**Introduction**

Pseudodementia is a syndrome in which dementia is mimicked or caricatured by functional psychiatric disorders (Wells 1979). Madden et al. (1952) reported that symptoms ordinarily considered to indicate dementia could be reversed with appropriate psychiatric interventions and that such pseudo-dementia was present in 10% of their series. The first description of a pseudo-dementing illness can be dated back to Ganser (1898). Patients who manifest pseudodementia are in danger not only of therapeutic but also of superflows and possibly harmful diagnostic procedures (Kiloh 1961). This clinical profile has been described in affective disorders, hysteria and other neurosis, schizophrenia, post-traumatic states, malingering and Ganser state (Carney 1983). In depression while Kramer (1982) uses the term pseudodementia, Folstein and McHugh (1978) refer to it as the dementia syndrome of depression.

Occasionally it is recognised that pseudodementia may be simulated by other illnesses (Carney 1983). When this happens with organic brain disease Lishman (1978) terms it pseudo-pseudodementia. In schizophrenia while some authors have used the term pseudodementia (Kiloh 1961, Carney 1983) others have preferred pseudopseudodementia or intellectual deterioration (Hamilton 1974) with the basic premise that the symptom is part of the illness and not masquerading as something else. We present here a case of schizophrenic pseudo-pseudodementia.

**Case Report**

23 year old Mr. R. was brought with a history of being dull and withdrawn for $3\frac{1}{2}$ years, smiling to self for $2\frac{1}{2}$ years, and not attending to personal needs for 3 months. This was the first episode of mental illness, of insidious onset and progressive course. Initially he was noted to be dull and withdrawn with decreased spontaneity. He ran away twice from the army where he was employed. Subsequently he spent 18 months in a beggar's home as he was unable to give a coherent address. After coming back home he was still found to be smiling to self, not interacting much, not attending to personal needs, occasionally staring blankly and occasionally forgetful. Sleep was decreased and food intake erratic.

He was the youngest of 8 sibs. There was family history of affective psychosis in maternal grandmother, of paranoid schizophrenia in mother, of schizophrenia.

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in a maternal uncle and of alcohol depen­
dence in an elder brother. Early develop­
mental milestones were comparable to
other sibs. He was not interested in
studies, used to play truant and discon­
tinued studies after the 9th class to join the
army of his own accord. For the last 2 years
he had been unemployed. Premorbidly
there was no history of schizoid, paranoid
or cyclothymic traits.

Mental status examination revealed
formal thought disorder in the talk and
written sample of speech. Affect was re­
stricted and at times inappropriate. There
was apparent impairment in concentra­
tion, memory and orientation. His answers
at times would be correct, at times slightly
off the mark (approximate answers) and at
times totally wrong and absurd. The pic­
ture would change from interview to inter­
view and was totally unpredictable. This
was thought to be the cause for apparent
impairment in cognitive functions al­
though the final assessment was that there
was no organic component. General infor­
mination and intelligence was also below av­
erage because of the same reason. Judge­
ment was impaired and insight absent.

He was investigated to rule out de­
mentia. Hemogram and liver function tests
were within normal limits. Blood STS was
non-reactive and blood sugar 64 mg%. 
Routine CSF analysis was normal, there
were no organisms on smear or culture,
and STS was nonreactive. Urinanalysis did
not reveal any abnormality. EKG showed
increased theta activity, with bursts of
sharp and slow waves in left fronto­
temporal leads which was thought to be
phenothiazine induced. CT scan was
normal.

Psychometry was also carried out. 
There was very high variability in his
performance on all tests. On Bhatia full
scale he had a score of 54, but there was
evidence of intra and inter test scatter. On
PGI Memory Scale he had below average
memory functioning again with evidence
of scatter. His abstractability was poor. 
The Rorschach protocol revealed predo­
minantly schizophrenic features with fluctu­
tuating form level and few popular re­
sponses.

Discussion

Inconsistent inconsistency with re­
gards to his approximate answers was the
hallmark of this case. Testing of cognitive
functions and detailed mental status
examinations were difficult because of
this, more so their interpretation. For
example, although he got an IQ of 54, the
wide scatter suggested that this may have
been secondary to his psychopathology.
The term *voibereden*, or approximate
answers was first used by Moeli (1888)
while that Ganser (1898) actually used was
*voibergehen*, which means to pass by;
Kiloh (1961) and Enoch and Trethowan
(1974) have sought to differentiate bet­
ween the Ganser symptom and state.
While the former consists only of approxi­
mate answers, the latter in addition has
narrowing of consciousness, hallucinations
and conversion symptoms with a rapid re­
covery.

Depressive pseudodementia is ruled
out here in the absence of depressive fea­
tures and a different profile (Kramer
1982). Wells (1979) stressed a previous his­
istory of psychiatric consultation, symptoms
of short duration, rapid progression, voc­
iferous complaints of cognitive deficits, be­
haviour and cognitive patterns inconsis­
tent with apparent degree of cognitive dys­
function and ‘don’t know’ answers in de­
pressive pseudodementia. Simulated or
hysterical pseudodementia is likewise unlikely. In malingering, Lishman (1978) suggests that the occurrence of increasingly normal answers with fatigue, with the patients being on guard and anxious, and irritability when confronted should alert the clinician. These patients are not suggestible and non-cooperative for a full examination.

In Conrad's initial description of schizophrenic pseudo-dementia the patient was usually adolescent and found the effect of his approximate answers amusing. The pseudo-pseudodementia profile has been regarded as a hebephrenic symptom and has been observed in acute, chronic and catatonic schizophrenics (Hamilton 1974). A related syndrome would be the buffoonery syndrome of schizophrenia (Bleuler 1924). This was observed after a prolonged illness and was more a part of concrete thinking and perseveration. These patients had shown a penchant for clowning and infatuous jocularity. Sims (1963) characterises the buffoonery syndrome with an air of indifference, the answers being incongruent rather than ridiculous and the approximate answers never being so crude. These three points make such a diagnosis in this patient unlikely.

The diagnosis in this case according to ICD-9 was hebephrenic schizophrenia (World Health Organisation 1975) because of the predominant disturbances in affect and thought. The case is being presented as it is an unusual clinical presentation of schizophrenia, namely pseudo-pseudodementia.

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References

BLEULER, E.P. (1924) Textbook of Psychiatry translated by A.A. Brill. New York: McMillan.
CARNEY, M. (1983) Pseudodementia. British Journal of Hospital Medicine 29, 316-318.
ENOCH, M.D. & TRETHOWAN, W.H. (1974) Uncommon psychiatric syndromes. Bristol: John Wright & Sons.
FOLSTEIN, M.F. & MCHUGH, P.R. (1978) Dementia syndrome of depression. In Alzheimer's dementia: Senile dementia and related disorders. Ed. R. Katzman, R.D. Terry, K.L. Bick. New York: Raven Press.
GANSER, J.M. (1898) A peculiar hysterical state. Archive fur Psychiatric and Nervenkrankheiten 30, 633-654.
HAMILTON, M. (1974) Fish's Clinical psychopathology. Bristol: John Wight & Sons.
KILCOH, L.G. (1961) Pseudodementia. Acta Psychiatrica Scandinavia, 37, 336-351.
KRAMER, A. (1982) Depressive pseudodementia. Comprehensive Psychiatry 23, 538-544.
LISHMAN A. (1978) Organic Psychiatry. Oxford: Blackwell Scientific Pub.
MADDAV, J.J., LUHAN, J.A. & KAPLAN, L.A. (1952) Non dementing psychosis in older persons. Journal of American Medical Association 150, 1567-1570.
MOELL, C. (1888) Uber ihre Verbrecher. Quoted in M.D. Enoch & W.H. Trethowah (1974) Uncommon psychiatric syndrome. Bristol: John Wright & Sons.
SIMS, M. (1963) Guide to psychiatry. London: E & S Livingstone.
WELLS, C.E. (1979) Pseudodementia. American Journal of Psychiatry 136, 895-900.
WORLD HEALTH ORGANISATION (1975) International classification of disease, 9th revision. Geneva: WHO.