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Problems of Obsessional Illness

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IN a would-be definite inquiry that I have been making into obsessional illness, I have been struck by the variety of problems and the difficulty of stating them. This would no doubt be true of any psychiatric topic as wide as obsessional illness, but here I found to my surprise that it would be harder to state the problems clearly than to present the alleged solutions offered in the literature. Some of these solutions deal with problems that are indefinite and indeed unsubstantial; others are global; they cover so wide a field that it is difficult to examine them without examining also the nature of man. It may well be that obsessional illness cannot be understood altogether without understanding the nature of man, or perhaps inquired into profitably without much bold speculation and the use of methods as yet unthought of or suspect; but one is reminded of Descartes' rules—to doubt everything that is not clear, to avoid precipitancy, and to divide up every difficulty into as many parts as are possible and necessary for its better solution: also to proceed from the simplest and plainest facts. Obsessional illness has not usually been treated on such lines. I have tried in this paper to raise the difficult issues that seem to need clarification before an answer can well be sought, much less accepted.

The first of them is definition or, if one likes to call it so, diagnosis. Whether one is seeing a patient oneself or reading the literature of the subject, doubt as to diagnosis often turns out to rest upon vagueness as to what are the essential features of an obsessional symptom. This is of some consequence; a great deal of psychopathological literature about obsessions is made dubious for the reader by carelessness on this point. Dynamisms and relationships are discovered which depend upon hardly tenable notions of what is obsessional. Those who have occupied themselves with this question, from St. Ignatius Loyola onward, are divided by their emphasis on the formal disorder of thought on the one hand, and on the disorder of affect on the other. The definition that I have found at once precise and practicable is Schneider's, which defines obsessions as "contents of consciousness which, when they occur, are accompanied by the experience of subjective compulsion, and which cannot be got rid of, though on quiet reflection they are recognized as senseless." This is a practicable definition though not the ideal one. It can be applied readily to the recorded cases of other psychiatrists—a merit which I have appreciated in working through more than a hundred old cases for an investigation of which I shall speak presently. But it contains more than it need, and omits an important point. The recognition that the obsession is senseless is not an essential characteristic; there should, instead, be mention of the feeling that one must resist the obsession. This resistance is experienced as that of one's free will. The innumerable devices, rituals and repetitions of the obsessional are secondary expressions of this immediate experience; they carry into effect the urge to ward off the painful and overwhelming obsession. The more overwhelming and painful the obsession, the more urgent and unsuccessful the devices to ward it off. It is

misleading to consider such devices as essential. They certainly cannot be judged on behaviouristic grounds. Constantly in the writings of some psychopathologists it is assumed that a ritual or ceremonial is, *ipso facto*, obsessional—ignoring the absence of the essential subjective features of compulsion. Repetitive mental happenings and more or less stereotyped motor activities occur in a wide range of illnesses—schizophrenia, idiocy, diseases of the basal ganglia, frontal lobe lesions and others; interference with their performance, in all of these, may cause the patient distress, as it also does in the obsessional rituals or repetitions. But clearly, by observing that a ritual or repetitive motor activity is pursued, whether it be with or without anxiety, with or without evident purpose, one cannot tell that it is an obsessional activity. Many reports on obsessional behaviour in children fall into this error. The more the doing of the repetitive act is enjoyed, the less is it like an obsessional act.

The experience of subjective compulsion is the essential feature of obsessions; others follow from it. Critical appraisal of the obsession, and recognition that it is absurd represents a defensive, intellectual effort, intended to destroy it: it is not always present, nor is the obsessional idea always absurd. Perhaps it is emphasis on this criterion that has in part led to the belief that intelligent people are more prone than stupid ones to obsessional neurosis. It need hardly be pointed out that an obsession cannot be experienced except in relation to a freely conducted psychic life; that although psychic activity be fully determined, the quality in conscious experience which is commonly attributed to free will must be present before an obsession can occur. This active experience of willing is, so far as obsessions are concerned, characterized by its feeling of integration with the whole stream of psychic life, indeed with one's self.

The ignoring of this aspect of experience by dynamic psychology has tended to a blurring of the issue here between obsessions, and other compelled mental happenings, especially those of schizophrenia. It has repeatedly been pointed out by Jaspers and others, that an "obsessive" hallucination or an interpolated, passively experienced autochthonous idea, cannot be obsessional.

In thus considering the problem of definition a number of fresh problems have been opened up—problems of dynamic causation, of constitution and of the relationship to other morbid activities of the mind. Definition itself can only be concerned with abstracting from the complex phenomena certain features which are so constant as to be final criteria. But without such final criteria all other problems of obsessional disorder lose their sharpness and even their reality; the very term or conception "obsessional" becomes worthless, because it can then be extended to cover everything, as "neurasthenia" was yesterday, or "anxiety neurosis" is to-day.

There are some other features of obsessional illness which are conspicuous. Everyone has been impressed by the frequency with which filth, harm, sex, or religion give the content to the obsessional idea. There are other recurring features: the seemingly "trivial" content of many obsessions; the "au delà," literally interminable nature of much obsessional thinking; the hindrance there is to decisive action; the self-tormenting aspect; the apparent contrasts between kindness and cruelty, logicality and unreason, fear and desire, and so on. It is impossible sometimes to escape from the impression that many of the writers have founded their interpretation of the genesis of obsessions on a few cases that had come their way and in which one or more of these aspects were very conspicuous; some writers seem to publish revised versions of their theory with every two or three new patients they see.

In considering the psychopathology of the obsessional symptom—I shall speak of the obsessional neurosis in a moment—the first and easiest point must be to discover what has determined the content of the obsession. Individual experience

is here clearly responsible, and the familiar psychological mechanisms of repression, displacement and substitution are at work, resulting in symbolic representation of harmful or significant earlier happenings. These mechanisms do not differ from those found in other types of mental disorder. Consequently they tell us nothing of the specific obsessional quality and its modes of development. The theories concerning this are, with one exception, concerned with the battle of instinctual drives: the exception is the view that the specifically obsessional characteristic is a repetitive, perseverating quality which cannot be further analysed. All the theories work back to a constitutional, i.e. hereditary basis for the disorder. The most developed and dialectically impregnable of these, the psycho-analytic, rests on a mythology, which is the Freudian theory of instincts; the others are equally unsure of their foundations.

But, as usually conceived and with no more than our present knowledge, the psychopathological problem, genetically speaking, seems to me so difficult to state and so far from being answered, that I should prefer to leave it alone, in its general form. It is well, I think, to remember that psychopathology is properly only an answer to the question "How?" To answer this does not perhaps call for much of the speculation and metaphor that make psychopathology sometimes sound like metaphysical allegory. I hope I may be forgiven for saying that more than one of the sometimes conflicting theories seems to account plausibly for the facts, but can neither be proved nor disproved because of the nature of its assumptions: Dr. Glover has his theory, and Dr. Mayer-Gross has his, and Dr. Kronfeld and Dr. Schilder have theirs, and even I—*sed longo intervallo*—have mine; all of them, I suppose, based on fairly good opportunities of seeing some of the facts.

The more limited question "How does the quality which appears as obsessional disturbance of function show itself during development?" can, however, in some measure be studied and tested. Most of the work that has been done, has been based on recollection by the patient under special conditions, and on observation of children, again under very special conditions. It would be more convincing if there were less tendency to infer that behaviour is obsessional because it is repetitive and anxious, and if the behaviour and observations had not been influenced by the interposition of verbal suggestions to test theory. It is necessary that we should know more of the development of the average child and the appearance in him of the supposed manifestations of obsessional tendencies. Gesell, for example, finds that little children show a tendency to ritualization; spontaneously they pour pellets out of the bottle in one of his tests and reinsert them without suggestion or command. "Ritualization is a reinstatement of the situation, a method of defining, and perhaps improving, new abilities; but it is itself a general ability, an intrinsic product of growth." A few others have examined magical thinking and ordered ways of behaviour in normal children, but the material is meagre. We do not even know whether well-marked obsessional features in early childhood are more often the precursors of obsessional illness in later years than of other morbid states; the children that Ziehen reported, for example, have not, as far as I know, been followed up. The occurrence of slight obsessional symptoms in everyone's psychic life is a reminder that the problem is better posed if one asks what have been the previous manifestations of obsessional tendency in persons who now show obsessional neurosis. There is, moreover, little but psycho-analytic evidence for assigning to the first three or four years of life so prepotent a rôle or supposing that they are the microcosm of which all mental disorder is the larger repetition.

The question worth considering at this point is whether it is sound to regard obsessional neurosis—or Janet's "psychasthenia"—as a special type of morbid reaction, or as merely a manifestation of universal psychic attributes, aggravated and furthered by the occurrence of some morbid state such as severe anxiety or depression. Thus Bleuler considers obsessional neurosis to be latent schizophrenia

Stöcker and Henry Maudsley aligned it with affective psychosis. The syndromes of psychiatry, however, have at present only a provisional heuristic value: they have not yet the firm biological foundation which one anticipates and strives after. It is therefore still convenient to speak of obsessional neurosis, though it seems to me that the obsessional experience is so widespread over psychic activity and so commonly found with other abnormal psychic states that this neurosis is almost as insecure a category as anxiety neurosis, however hard one may try to delimit both and prop them up. The obsessional neurosis, qua neurosis, rests more on its occasional tendency to become stabilized and systematic than on its exhibiting a constant grouping of symptoms. It is tempting here to stop to classify the manifold phenomena of the obsessional neurosis, but it has been done so successfully by Kronfeld and Janet and Friedman that one may take for granted the general subdivisions into obsessional ideas or images, impulses, phobias, and thinking or rumination.

It is, however, in relation to personality that one sees another aspect of the problem of psychopathology. In the personality of a patient who has pronounced obsessional neurosis, have there been features which betokened this predisposition? This is to ask for late childhood and postpubertal life the question above raised with regard to young children. The question has of course often been answered: and every book on psychopathic personality now describes the anankastic character, just as Freudian manuals take the anal-erotic character for granted. But if we are concerned only with the demonstration of a sequence of related phenomena, with answering the question "How?", in short, then much that is summed up in the concept of an anal-erotic character will remain unproven. Of course many obsessionals have shown excessive cleanliness, orderliness, pedantry, conscientiousness, uncertainty, inconclusive ways of thinking and acting. These are sometimes obsessional symptoms themselves, sometimes character traits devoid of any immediate experience of subjective compulsion. They are, however, especially in the latter case, just as commonly found among patients who never have an obsessional neurosis, but who get an agitated melancholia during the involutional period; I have verified this on a large number of patients at the Maudsley Hospital. The traits are also, of course, common among healthy people. They are, conversely, sometimes undiscoverable in the previous personality of patients who now have a severe obsessional neurosis. I have collected a number of such instances. For example, a woman aged 23, who had shown none of the accepted obsessional traits either in childhood or since, became depressed during her pregnancy and afterwards worried that her child was swallowing pins and nails; this spread, other compulsive thoughts and fears troubled her. With treatment lasting nearly a year she improved.

Sometimes these supposedly obsessional character-traits have been restricted to one field, e.g. repetition of acts to make sure things are right; in others there has been no such special attitude towards money and possessions, cleanliness and defæcation, or other matters as the name "anal-erotic" implies. It is perhaps true that the rigid view of regression and fixation at a particular stage of instinctual development, whether it be called anal- or oral-aggressive, has been by some modified into a conception of the primacy of developmental phases and mechanisms. But in any case it is not sufficient for the character-trait, in so far as it is not itself an obsessional symptom, to show a connexion with the neurosis that is essential and understandable in the light of a special theory; it is necessary that it shall be at least significantly more frequent in those who show obsessional neurosis than in others. At present one can say only that to the "nuclear" group of chronic severe obsessionals who have shown symptoms since childhood, there correspond two types of personality—the one obstinate, morose, irritable, the other vacillating, uncertain of himself, submissive. There are more detailed descriptions of these matters in Kahn's monograph and other well-known works. The evidence is incomplete for the

common assumptions underlying the phrase "an obsessional personality," just as one has to beware of the careless use of "schizoid" and "paranoid" when applied to personality.

Before going on to consider the vexed problem of the relation of obsessional neurosis to schizophrenia and other mental illness, it is appropriate to consider where else in psychic happenings do we find the obsessional characteristic, viz.: the experience that some part of one's self or one's mind is working independently, that it is not an integrated part of oneself. There is first the experience of internal speech, as it is known to some people with strong auditory imagery: what is said to them is repeated in their minds, they formulate verbally their own utterances before speaking, and they cannot escape this necessity. M. Henri Ey has recently discussed fully the bearing of this on auditory hallucinations, and the value in regard to it of the conception of mental automatism, so widely used in France. He remarks, concerning this internal speech :—

"Où cette conduite interne manque de vigueur, où l'esprit vagabonde, où la forme, l'aspect, l'image des mots et des choses l'emportent sur leur signification, il a l'impression de ne plus être maitre de sa pensée, d'être parasité par ses propres idées, par la masse de tous ses automatismes toujours en éveil."

It is, I think, more common in patients who have tinnitus with loss of bone-conduction but no local lesion. Thus a woman of 36 who had all her life been a worrier and a great hand-washer came to hospital complaining of having been bothered for several years by a hissing noise in her ears and by having to repeat in her head all that people said to her: she had also to speak her own thoughts over and over internally: "as I talked my own words used to come back into my head." She had to fight against it, and against the thoughts of injuring herself or her child which beset her. The compulsive inner speech and repetition are still, seven years later, very distressing; the tinnitus also persists.

The transition from this to the experience of hearing one's thoughts spoken aloud outside one's head is an understandable one, though fortunately rare (Gedankenlautwerden) and, in both, motor accompaniments of inner speech are conspicuous. I have found it sometimes difficult to distinguish between "Gedanken-lautwerden" and obsessions, as in a young man I lately saw who had also visual hallucinations and forced movements of one leg. I have been impressed also by the frequency with which obsessional patients who are depersonalized complain of this necessity for inner verbal repetition of all they hear and precise verbal formulation of their own thoughts. Of course in depersonalization the patient is commonly so far from feeling the master of his own thoughts that he has almost no personal or free share in them at all, but this is true of all his thinking, not of small parts of it, as is the case in obsessions.

There are, then, these allied experiences in which subjective compulsion and an incomplete integration are noticeable. But it is in relation to more pronounced disorders that obsessions have been actively discussed. On the one hand are Bonhoeffer, Stöcker, Reiss, and others, who insist on the close connexion between the manic-depressive psychosis and obsessions; on the other hand, Bleuler, Schneider and Jahrreiss who point out transitions to schizophrenia. At the Maudsley Hospital it has been taught and often demonstrated that obsessional symptoms are not uncommon in depressive illnesses, and that obsessions may develop into definitely schizophrenic symptoms such as hallucinations and ideas of reference.

Taking the depressive illnesses first, I found in an earlier investigation that there were indubitable obsessional symptoms in at least a fifth of a series of casually selected depressive patients; a third of the patients had shown the so-called obsessional character-traits. If one takes only the patients with agitated depression

the proportion is much higher. As I discussed the matter rather fully on that occasion, I shall pass to the more difficult question of schizophrenia.

The surprising thing here is not that some obsessionals become obviously schizophrenic, but that only a few do so. It must be a very short step, one might suppose, from feeling that one must struggle against thoughts that are not one's own, to believing that these thoughts are forced upon one by an external agency; and indeed a religious patient who has never been anything but obsessional will sometimes go so far as to impute his obsession to the devil. The actual projection, however, is rarely made; the patient does not, any more than in depersonalization, make the causal interpretation which would be understandable. It is a useful warning against the more facile explanations of what happens in the genesis of schizophrenia. It is also surprising that the projection should not occur, seeing how close are the links between compulsions and ideas of reference; Ewald and Kehrer and one or two of the Freudians have even thought that there were affinities between obsessions and paranoia. One can easily, of course, be led astray into supposing that a stereotyped, outwardly affectless, compulsive action is in fact a catatonic manifestation, or that the more bizarre rituals or compulsive movements are schizophrenic symptoms. Jahrreiss puts some weight on the normal tendency towards persistence or perseveration as explaining the common features in stereotypies and long-standing compulsions, but prefers to insist on the differences rather than on the points in common. I have been collecting relevant cases, but they are not easy to unearth from the mass of records; from such material as I have I should say that as a rule it is only under the influence of drugs (such as bromide) or organic cerebral changes that a long-standing obsessional can come to show schizophrenic features or a hallucinosis that looks schizophrenic; but that florid schizophrenia may be preceded by, or may set in with, obsessions often of a stormy and imperative kind, and that this is especially true of adolescents. Schizophrenics may however have shown numerous obsessional features together with the more usual schizophrenic ones all along. The following cases illustrate some of these points:—

A woman of 38 had since childhood been abnormally clean and afraid of contamination. At the age of 32 she had a mild attack of depression, with some fears (walls falling). At 34 she became afraid she would get vermin on her from contact with menstruating women. She became irritable and had outbursts of screaming, especially at her periods. She described her fear of contamination as "this mania of mine." "It's as if there's some unseen power; the Devil's been persecuting me ever since I married—a figure of speech really." She also said, a month after she had begun to attend hospital, "I get a lot of hallucinations. All Derby week I could see a white fish in green water. Silly imaginings, I know. I think my father has bits on him that smell. I tell my mother not to touch him." (The visual phenomena were mostly, as is usual in these cases, hypnagogic.) During the two years she attended the out-patient department these symptoms became rather worse; she believed that the physician was hypnotizing her, she had ideas of reference, was uncertain as to the reality of the visual images, and included more and more contaminating objects. She has twice been a voluntary patient in a mental hospital during the last six months. There were grounds for regarding many of the apparently schizophrenic features as hysterical.

A younger case:—

A boy of 18 had been irritable, sensitive, timid, and excessively clean from the age of 6. At 16, a month after a blow on the head, he suffered much from fears of death, such as he had had mildly for years. He had to touch things. He had been having intensive psychotherapy for several months before he came to the Maudsley Hospital. He described his fears: "Wherever my eyes direct me I see these thoughts. I've got to gesture and take them up and throw them out of the window. I'm afraid of putting them on anybody." In fact he did make throwing-away gestures. He also had ideas of reference and believed his body was changing its shape and appearance. He felt that his own thoughts were trying to harm him. His condition fluctuated, depending on external circumstances.

Another adolescent, a girl of 17, had been obstinate, jolly, sociable, free from any obsessional traits, until an illness at 16, characterized by depression and inclinations to suicide. She was treated at a Child Guidance Clinic, but made an attempt to gas herself. In a mental hospital to which she was sent she expressed hypochondriacal fears. She was referred to the Maudsley Hospital after she had left the mental hospital: when I saw her she said: "Always there seems to be someone speaking to me. If a bus goes along it says 'Why don't you jump under it?' I can't tell what kind of voice; it's just a voice, inside my head. Well, I don't know really, it seems inside. It makes me walk over to the gas-stove at home and tells me to do things. I think it always comes from my own mind." She felt she must obey the voice. She also said: "Sometimes I hear a voice, a deep commanding voice over my shoulder behind me; sometimes it's in my head; it must be, because other people don't hear it."

And one more example, this time of obsessions passing over into hallucinations as dementia progressed.

The patient was a woman, aged 56 when first seen, who had developed obsessional thoughts, chiefly blasphemous and obscene, after the suicide of her husband two years before. She also had impulses to injure herself and others, and to take sexual liberties with women. She was depressed. The physician who treated her at Maudsley Hospital recorded "the thoughts and impulses are so alien to her that she thinks she must be mad, and though she does not actually hear them as voices or think they are put into her mind by some external agency, yet her attitude towards them suggests that further projection is likely to occur." In the eleven years since then she has been in a mental hospital. She has gradually lost the acute depression and anxiety she had, but has complained more of the weariness and loss of feeling—"no life in me"—akin to depersonalization, and often found in one group of chronic obsessionals. As her arteriosclerotic dementia advanced she became so certain that the abusive and obscene voices were external to her that she now stuffs her ears to keep them out.

Even more important in its bearing on the ætiological problem is the occurrence of obsessions in persons who have had encephalitis lethargica.

Thus a woman of 28, a severe encephalitic of ten years' standing, with oculogyric crises, is obsessed by the ruminative thoughts "what is what" and "did you say did I say." These she has to revolve and rearrange endlessly in her mind, e.g. "What is what, did you say did I say, what word is that word what, what do the words the word what mean." Besides this thought, so reminiscent of the literary output of Gertrude Stein, she sometimes sees her obsessing sentences as though spelt, and spelt wrongly, e.g. "what is thē or thĕ," the first "the" being spelt "thee," and the second "ong." She also has premonitions of evil and anxiety attacks. The obsessional thoughts occur independently of her oculogyric crises.

Another, a man of 25, whose encephalitic attack occurred when he was 11, had had to clap his hands and perform other habitual movements which made him a butt at school. At 16 he was in court for stealing; at 18 he began to fear that buildings would collapse on him; a year later oculogyric crises began. Now, besides depressive inclinations to kill himself, he has obsessional symptoms. "I have to fight against thinking. I keep on continually thinking: 'What's going to become of the country? Where do clothes come from, and electricity and wireless?' I can't stop myself. I feel frightened—I feel something terrible is going to happen—buildings will fall; and then I think where cement comes from, where wood comes from, how trees grow? And I think I'm a murderer—I'm a spy. I know they're silly ideas, but I can't help thinking them. I try to put it out of my mind, but it seems impossible." Here, too, the ideas did not occur during an oculogyric crisis, but might occur just before or just after it.

In many of these cases there have been no indications, before the febrile illness, of any obsessional predisposition—nothing more than we all have. But either with the oculogyric crises or independently these typical obsessional features appear. It has been questioned whether they are in fact typical: some writers have emphasized that they are often formal and do not tend to become systematized. But systematization, which I should have liked to discuss more fully, is not a necessary characteristic of obsessional neurosis, and, where it occurs suggests connexions with

schizophrenic and paranoiac development. A more important point is the readiness with which they are translated into or associated with motor iterations. This is not always so, but it is significant that in this disorder subjective compulsion in the sense referred to in the outset of this paper should so often go hand in hand with objective compulsions in the field of motor behaviour. Compulsive laughing and crying, bellowing, turning of the eyes, chewing, and other actions are common enough in encephalitis lethargica: is one to call them obsessional because the patient is aware of them, and dislikes them, and fights unavailingly to suppress them? I should say not, because they are either accompanied by the appropriate effect (in which case the same objections apply as to preoccupations and delusions, and Jaspers' requirement as to freely conducted activity is not fully met); or, on the other hand, the appropriate effect is lacking and the movement is a forced one, viewed with as much detachment as any other unwilled movement. And, still more important, these movements are the primary happening, which the patient perhaps resists, they are not the secondary happening, expressions of a resistance, which we have seen to be the case with almost all obsessional actions. Only the very rare impulsive obsession that is carried into action, e.g. jumping out of a window, corresponds to these, and even then the action is preceded by a conscious image or idea of it to which there is nothing intrinsically corresponding in the forced movement. If one is to regard forced movements, however purposive or however emotionally expressive, as obsessional, one must say the same of a great variety of motor phenomena determined by structural changes in the central nervous system but also open to psychic influences—certain tics, coprolalia, automatoses, torticollis and more. This is to extend the conception of obsession as unwarrantably and loosely on the one side as it has been stretched on the other side to include dominant preoccupations, delusions, autochthonous ideas, impulses and disagreeable effects. It may be objected that although for the sake of precision these motor phenomena can justly be denied the epithet "obsessional," they are dynamically and functionally akin to obsession. Some such view is held, though in very different ways, by Goldstein, Stern, Jelliffe, and Schilder. That the iterative and forced quality of these motor phenomena enters into and is indeed a part of the structure of the personality of these patients is certain, but whether it modifies it in the direction of obsessional modes of mental behaviour is undecided. I should think it is so; and Dr. Mayer-Gross has based his psychopathology of obsessions on some implications of this view. But as both Dr. Guttmann and Gabriel Steiner have pointed out, we know very little indeed about the incorporation of motor expressions and attitudes in the personality or of the relations between them that are favourable to the peculiar obsessional experience. Explanations have been, of course, offered, and with varying confidence; it would be very tempting to enter more fully now into this fascinating and controversial field. The significance here of motor expression of instinct especially in early life may be mentioned, and I might quote the case of a man of 46, always very cleanly, conscientious, and tidy, who had an attack of encephalitis lethargica seventeen years ago. He is now troubled by obsessional palilalia. "I can't help repeating things, I try not to. Singing a song, for example, I keep on repeating over and over again 'Is it in the trees, is it in the trees, is it in the trees?' It's when I'm agitated, too, I'll keep on saying things 'I'm going to hang that cup up, I'm going to hang that cup up, I'm going to hang that cup up,' I can't stop myself and when I go to wash my face, I keep splashing the water, I can't get my hand to my face. Everything I do seems to be wrong. I used to say 'Damn' all the time, I couldn't help it."

It is perhaps sufficient, in leaving this topic, to emphasize the problem that is offered by obsessions occurring otherwise than on a demonstrable constitutional basis. Before I pass on to consider constitution in its hereditary aspects, I should perhaps mention that I have observed over a long period a woman in whom

obsessional features appeared only during the years she had an untreated myxœdema and disappeared completely after adequate treatment had been instituted; and that in the early stages of an arteriosclerotic dementia I have seen obsessional symptoms make their appearance for the first time in the patient's life.

Constitution is universally recognized as the essential determinant of obsessional illness; all else is only the manner of its working out. Constitution, however, is the loose term we use for the more or less stable product of the interaction of heredity and environment while the organism is developing. It would be more precise to speak of the hereditary determinant of obsessions than of the constitutional factors.

The literature on the heredity of obsessional neurosis is meagre. Apart from a few individual pedigrees and some unsystematic collections I know only of Jahrreiss's report on the families of his sixteen schizophrenic obsessionals, and Luxenburger's brief presentation of his findings on 71 families. In order to make use for this purpose of the very large material which the Maudsley Hospital affords I took fifty obsessional cases. I was fortunate in having the collaboration of Miss Ashdown, to whom is due whatever credit may attach to such an investigation. We were able to get detailed information not only about the mental illnesses of all the patient's immediate relatives but also of their personalities, a valuable but hitherto neglected aspect of such inquiries. As this is being published in full elsewhere, I shall only say here that of the 100 parents of the patients four were psychotic, 22 had been treated for neurotic illnesses, 30 had been regarded by their families as eccentric, unusual or different (these were classed as "psychopathic personality") and 18, though normal, showed either the accepted obsessional traits, e.g. being very methodical, or else a kind of personality which was surprisingly frequent—a mixture of strong religious feelings, irritability and strictness. The number of parents who showed pronounced obsessional traits in one form or another was 37: in a number of instances both parents had been obsessional, and in several cases grandparents were likewise: I shall not now, however, speak of the findings in any but parents and siblings. Of 206 siblings who had survived beyond childhood, twelve had been in mental hospitals, 55 had been treated for neurosis, 27 had some kind of psychopathic personality and 20 showed such obsessional traits as may occur in healthy normal people: 43 of these 206 siblings showed mild or severe obsessional traits. My findings differ from those of Luxenburger in that he found a much higher proportion of schizoid persons, but I think he reckoned those stern, harsh domineering people as schizoid. There are many other aspects of the inquiry which I must now omit.

It is agreed that one cannot distinguish satisfactorily by this method between hereditary influences and the environment that is constituted by the parents. Moreover, to find the meaning of such statistics, one must have comparable data about the incidence of psychopathy and varieties of personality in normal or average families, and in those of propositi with other than obsessional illness: these data are as yet only available for definite psychoses among the relatives.

For the determination of the relative importance of hereditary and environmental factors twin studies are an obvious mode of research. I need not detail the reasons why this method is invaluable but only remind you that a striking concordance in one or two pairs of monozygotic twins proves nothing: one needs a series and a control group of fraternal twins. Specially valuable also is the monozygotic pair in whom the conditions of the environment have been very different. I have one such pair: healthy girls of 17 who have lived apart from the age of 3 months. They are both very particular about their clothes and other details and fussy about tidiness, but the one who was brought up by her mother at home shows these tendencies more, and was a sleepwalker till puberty; she had clung to a dummy till she went to school. I have also been fortunate enough to find a pair of

male monozygotic twins, one of whom is a severe and typical obsessional, with complicated rituals, and chronic course: many of his obsessions were concerned with bodily functions, e.g. he blew his nose thirty times, always having to stand in a particular place to do it; his bowels and cleanliness were other topics. His twin had a brief spell of hypochondriac pre-occupation two years ago, being convinced his eyesight was bad; the symptoms cleared up without medical aid. Dr. F. E. Pilkington has kindly let me see the record of another pair of probably identical twins who show striking similarity in their respective obsessional illnesses. But two or three pairs tell very little; it is a pity that twins are so rare.

The value of treatment and the choice of procedure are the most urgent questions for the practising psychiatrist. All of us who have treated obsessionals know how exacting it can be. Most writers are gloomy as to the prospect of recovery and the duration of treatment. Fenichel, a psychoanalyst, says

"Every analysis of a compulsion neurosis is a difficult and time-consuming undertaking. . . . Cases of short standing are the most amenable to analysis; those called "terminal states" and those forms which present transitions to schizophrenia are the least amenable. However, since other types of therapy are so fruitless in such cases, it is pertinent to advise that any compulsion-neurosis, generally speaking, should at least try psychoanalysis, providing the external circumstances permit it."

This is now echoed by many writers who are not adherents to the analytic theory. It is difficult to understand why this sad belief should prevail. I suspect it has little to do with observed results of treatment, and a great deal to do with less rational considerations, such as the irksomeness of having to deal with some of these patients, and their attitude towards treatment.

In order to find out what happened to obsessional patients, I collected from the Maudsley records 50 patients in whom the diagnosis was certain, and in whom there had been an interval of at least five years, often much more, since they were under treatment there. The inquiry into their present state, and the interval history was as complete as one could hope to make it. In most instances the patient and one or more relatives were seen and any hospital records were obtained; in no case was the conclusion as to the patient's present state based only on letters from himself or his relatives, which are, as I have often found in investigations of this sort, fallacious. Now taking the outcome, irrespective of what treatment had been given, 16 of the patients are quite well and have been so for years; seven are much improved; five quite well for years but have had a recurrence from which they recovered or they are now in it; five patients are a little improved; 17 are no better or are worse. It must be remembered that this group has not been selected because of supposedly good or bad prognosis; it is a sample of the obsessional patients who are referred to the Maudsley Hospital either as in-patients or out-patients, and there is reason to suppose that it is a good sample of the obsessionals of London. Certainly it contains examples of every variety of obsessional state. There are of course many provisos and explanations necessary before one makes use of these figures: I quote them cursorily now only to indicate that in an unselected sample of obsessional patients, roughly one-half may be expected to do well. I do not consider that one is justified, from such a series as this, in deciding on the value of one or other form of treatment. Two of the patients have had no continued medical treatment; one is very much worse—she spends her day sitting naked behind a screen to avoid any contamination—and the other has been quite well for eleven years. By "quite well" I mean what everybody means, i.e. freedom from symptoms. An attempt to distinguish between the value of one form of treatment and another proved futile because there had been no rigidity of method, and sometimes the change in the patient had less apparent connexion with the medical treatment than with external happenings, such as obtaining employment, getting married and so forth. Actually in this series 31 had psychotherapy conjoined with medicinal treatment and hospital

régime: 17 had more intensive psychotherapy of an analytic kind, though not strictly Freudian. Of the former group a considerable majority had done very well; of the latter group a majority had done badly, not because of any insufficiency in the method or its application, one may suppose, but because the most difficult and demanding cases were referred for this treatment.

One has so many things to correlate—the patient's attributes (heredity, personality, form and duration of illness), the doctor's treatment, the other external happenings in the patient's life, and the course of his illness and health since the treatment. For these reasons assertions about the superior merits of any one form of treatment seem premature.

There are many other points in this inquiry which I can only touch on here. Some of them are: The capacity of all but the most severe obsessionals to continue to work; the very gradual return to health in many, sometimes beginning years after treatment has stopped; the influence of intercurrent happenings on the course of the illness, e.g. a very severe case in which all the obsessional symptoms disappeared completely during the patient's period of war service—with its routine and lack of responsibility or need for decisions—to return and persist afterwards; the inherently cyclical nature of one large group, quite apart from any accompanying depressive or other affective features; the persistence in some cases of the obsessional idea after it had lost its obsessional quality, viz.: the obsessional experience, so that there was no complaint about it any more than about any other integrated habit. The following case-history emphasizes that it is not always safe to assume a bad prognosis or a need for long analytical treatment because the symptoms have been present for many years or since childhood.

A chorus girl of 22 had had obsessional symptoms since the age of 15, and obsessional traits for years before that. At 15 she had washing mania and feared she had picked up some germ. She thought she might somehow have dirtied her tongue by licking the pavement. She was afraid she had harmed a baby by looking at it and touching it. At 16, when her periods started, these symptoms were a little relieved, though she has never been rid of them, e.g. at 17 she thought she might have been implicated in a murder that she had read of on the page which had a favourable press notice of her dancing. Following the suicide of a friend the symptoms became more severe. Her last obsession before being referred to hospital had been the fear that she might have written notes to people encouraging them to hurt her friends. She was an in-patient for six months at the end of 1930. A week after admission she was referred to a colleague who had been through the Freudian discipline. After a month during which he saw her twice a week, he stopped it, as he considered her unsuitable for the modified analytical method he had been using. She became clinically worse during that month. From then on she had no other psychotherapy than brief occasional reassuring conversations on topics which she herself raised. Later she began to improve. She has been seen since, and both she and her mother are quite certain that she is cured: she has been happy and free from obsessional symptoms now for five years.

These cases do not confirm the belief that schizophrenic features are necessarily ominous, even in young persons. I could quote several instances to the contrary.

I should say, if I may sum up my own impressions, that the choice of treatment in obsessional disorders is to be decided on the same general grounds as in depressive disorders, and that the prognostic considerations are much the same. In both the constitutional basis is conspicuous and may show itself either by outbursts of acute illness, or by a long-continued psychopathic personality with neurotic symptoms; gradations of every sort occur between these two forms. The important matter in settling on treatment is to discover how far the patient is responsive to external happenings, especially as regards her obsessions; how her character will enter into her attitude towards treatment and symptoms; and how far the lasting obsessions have become formalized, systematic, progressive. I doubt whether the content of the obsessions is of much consequence as a prognostic or therapeutic signal. I do not think age is, either—I have known a patient aged 88 with pronounced obsessions

who has been well since, he is now 93; and several people over 50 who recovered. Perhaps it is worth saying that so many of these obsessional patients have been happy and well on their own telling and that of their families for six to ten years since they were treated by non-Freudian methods, that one may think it would have been superfluous, if not unkind, to have taken them through the storms and sacrifices of a Freudian analysis: in some cases one would say, of any analysis at all. What psychoanalysis can do for some of the intractable, progressive forms is a matter not for assertion but for demonstration; the same is true of its efficacy or inefficacy in improving obsessional character and in warding off later obsessional illness by treatment of children or adults. The published records of the London psychoanalysts are informative but clinically unconvincing.

There is one other aspect of the illness to be alluded to before I end. It has a forensic bearing. How far do obsessionals give way to their impulses; are their fears of wrongdoing realized? When "kleptomania" or "irresistible impulse" are mentioned in a court it is often put forward that these are of the nature of obsessional acts. But the obsessional does not in fact commit criminal acts, nor does he, except in rare instances, yield to his sudden obsessional impulses. Suicide may occur, but even then it is when the patient is also depressed. None of the patients in this series have committed suicide, though two, while depressed, made abortive attempts: none of the patients committed any legal offence, though several were dogged by the fear of it. Those who have much to do with criminals arrive at the same conclusion as this. Sexual offences or perversions are sometimes referred to as though they were obsessional: they are really no more so than gluttony. The patient enters into the act and willingly entertains the anticipations of it; he has none of the true obsessional experience, even though afterwards he recognizes the unwisdom of his act and may say that he had a preliminary repugnance which had been more of the intellect than of the will, if one may so express it. There are, of course, rare instances, in which sexual offences have been of an obsessional nature (Mercklin's case). When an impulsive act has occurred in a person with obsessional traits, other morbid qualities will generally be found to have been responsible. Encephalitics are a very special case.

In this paper I have been concerned with the difficulties that present themselves in a typical neurotic disturbance. They are clearly manifold, and have been tackled by clinical psychiatrists and psychologists, neurologists and psychoanalysts. Anthropologists with their observations on magical thinking and primitive rituals, and geneticists with their special methods have indicated further approaches to the phenomena. But about these phenomena, seen with the least distortion and the most detail, we still know too little. Heredity and psychopathology may be feeling their way to a grounded doctrine of transmission and development and function; no doubt it is fascinating to guess and grope with them in their search. But the problem is primarily a clinical one; it turns about this end-product, the obsessional symptom, which has to be accounted for. It would be a pity if other quests kept us from making sure of all the plain clinical things that are yet to be seen and studied.