is asked to do simple calculations, he makes obvious mistakes—for instance, giving 5 as the sum of 2 plus 2. When he is asked to identify objects, he gives the name of a related object. Upon being shown scissors, the patient may say that they are knives; a picture of a dog may be identified as a cat, a yellow object may be called red, and so on. If he is asked what a hammer is used for, he may reply, to cut wood. If he is shown a dime, he may state that it is a half dollar, and so on. If he is asked how many legs a horse has, he may reply, six.

At times, almost a game seems to go on between the examiner and the patient. The examiner asks questions that are almost silly in their simplicity, but the patient succeeds in giving a sillier answer. And yet, it seems that the patient understands the question, because the answer, although wrong, is related to the question. Often, if pressed, the patient will begin to answer, “I don’t know,” until he refuses to answer at all, lapsing into a state of lethargy or stupor.

Of the other features mentioned by Ganser, conversion reactions are occasionally seen, but headache is the most frequent somatic complaint. Hallucinations, when present, may often be of a fantastic nature such as those reported by a patient cited by MacDonald. This individual claimed he saw red horses, partially dressed in human clothing, sitting atop lamp posts. In their review of the syndrome, Ingraham and Moriarity specified visual hallucinations, as well as clouding of consciousness, disorientation of time and space, amnesia, and lack of insight, as prominent features of the Ganser's syndrome.

Diagnosis

Ganser's syndrome may be confused with voluntary malingering in prisoners who want to escape indictment. In some cases, the diagnosis is difficult. The malingerer will at times lose the air of bewilderment and confusion when he is not watched, whereas the Ganserian patient remains in that state all the time. The malingerer is watchful, suspicious, and (although he appears indifferent) ill-at-ease all the time, being conscious of the unreality of his symptoms.

The syndrome can also be confused with schizophrenia. The answers of the Ganserian patient are reminiscent of those given by schizophrenics, the productions Cameron calls "metonymic distortions." The answers given by

the Ganserian seem even sillier, however, almost as if a voluntary effort had been made to say something ridiculously inappropriate. Even the most deteriorated schizophrenic will not lose his memory for simple everyday behavior, such as how to unlock a door or how to use eating utensils. Also, unlike schizophrenics, some of the patients with Ganser syndrome recover in a few days if withdrawn from stress, although recurrences are common.

A third misdiagnosis easily made is one of mental deficiency or organic conditions. But a mental deficiency of a degree that would explain such absurd answers would have been known prior to the onset of the disorder. Similarly, an organic condition that might lead to these symptoms would have to be at a very advanced stage; again, there would be no difficulty in making the diagnosis.

Interpretation

Is the Ganser syndrome a psychosis? Ganser himself, Kraepelin, Bumke, Henderson and Gillespie, and MacDonald, felt that it is a psychoneurosis, similar to what Wernicke called "hysterical pseudodementia," and should be included in the group of hysterias. The conversion syndrome would consist in the patient's acting as if he had lost his rationality. The secondary gain, of course, would be the avoidance of the indictment or whatever unpleasant situation he has to face.

Other authors felt, instead, that the condition is a psychotic one (Moeli, Weiner and Braiman, Dogliani, Whitlock). We must say that the syndrome indeed presents a psychotic flavor not usually found in psychoneuroses. The psychodynamic mechanism also seems surprisingly simple: It is obvious that the patient wants to avoid the unpleasant situation and the burden of responsibility. Perhaps, as Weiner and Braiman state, he wants to do more than that. By unconsciously selecting symptoms which make him lose his rationality and often forget his personal identity and his past, he wants to reject his whole self, his whole life history—a denial of his total self. While many reported cases have demonstrated accompanying psychotic symptoms, other patients have shown this syndrome in "pure form," without psychotic contamination, leading to the opinion that the Ganser syndrome may be encountered in a number of psychopathological states.

We encounter difficulties when we try to explain the symptoms from a formal point of view. The answers of the patient are related to the questions, although inappropriately, and are reminiscent of the metonymic distortions of the schizophrenic, and in particular of the negativistic answers of some catatonics. The similarity is, however, only apparent. The Ganserian seems almost to make an effort to give a silly answer; a catatonic would not say that a horse has six legs.

Many authors have reported that this condition occurs mostly among

people who, although not mentally defective, were at least dull adults of borderline intelligence, or high-level morons. It has never occurred in a person who was of superior intelligence prior to the disorder. This fact suggests the possibility that the low mentality of these people had made them aware of one thing: that at times in life it was convenient not to be smart. The mental defect, although not present, was within grasp or could be exaggerated.

Capgras' Syndrome

Capgras' syndrome is a condition that has received considerable attention in the European literature, especially the French and Italian. In the American literature, Davidson, Stern and MacNaughton, and Todd have published articles on the subject. Recently three cases have been reported in the Australian literature.

In 1923, the French psychiatrist Capgras, in collaboration first with Reboul-Lachaux and later with several others, started a series of articles on what he called *"L'illusion des sosies." Sosie* means "double," a person who looks exactly like another one, just as an identical twin would resemble the other twin.

The phenomenon (or syndrome) described by Capgras is the following: The patient will claim, on meeting someone he knows well, that the person is

a double or an impostor who has assumed this person's appearance. For example, the mother of a female patient comes to visit the patient at the hospital. The patient claims that this visitor is not her mother, but either a double or an impostor who has tried to assume the appearance of the mother in order to deceive the patient. This phenomenon is thus a complicated type of misidentification, much more characteristic and specific than the usual misidentification occurring in schizophrenia.

Although the first publications reported cases of female patients only, a few cases among males have recently been described.

Is this condition, described by Capgras, a special syndrome, or just a symptom occurring in one of the well-known clinical entities? The problem is controversial. Generally, French authors tend to give Capgras' syndrome a special place in psychiatric nosology, whereas German authors tend to see it as a symptom. From the cases reported in the literature, however, it is obvious that, although the patients presented other symptoms, this particular delusion of the double was the center of the symptomatology.

The authors of this chapter have never seen a case as typical as those described in the literature. The senior author, however, has seen two patients, paranoids with almost completely well-organized delusions, who doubted that their parents were their real parents. One of them felt that most probably

her parents had died a short time before (that is, at the onset of her illness) and the persons who acted as her parents were either impostors or reincarnations of her parents. The writer considered this delusion part of a paranoid condition (bordering on paranoia). The second patient, together with the typical picture of paranoid schizophrenia, had the idea that her mother was an impostor. The senior author has also seen Capgras-like syndromes in elderly patients.

From an examination of the literature one gets the impression that the patients described could be classified under either paranoid schizophrenia or paranoid states. Capgras' syndrome thus should be more properly called Capgras symptom. As a matter of fact, similar phenomena are described in the European literature in even rarer syndromes: for instance, the illusion of Fregoli, described by Courbon and Fail. The patient identifies the persecutor successively in several persons—the doctor, an attendant, a neighbor, a mailman, etc. The persecutor allegedly changes faces, as the famous European actor, Fregoli, used to do on the stage. Courbon and Tusques have also described the delusion of inter-metamorphoses. The patient believes that the persons in his environment change with one another: A becomes B, B becomes C, C becomes A, etc.

But, going back to Capgras' syndrome, several authors report that they have found the syndrome not only in schizophrenic-like or paranoid patients,

but also in manic-depressives.

Many patients reported recently in the literature have been treated with insulin or electric shock treatments, apparently with good results. Others retained their delusions and illusions or had relapses.

Recently Moskowitz reported the successful treatment of a twelve-year-old boy with Capgras' syndrome by psychotherapy. Perhaps due to the young age of this patient, paranoid elements were not as prominent as in other reported cases.

Interpretation

Even if we deny recognition as a clinical entity to the Capgras phenomenon, it deserves further study from dynamic and formal points of view. The already abundant literature seems to be preoccupied almost exclusively with classificatory controversies.

Cargnello and Della Beffa, reporting on existentialist analysis of the phenomenon, write that in the delusional experience of the patient three persons enter: the patient, the *alter* (the other, the person who was well known to the patient), and the *alius* (the double or the impostor). They conclude that actually it is the *alius* who is lived intensely in the *Erlebnis* of the patient and, although mis-identified, is the closest to the ego of the

patient.

A few things seem obvious in this syndrome. First, the person whose existence is denied is a very important person in the life of the patient—for instance, the mother. The patient rejects the mother, actually attributes very bad traits to her, but cannot allow herself to become conscious of this rejection because of concomitant guilt feelings or other ambivalent attitudes. What the patient feels about the mother is thus displaced to the double or impostor who allegedly assumes her appearance. Often, the idea that the misidentified person is a double or an impostor occurs to the patient as a sudden illumination or "psychotic insight."

Capgras' syndrome thus may be seen as an unusual form of psychotic displacement. All gradations of displacement occur from normal states to neuroses and psychoses. In private practice, we often see how the young wife's resentment toward her own mother is freely displaced and freely expressed to the mother-in-law, for whom she has no ambivalent feelings.

In Capgras' syndrome the real person is spared the hate of the patient—even becomes sanctified, a model of virtue—and the impostor made the target. But the real person, the person whom Cargnello and Della Beffa called the *alter,* becomes a pale, peripheral figure. The patient is really concerned with the *alius,* the impostor.

More difficult than the dynamic is the formal understanding of the Capgras phenomenon. Often, in schizophrenia, the opposite process takes place: Persons and things which, in thinking processes, should only be associated, are identified. In the Capgras phenomenon, not only is there no increased tendency to identify, but a person who should be easily identified is not.

The real person is almost divided into two parts (the *alter* or the good part, and the *alius,* the bad part), as it often happens in dreams. In the Capgras phenomenon, the persons are different, but the body has the same appearance. There is thus not only a denial of the Aristotelian first law of logic (law of identity), but also a denial of von Domarus' principle (for instance, in spite of characteristics in common, the visitor is not the mother but an impostor). Obviously, the mother is identified with the impostor, but this identification remains unconscious.

This syndrome seems to represent in a dramatic fashion what Melanie Klein proposed as the early infantile solution to ambivalence, the "splitting" of the parent into good and bad imagos. Moskowitz' case, whose therapy is described in detail, recounted how he began to believe that his parents were being impersonated by aliens after he realized that they preferred his brother and that they had treated him unfairly. He could not believe that his real parents could act in such a fashion, nor could he tolerate the anger he began

to feel toward them. By creating the impersonation fantasy, he was able to continue to love the idealized image of his parents while transferring his hatred to the supposed impersonators.

Autoscopic Syndrome

Clinical Picture

Like Capgras' syndrome, the autoscopic syndrome consists of the delusional experience of a double. In the autoscopic syndrome, however, the double is not a person from the patient's environment but the patient himself. The patient sees a person nearby who looks exactly like himself, talks, dresses, and acts as he does. Quite often, this double seems exactly like a mirror image of the patient. Lukianowicz reported an excellent study of this syndrome. Other important reports are those of Lippman, Lhermitte, Pearson and Dewhurst, and Todd and Dewhurst.

The double may appear suddenly and without warning; at other times, there are aural warnings. It generally appears in gray, or black and white, like images in dreams. Colors are seldom perceived. The patient occasionally reacts to the discovery of the presence of the double with sadness and amazement, but more often seems indifferent or even happy about it. In a few cases, the double is constantly present; in the majority of instances, however, the appearance of the double lasts only a few seconds. Some patients have the

experience of the double only once in their life; others repeatedly or constantly, after an important event has occurred. Many patients experience the phenomenon only in the evening, at night, or at dawn. Although occasional instances of autoscopic syndrome have been reported in schizophrenia and in depressions, the majority of cases occur in patients suffering from migraine and epilepsy.

Numerous works of fiction have dealt with the theme of a person encountering his double. In some cases (Hoffmann's *The Devil's Elixir* or Poe's *William Wilson),* the two protagonists represent the good and evil sides of man. Perhaps the best known of such stories is Dostoevsky's *The Double,* in which Golyatkin, a petty bureaucrat, meets his exact double who increasingly takes over his life until Golyatkin is sent to a mental hospital, helped into the carriage by his double. This story may be loosely interpreted as the struggle between the benign and malicious aspects of the same person. It is questionable, however, how much value these literary works offer in terms of explaining the condition as it occurs in psychiatric practice. Rogers has written a valuable summary of the use of the "doubles" as a literary device and presents an interesting psychoanalytic interpretation.

Interpretation

Autoscopic manifestations may be remotely related to, but certainly are

not identical with, others which are encountered more often in psychiatric practice, such as eidetic images, hypnagogic hallucinations, or those imaginary companions about whom some patients, especially children, have enduring fantasies.

The term “autoscopy” was used by Schilder to describe the process by which the individual is capable of doubling his body image and projecting it into the outside world. As used by Lukianowicz, the term refers to hallucinatory phenomena, predominantly visual. These hallucinatory phenomena have only a remote resemblance to those found in schizophrenia; they have a much stronger resemblance to the phenomena found in organic conditions, especially those involving the parietal and temporal lobes (Critchley, Penfield and Rasmussen, Gerstman), and in some cases of epilepsy. Sperber has mentioned the possibility of sensory deprivation in some cases of autoscopic illusions.

The greatest resemblance is to those conditions in which a psychological picture is superimposed on an original organ condition, such as symptomatic epilepsy, cases of phantom limb, duplications of parts of body, and denial of illness.

There seem to be indications, however, that the psychogenic element is important in some cases. For instance, one of the cases reported by

Lukianowicz was that of a fifty-six-year-old woman who experienced autoscopic phenomena upon returning from her husband's funeral. These phenomena continued thereafter. Lukianowicz does not attempt a dynamic interpretation of the case, although no organic findings are reported. One could speculate that the hidden purpose of the symptom was to make the patient aware that, although the husband was dead, she did not need to feel alone; she could be her own companion.

Wagner has described the case of a twenty-one-year-old woman who, after being rejected by her fiancé, started to complain that her friends were persecuting her by telling her about having encountered a married couple whose description exactly fit that of herself and her former lover. In this instance, the patient did not hallucinate a double, but rather created one as part of a delusional system. Wagner found that many of his patient's Rorschach responses consisted of bilateral identical figures looking at each other, so that he concluded that her cognitive set partially predisposed toward the creation of a double. In this case, as in that described by Lukianowicz, the creation of a double appears to serve as a reparative process after a loss.

Ostow has reported two patients who experienced autoscopic phenomena during the course of psychoanalysis. Both patients had a tendency to "split" themselves into acting and self-observing parts, and both

patients experienced the phenomenon at a time of self-depreciation and disappointment. Ostow interprets the disorder as "an attempt to fracture off from the suffering ego the fragment which is felt to be the source of pain." On a deeper level, Ostow believes, that the autoscopic phenomenon represents a wish for the death and rebirth of an unacceptable part of the self.

Todd and Dewhurst have attempted to delineate these factors that seem to predispose to autoscopic phenomena. General factors are a state of fatigue and above-average powers of visualization. A specific factor of psychogenic origin is an extreme narcissism and self-preoccupation. In defense of this, Todd and Dewhurst cite many authors who have experienced autoscopic phenomena. They believe this is because a writer always pictures himself in situations in order to create works of literature. An organic specific factor is damage to the parietal lobes, and they present a case who experienced autoscopic phenomena after injury to this area. A general factor that is mentioned is the use of archetypal or paleologic thought, which allows for concretization of an idea into a visual image. In his presentation of a case, McConnell states that the most important psychogenic factors are excessive narcissism, a tendency toward wish fulfilment, and the use of visual imagery.

Cotard's Syndrome

In 1880, at the meeting of the Societé Medico-Psychologique in Paris,

the French psychiatrist Cotard reported cases of what he called *"délire de negation,"* or delusional state of negation. Since that time, controversy has continued as to whether this syndrome deserves a special place in the psychiatric classification or whether it should be included among recognized entities.

In 1892, a congress of neurologists, which took place in France, devoted itself to this topic, but no definite conclusions were reached. At the present time, it is only in France and in Italy that the condition continues to be described as a separate entity, but even in these countries there are many psychiatrists who deny its existence. In the United States, the condition would probably be included in the paranoid type of involutional psychosis. This symptomatology is in fact somewhat rare in the United States. A brief description follows:

After an interval of anxiety, the patient, generally a woman in the involutional age, but at times even men and younger or older women, denies any existence to the surrounding reality. Nothing exists; the world has disappeared. After the cosmic reality is denied, the physical reality of the patient himself is denied. At first, the patient claims that he has lost all sensation throughout his body; in some cases, he later claims that he does not exist. Everything is denied in this overwhelming delusional state. At times, even the possibility of death is denied—the patient considers himself

immortal. Other symptoms resemble the picture of involutional psychosis—the patient is depressed, may refuse food, has ideas of having been condemned by God. He may also hallucinate. He retains, however, the capacity to talk freely in spite of the depression, and often is given to philosophical contemplations about his own life, life in general, and the world.

In the past few years, additional cases of Cotard's syndrome have been described in the Italian literature. Ahlheid states that the nihilistic experience is common to many psychotic states and cites three cases, an arteriosclerotic, a syphilitic, and an alcoholic, with incomplete Cotard's syndrome. His point is that these symptoms can be seen in a number of conditions. Vitello reports a case of paranoid schizophrenia who demonstrated excessive negation. These recent articles further question the validity of separating Cotard's syndrome as a specific diagnostic entity.

For further study, the reader is referred to Cotard, Ey, Capgras and Daumezon, Perris, and De Martis.

"Psychose Passionelle" of Clérambault

In the French literature and to a lesser degree in the Italian, the so-called *"psychose passionelle,"* or "pure erotomania," is still given a distinct nosologic place by some psychiatrists. It is sometimes called Clérambault's syndrome, after the author who devoted many studies to it.

The condition is not too rare, even in the United States, and the senior author has seen several cases of it. In the United States, however, the condition is generally classified as a paranoid condition, paranoia, or paranoid type of schizophrenia. A brief description is reported here of the symptoms, which in some European psychiatric schools are generally considered part of Clérambault's syndrome.

The patient, generally a woman, claims that a man is very much in love with her. The man is generally of a social rank superior to hers, at times very wealthy, or a prominent actor, lawyer, physician, etc. The patient would like to reciprocate this love, but the world does not permit her to do so.

In other instances, the patient is convinced that the rebuffs or lack of interest on the part of the alleged lover are only pretenses, and that he is hiding his love for some hidden motive. The patient's love becomes the purpose of the existence of the patient, and everything else in her life revolves around it. The patient starts to interpret everything as a proof of the love this man has for her, and a delusional system is thus built. For instance, one patient, the wife of a successful storekeeper, considered the business success of her husband as a proof of the other man's love for her. Because of his love, he was directing many customers into the husband's store, so that the husband would make a lot of money. Any gift the husband bought for the patient was interpreted as an indirect gift from the other man.

Despite the persistence of this irrational belief of being loved, some patients may function normally in other areas. Enoch et al. have reported the case of a forty-one-year-old spinster who, although convinced that she was secretly loved by an older professor, was able to carry on her work as a university lecturer.

In general, patients with this syndrome cling stubbornly to their delusion, despite all sorts of proof to the contrary. Even repeated confrontations with the alleged lover, during which he disclaims any feeling for the patient, are interpreted as his having been forced to "pretend" not to love her. Usually, the illness is chronic, with little change in the delusional system, despite various forms of treatment. For further study, the reader is referred to Clérambault and Balduzzi.

Munchausen's Syndrome

While this syndrome has been recognized for decades and has plagued innumerable physicians in the past, it was not until 1951 that Asher formally described this condition and termed it "Munchausen's syndrome." This eponym was based on Baron Munchausen who lived in the eighteenth century, traveled widely, and was fond of telling fantastic tales. Raspe portrayed the Baron in a somewhat fanciful biography, inventing even more fantastic adventures and anecdotes. The similarities between the legendary

Baron and the patients described by Asher rest on both being compulsive travelers and both telling somewhat believable yet fantastic stories. More specifically, Asher's patients used their stories to gain admission to hospitals for factitious illnesses. Usually, these individuals will present themselves at emergency rooms late at night or on weekends when admission is easier. They will present themselves with dramatic symptoms which, however, are medically plausible.

Those patients who have been followed up or whose histories have been traced reveal that they have deceived numerous doctors by feigning serious illness, often to the point of undergoing surgery or other complex procedures. More commonly, however, once admitted to a hospital, these individuals tend to be argumentative and demanding, antagonize the staff, and ultimately sign themselves out against medical advice. While in hospital, they often assume dramatic impostures, such as war heroes, or other esteemed personages.

Since Asher's initial description, about forty cases have been reported, but these have been primarily in the nonpsychiatric literature. In fact, few patients have been studied by psychiatrists, because these patients appear skillful in avoiding psychiatric examination, and, also, since they present plausible medical histories and symptoms, psychiatric consultation is rarely sought. In reviewing the literature, caution is needed to make sure that the

various articles do not refer to the same patient in a different guise. For example, one individual was responsible for no less than seven publications. On the whole, however, the following generalizations may be considered. Munchausen's syndrome usually presents in three forms: (1) the acute abdominal type, in which the patient complains of severe abdominal cramps, often requiring emergency laparotomy; (2) the hemorrhagic type, in which the patient induces bleeding from various orifices; and (3) the neurologic types, in which mysterious yet striking neurologic symptoms are manifested. Cardiac and dermatologic symptoms have also been reported.

The syndrome appears more frequently in men than in women. Among the latter, hysteria is the most frequent psychiatric diagnosis, while among men there is an equal mixture of psychopathic personality and chronic undifferentiated schizophrenia. Because of the notoriety that this disorder has received, there is the danger of over-diagnosis, and Jensen has reported the death of two patients believed to have Munchausen's syndrome because surgery was deferred. One of the present authors is familiar with an unfortunate woman who was repeatedly turned away from emergency rooms where she presented with abdominal pain, unusual neurologic symptoms, and mental confusion. Eventually, she was properly diagnosed as suffering from acute intermittent porphyria.

Spiro has reported one of the few cases that was studied in detail from a

psychiatric point of view. This patient was a thirty-year-old man who had repeatedly sought and obtained admission to hospitals because of abdominal pain. In addition to his feigned illness, the patient was unable to hold a job, frequently assumed false roles, and was a heavy drinker. Past history was significant, in that he was the second of ten children and was subjected to early deprivation. At age four, he was hit by a car and had both legs broken. This incident began a series of hospitalizations, during which the patient was the center of attention. His earliest memory, in fact, was of this initial hospitalization which was remembered as extremely pleasant. After a prolonged and complicated recovery from his injury, he continued to use somatic symptoms, such as leg cramps, for secondary gain.

His later symptom of abdominal pain began when he could not cope with the rigors of military life. He was discharged from the service on the grounds of "unadaptability," and for years drifted from job to job. Gradually, he began to seek hospital admission following life stresses, such as the break-up of his first marriage, so that by the time he was thirty years old he had been hospitalized for feigned illnesses no less than fifty-three times. Once admitted, he was hostile and demanding of the staff, made fun of other patients, and assumed imagined identities. Despite attempts at psychotherapy, Spiro notes that a year after terminating treatment he was informed that the patient had been admitted to yet another hospital and had undergone a partial gastrectomy.

In his discussion of this patient, Spiro notes the early deprivation, the positive memory of hospitalization, leading to an effort to parentify hospital staff and create a hostile-dependent relationship in times of stress. Barker believes that such patients harbor a grudge against the medical profession for real or imagined past mismanagement. Menninger, while not referring to Munchausen's syndrome, per se, describes instances where individuals seek surgery as a means of punishment or as a way of escaping an imagined greater disaster by sacrificing part of themselves. In these cases, the individual sets himself as the passive victim of the doctor or surgeon to whom he has transferred responsibility for self-punishment. Most probably, different motives are active in various patients with this syndrome. The features that seem to stand out, however, are a need for dependency on a hospital in time of stress, and the use of illness to express anger at authority figures without threat of retaliation. The frequent use of assumed roles points out the severe lack of self-esteem in these patients, as well as the marked degree of psychopathology. At present, additional detailed psychiatric studies of such patients are needed to explain the use of self-mutilation or feigned illness as a prime symptom.

Collective Psychoses

In old books of psychiatry, one can find reports of collective psychoses or "psychic epidemics" occurring in Europe, from the eleventh to the

seventeenth centuries. These reports have to be read with more than a grain of salt, as they lack scientific rigor, although Hecker's volume, published in 1832, is a valuable study.

We believe that many cases dealt not with real psychoses or neuroses, but with collective manifestations of fanaticism in members of particular religious sects. The Flagellants of the plague epidemics in the thirteenth and fourteenth centuries, trying to atone their sins, the Palamites who tried to touch the umbilicus with their head in order to see the glory of the Divinity, the Adamites who walked naked, can hardly be called "psychotic" in a medical sense.

Nevertheless, one gets the impression that actual "collective psychoses" or psychic epidemics occurred at times in the Middle Ages. In our opinion, these were not psychoses, but psychoneuroses of hysterical nature which were induced by the effect the crowd had on the predisposed person. The atmosphere of superstition, ignorance, and intense religiosity, predisposed unstable individuals to this form of collective hypnosis. Perhaps, a type of society that Riesman has called "group-directed" is necessary for the occurrence of such epidemics.

Ferrio, from whom most of this information is taken, reports that between the eleventh and the fifteenth centuries a psychic epidemic of St.

Vitus' dance occurred, especially in the German and Flemish countries. People affected by the disease gathered together in the vicinity of churches, dancing and singing for several days and nights until they lost consciousness. Many of them had convulsive seizures. In the midst of this excitement, some women were made pregnant. In the year 1278, when two hundred afflicted people gathered on a bridge on the Rhine at Utrecht, the bridge collapsed and many of them perished. According to Ferrio, it seems that the name of "St. Vitus' dance" comes from the fact that some of the afflicted were kept for treatment in a chapel dedicated to St. Vitus, in Zabern.

A similar epidemic occurred in the south of Italy in the fifteenth century. According to Zilboorg, it was first described scientifically by Gaglivi, under the name "tarantism" or "tarantulism." The name has nothing to do with the Italian city Taranto, as some believe, but with the fact that the sick were thought to have been bitten by a particular spider, Lycosa tarantula. The patients presented convulsions and general excitement. It was also believed that music would be an effective treatment for it—thus, the melody "tarantella" was created, a popular dance music still played in Italy.

Perhaps, of all the collective psychoses, the most important is lycanthropy, some cases of which are said to occur even now in some mountain villages of Italy. According to Zilboorg, lycanthropy has been described and reported in the medical literature by Marcellus in the third

century, by Paré, Pomponazzi, Leloyer, Weyer in the sixteenth century, and by Sennert in the seventeenth century (all quoted by Zilboorg). People affected by this condition considered themselves transformed into animals, especially wolves. They saw themselves as animals and acted as such. Many of them committed crimes while they were in this state. People recognized as affected by this condition were often arrested and executed. According to Ferrio, a French judge named Boguet prided himself on having condemned to death about six hundred people suffering from lycanthropy during an epidemic that occurred in France in the department of Giura.

Although some of these lycanthropous were probably schizophrenics, it seems possible that the majority of them were suffering from some kind of collective hysteria. The conviction that men could be transformed into animals is described in the myths and literature of various peoples. Nebuchadnezzar, King of Babylon, thought he was a wolf, and St. Patrick is reported to have transformed Veneticus, King of Gallia, into a wolf.

A strong feeling of guilt and unworthiness, experienced so deeply as to make the individual feel that he did not deserve to belong to the human race, found this concrete expression in a suitable cultural atmosphere. In a certain way, lycanthropy is a counterpart of other neurotic symptoms, such as phobias, obsessions, etc. In phobias, the patient is apparently afraid of a danger coming from the outside world, in lycanthropy he is afraid of

undergoing a metamorphosis. Later, the patient must act out the metamorphosis by behaving like an animal. He acts hysterically or impulsively, rather than compulsively, but in order to do so he must receive the assent of a group of people who behave as he does. This group replaces his usual social self or superego.

Today, lycanthropy is a term reserved to describe the delusions appearing in isolated cases of schizophrenia and paranoia of having been transformed into animals.

Other collective epidemics are said to have occurred in convents where all the nuns would suddenly become possessed by the illness, abandon the religious discipline, and give vent to hysterical and bizarre actions. Ferrio reports that around the year 1700 the nuns of a convent near Paris started to mew as if they had been transformed into cats.

A similar event, described by Mackay, occurred at a girl's school in Lille in the seventeenth century. The headmistress imagined that she saw black angels flying over the heads of her pupils. In her alarm, she warned them to be on guard against the devil. The girls reinforced the hysteria among themselves until all fifty confessed that they were witches and that they had attended a meeting of fiends, could ride through the air on broomsticks, and feasted on the flesh of infants. These forms of collective psychoses or hysteria

seem predisposed by certain factors. Usually, the affected members of a group live in close proximity with each other but are isolated from society at large. The group is arranged into a repressive, authoritarian hierarchy that discourages independent thought or inquiry.

These factors reduce the individual ability to test reality and are conducive to suggestion, especially when sanctioned by authority figures, and when the pathologic behavior allows expression of repressed desires.

Bibliography

Ahlheid, A. "Considerations on Nihilistic Experience and on Cotard's Syndrome on the Organic and Symptomatic Psychoses," *Lav. Neuropsichiat,* 43 (1968), 927.

Anderson, E., W. H. Trethowan, and J. Kenna. "An Experimental Investigation of Simulation and Pseudo-dementia," *Acta Psychiatrica Scandinavica,* 34 (Supp. 132):1 (1959).

Asher, R. "Munchausen's Syndrome," *Lancet,* 1 (1951), 339.

Balduzzi, E. "Un Caso di Erotomania Passionata Pura Secondo Clérambault," *Riv. sperim. di freniatria,* 80 (1956), 407.

Ball, J. R. B., and M. A. Kidson. "The Capgras Syndrome—A Rarity?" *Aust. N.Z.J. Psychiat,* 2 (1968), 49.

Barker, J. C. "The Syndrome of Hospital Addiction (Munchausen Syndrome)," *Journal of Mental Science,* 108 (1962), 167.

Bumke, O. *Handbuch der Geisteskrankheiten.* Berlin: Springer, 1932.

Capgras, J., and P. Carrette. *"L'lllusion des Sosies et Complexe d'Oedipe," Ann. med.-psych.,* 82

(1924), 48.

Capgras, J., and J. Reboul-Lachaux. *"L'lllusion des Sosies dans un Délire Systematisé Chronique," Soc. Clin. Med. Psych.,* 81 (1923), 186.

Capgras, J., P. Lucettini, and P. Schiff. "*Du Sentiment d'Estrangeté a l'lllusion des Sosies," Ann. méd.-psych.,* 83 (1925), 93,

Capgras, J. and J. Daumezon. *"Syndrome de Cotard Atypique," Ann. méd.-psych.,* 94 (1936), 806.

Cargnello, D., and A. A. Della Beffa. "L'lllusione del Sosia," *Arch. Psicol. neurol. e psichiat.,* 16 (1955)-473.

Carothers, J. C. *The African Mind in Health and Disease. A Study in Ethnopsychiatry.* Geneva: World Health Organization Monograph Series, 1953.

Chapman, J. S. "Peregrinating Problem Patients—Munchausen Syndrome," *Journal of the AMA,* 165 (1957), 927.

Clérambault, G. G. de. *Oeuvre Psychiatrique.* Paris: Presses Universitaires, 1942.

Cotard, J. *Maladies cerebrates.* Paris, 1891.

Courbon P., and J. Fail. *"Syndrome de Fregoli et Schizophrenie," Soc. Clin Med. Ment.,* July, 1927; quoted in Ref. 15.

Courbon, P., and J. Tusques. *"Illusion d'Intermetamorphose et de Charme," Ann. med.-psych.,* 90 (1932), 401.

Critchley, M. *The Parietal Lobes.* London: Arnold, 1953.

Davidson, G. M. "The Syndrome of Capgras," *Psychiatric Quarterly,* 15 (1941), 513.

De Martis, D. *"Un Caso di Sindrome di Cotard," Riv. sperim. di freniatria,* 80 (195), 49.

Dogliani, P. "*Su di un Caso di Psicose di Ganser*," *Nevrasse,* 6 (1956), 12.

Enoch, M. D., W. H. Trethowan, and J. C. Barker. *Some Uncommon Psychiatric Syndromes.* Baltimore: Williams and Wilkins, 1967.

Ey, H. *Etudes Psychiatriques.* Paris: Desclee de Brouwer, 1954.

Ferrio, C. *La Psiche e i Nervi,* Turin: Utet, 1948.

Ganser, S. *"Ueber einen Eigenartigen Hysterischen Dammerzustand," Arch. Psychiat.,* 30 (1898), 633,

Gerstmann, J. "Psychological and Phenoneurological Aspects of Disorders of the Body Image," *Journal of Nervous and Mental Disease,* 126 (1958), 499,

Gluckman, L. K. "A Case of Capgras Syndrome," *Aust. N.Z.J. Psychiat.,* 2 (1968), 39.

Hecker, J. F. C. *Die Tanzwuth: eine Volkskrankheit im Mittelalter.* Berlin: 1832.

Henderson, D. K., and R. D. Gillespie. *A Text-Book of Psychiatry.* New York: Oxford University Press, 1941.

Ingraham, M. R., and D. M. Moriarty. "A Contribution for the Understanding of the Ganser Syndrome," *Comprehensive Psychiatry,* 8 (1967), 35.

Jensen, S. E. "The Indications for Abdominal Surgery in Psychiatric Patients," *Canadian Psychiatric Association Journal,* 8 (1963), 267.

Jolly, F. Quoted in Ref. 59.

Kolb, L. C. *The Painful Phantom. Psychology, Physiology and Treatment.* Springfield: Thomas, 1954.

Lhermitte, J. "Visual Hallucination of the Self," *British Medical Journal,* 1 (1951), 431.

Lippman, C. W. Hallucinations of Physical Quality in Migraine," *Journal of Nervous and Mental Disease,* 117 (1953), 345,

Lukianowicz, N. "Autoscopic Phenomena," *Archives of Neurology and Psychiatry,* 80 (1958), 199,

McConnell, W. B. "The Phantom Double in Pregnancy," *British Journal of Psychiatry,* 111 (1964), 67,

MacDonald, J. J. *Psychiatry and the Criminal.* Springfield: Thomas, 1958.

Mackay, C. *Extraordinary Popular Delusions.* New York: Noonday, 1966.

Menninger, K. A. *Man Against Himself.* New York: Harcourt, Brace & World, 1938.

Minns, R. A. J. "A Case of Capgras Syndrome," *Medical Journal of Australia,* 57 (1970), 239,

Moeli, C. Quoted in Ref. 59.

Moskowitz, J. A. "Capgras Syndrome in Modern Dress," *International Journal of Child Psychotherapy*, 2 (1972), 45,

Ostow, M. "The Metapsychology of Autoscopic Phenomena," *International Journal of Psycho-Analysis,* 41 (1960), 619,

Pearson, J., and K. Dewhurst. *"Sur Deux Cas de Phenomènes Autoscopiques Consecutifs a des Lesions Organiques," L'Encéphale,* 43 (1954), 166,

Penfield, W., and T. Rasmussen. *The Cerebral Cortex of Man.* New York: Macmillan, 1952.

Perris, C. *"Sul Delirio Cronico Di Negazione (Sindrome di Cotard)," Neuropsichiatria,* 11 (1955). 175.

Raspe, R. E. *Baron Munchausen.* New York: Dover, 1960.

Rogers, R. *The Double in Literature.* Detroit: Wayne State University Press, 1970.

Schilder, P. *Mind, Perception and Thought.* New York: Columbia University Press, 1942.

Sperber, M. A. "Sensory Deprivation in Autonopic Illusion and Joseph Conrad's 'The Secret Sharer,' " *Psychiatric Quarterly,* 43 (1969), 711.

Spiro, H. R. “Chronic Factitious Illness,” *Archives of General Psychiatry,* 18 (1969), 569.

Stern, K., and D. MacNaughton. “Capgras’ Syndrome, a Peculiar Illusionary Phenomenon, Considered with Special Reference to the Rorschach Findings,” *Psychiatric Quarterly,* 19 (1949), 139,

Todd, J. “The Syndrome of Capgras,” *Psychiatric Quarterly,* 31 (1957), 250,

Todd, J., and K. Dewhurst. “The Double: Its Psychopathology and Psychophysiology,” *Journal of Nervous and Mental Disease,* 122 (1955), 47,

Vitello, A. “Cotard’s Syndrome in Schizoid Paranoia,” *Rass. Studi. Psychiat.,* 59 (1970), 195,

Wagner, E. E. “The Imaginary Lover’s Delusion,” *J. Proj. Tech. Personal Assos.,* 4 (1966), 394,

Weiner H., and A. Braiman. “The Ganser Syndrome: A Review and Addition of Some Unusual Cases,” *The American Journal of Psychiatry,* 111 (1955), 767,

Weinstein, E. A., and R. L. Kahn. *Denial of Illness.* Springfield: Thomas, 1955.

Whitlock, F. A. “The Ganser Syndrome,” *British Journal of Psychiatry,* 113 (1967), 19.

Zilboorg, G., and G. W. Henry. A *History of Medical Psychology.* New York: W. W. Norton, 1941.

Notes

1 See Chapter 32 for exotic psychiatric syndromes.

2 Older psychiatric works, such as Bucknill and Tuke’s textbook published in 1862, also report cases where patients under stress gave nonsensical yet approximate answers when interviewed. See Enoch et al.23 for a review of the early literature.