A CASE OF OBSESSIONAL STATE OF UNUSUAL CONTENT.

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WE wish to record a case of obsessional neurosis remarkable for its strange content and unusual form, and in doing so to draw attention to the comparative rarity of this condition as a primary diagnosis in Naval Psychiatry. Our observations on the last point may not be without interest in considering the aetiology of this condition.

Case Report.

The patient, a signalman of the Regular Navy, aged 24, was admitted to hospital in September, 1944. He said that he was quite well physically, but that (in his own words) "I have some nervous trouble which keeps making me go back and which keeps me in a state of doubt and indecision." Except that he looked older than 24 there was nothing to note in his appearance and physical examination was negative.

He proved to be a pleasant, well-spoken man, intelligent, and co-operative. His past history showed no serious illness except chorea when aged 5–6, and he had had no nervous upsets and there is no note that obsessional features accompanied his chorea. His father and mother are alive and well, his father being headmaster of a boys' school. His only brother, an R.A.F. pilot, had recently been grounded after three years owing to lack of confidence with landings. There was family history of two uncles having some nervous upset after the last war, but none of any upset obsessional in type. He was married in July, 1944, is a moderate smoker and of very temperate habits.

His birth, childhood and adolescence until 15 were apparently normal and he could recall no unusual characteristics. He did well at school and joined the Royal Navy at 15½ as a boy sig., doing normal training, during which he learned neatness and exactness in stowing kit, etc. He served in establishments and ships of all types until his admission to hospital, and had seen enemy action in the blitzes on Portsmouth and Liverpool and in the Dieppe raid, in which his ship had been temporarily grounded. The degree of stress in these incidents is difficult to assess, but must unquestionably have been fairly great, though with his Service training and high morale he tended to make light of them.

He recalled that he had first noticed anything incapacitating about 2½ years prior to admission to hospital when, he says, he became more exacting in how he put things and began to distrust it if he had not done a thing himself. He had first "checked up" on others' doings and later on his own. This tendency he felt had grown and enlarged, though his description was extremely clear and his feelings were strictly confined to tactile and spatial relationships. Thus he described considerable difficulty in convincing himself that a piece of paper which he had just screwed up and thrown into a wastepaper basket had, in actual fact, gone where he had seen it go and was not still in his hand. He knew it was not there and that he had seen it go into the wastepaper basket, but he retained the "feel" of it in his hand. He was able to remove the illusion by wiping his hand with some other object, e.g. against his trousers. He had similar difficulties in posting letters. Perhaps his most distressing disability lay in his spatial relationships. He described considerable difficulty in going from one place to another as, having walked from A to B, he would have to return to look at A to make sure that he had really left it and to retrace his steps. This feeling was often satisfied by being able to look back to A and see the place whence and the route along which he had come, but crowds and the presence of many others worried and upset him. He described how he relived incidents and journeys, and would tire himself out tracing and retracing his steps. One particular incident which stood out clearly in his memory was of how a vest which he had washed and hung up to dry blew away over the ship's side and, although he knew it was only a vest, he could still "feel" himself inside it—more particularly because he could so easily imagine the sensation of the vest in contact with his person.

There was apparently no affective disorder, his personality was excellent and well preserved, and memory, concentration, grasp and intellect all good. Intelligence measured by the Wechsler method was 121, Shipley's Vocabulary 36, Kohs Blocks (1st 10 subtests) 97, mental age 20 years. There was complete congruity and a normal warmth of emotion. He showed no thought disorder, ideas of reference, feelings of passivity, depersonalization or derealization, and no delusions or hallucinations (for his feelings with regard to things with which he had been in contact were

https://doi.org/10.1192/bjp.91.385.495 Published online by Cambridge University Press

not considered hallucinatory). He described his difficulties as "just stupid" and quite unreasonable, and we should like to point out that it was the IDEAS that were obsessive and that many of the actions were not compulsive, being done purely to ease his mind and to relieve tension, though what they may become in the future must remain for speculation.

He was seen in consultation by Surgeon-Captain Desmond Curran, R.N.V.R., who considered him to be suffering from a true obsessional neurosis of very bizarre and unusual nature.

In hospital he improved greatly following a period of prolonged heavy sedation. He was subsequently able to take part in games, including football, though after these he liked to be the last to leave the field so that he could look back at it quite clearly. Thereafter he would relive the game, again "feeling" the ball on his toe and himself in various places on the field, though he knew well and fully understood that this was purely "an idea" and could not actually be. He found movements to order, e.g. class physical training, considerably easier than movements carried out of his own volition. Cycling he found interesting and relatively easy, as his feet, hands and seat retained their contacts and relationships to the various parts of his bicycle and the movement of this in space did not worry him much, though he had a tendency (not overpowering) to look back.

One extremely interesting point in this man's history showed itself in relation to his work. As a result of his continual retracing of his steps he would tire himself out, and in August, 1944, whilst serving in one of H.M. battleships as a l./sig., he felt so weary one night that he slept for a few moments whilst on watch—a matter which was duly reported and an offence for which he was deprived of l./sig. rate and his good conduct badge, medical examination having failed to reveal any abnormal physical signs suggestive of disease. The patient bore no malice or ill-will over this and apparently regarded it as a fitting punishment for such an offence, completely overlooking the fact, which he only admitted on questioning and certainly did not produce as extenuating circumstances at the time of disciplinary action, that sleep was due to being completely exhausted through the constant climbing and reclimbing of ladders to check up that the way he had come was exactly as he knew it to be.

This rating was eventually discharged, invalided, as being unlikely to be able to give further good service in the Royal Navy, and in order to stand a more reasonable chance of adaptation and of building himself an ordered routine in civil life.

Definition.

Bernard Hart (quoted by Dawson (1)) gives as a definition of obsessional state "an idea, action or fear intruding itself into consciousness in a manner which is felt by the patient to be irresistible." Dawson goes on to say that the patient recognizes the compulsive insistent quality as subjective, dislikes, resents, and tries to fight it. He states that it is characteristic of patients with this disorder that they have full realization that their reactions are abnormal, and yet they persist in them in spite of all endeavours to be rid of them—it is just in this way that they differ from simple preoccupations. The acts may sometimes be taken on in an attempt to ward off anxiety as it were by magic; as Dawson puts it, "the making of pacts with himself is one of the characteristics of this type of illness." The acts serve no useful purpose and render life difficult, though the patient will try and rationalize his actions and adapt himself and his living to include them; although still recognizing that they are alien to his way of life.

Lewis (2) insists that daily life is interfered with, the obsessions intruding so forcibly that the patient is unable to attend to other things and to retain peace of mind. He holds that mere preoccupation is not enough, the condition is a morbid one, the patient actually suffering, though having a real insight into the subjective nature of it. Mere compulsive behaviour is in itself not necessarily obsessional for, not recognized as subjective, and occurring without insight, it may be a feature of a psychotic disorder.

Aetiology.

There has been longstanding discussion over the aetiology of this condition, and the importance played by psychogenic, constitutional and organic factors.

Gordon (3) quotes four out of six cases who went on to illnesses of the paranoid type, and Schilder (4) considers that there is an organic background with demonstrable physical signs in a third of the cases. Lewis (2) states that it is a disorder occurring usually in the first half of life, and that an organic basis should be suspected if it arises in the involutional period. He also hints at the possible constitutional origin in his reference to the heredity factor, the intractable nature of the complaint and its nearness to "formes frustes" of schizophrenia or manic-depressive psychosis.

https://doi.org/10.1192/bjp.91.385.495 Published online by Cambridge University Press

We can recall one other case seen at this hospital and not included in our figures which, after having had a well-marked obsessional neurosis for some time, developed a severe schizophrenic episode with hallucinations, only to return to the obsessional state when the schizophrenic reaction had disappeared. One case included in our figures was a man who had a well-marked obsessional state in addition to a manic-depressive psychosis.

Frequency and Occurrence.

The frequency of a diagnosis of obsessional neurosis in Naval psychiatry is very low. Figures for this hospital show :

In-patients.

Period.	1941, Sept.–Dec.	1942.	1943.	1944.	1945, Jan.–Mar.	Total.
Invalided with this diagnosis	—	1	2	2	2	7
Total admissions	397	1,043	866	969	234	3,509

Out-patients.

Out-patients seen at this hospital over a period only five months shorter show similarly low figures,

Cases : 4 Naval ratings and one W.R.N.S. rating = 5
Out-patients seen . . . . = 2,160

with the additional case already mentioned of the man seen primarily for his manic-depressive psychosis.

In one of the main Naval Depots the Neuropsychiatric Department has seen only four cases out of a total of 3,463 in 20 months, all of which are included in our In-patient table.

Neither at this hospital nor at R.N. Barracks were there any officer patients with this illness.

For Naval officers figures quoted from the hospital dealing with psychoneurotic officer patients, the figures show :

June, 1940, to February, 1942 (20 months) : Patients, 224 ; obs. neurosis, 4.
March, 1942, to October, 1944 (31 months) ; Patients, 244 ; obs. neurosis, 4.

We can, of course, give no figures for peace time and have, therefore, no comparison which we can make in incidence, but those we quote can hardly show a marked increase for the war period.

Gordon and others (5) give their incidence as 12 per cent. of psycho-neurotics, but Lewis (6) in his account of the incidence of neurosis in wartime England hardly does more than mention the occurrence of obsessional states, and notes that there has been no striking increase but rather a drop in the occurrence of neurosis in England in wartime. He is, of course, dealing with civilians up to 1942. The number diagnosed as obsessional state and seen at Maudsley Hospital Out-patients between January 1, 1932, and January 1, 1936, was 199 out of 9,396—slightly over 2 per cent. of cases seen.

The suggestion is that by now—1945—there is an increase in the incidence of illnesses of psychogenic origin, anxieties, hysterias and depressions being most markedly increased. Obsessional features do undoubtedly occur in the symptomatology of some of these conditions, but the incidence of obsessional neurosis as a primary diagnosis does not show an upward trend. Depressive and anxiety reactions showing obsessional ruminative features are perhaps expecially common, but these are not included in the discussion of this case, nor are we concerned here with the phobias (of which none has been seen at this hospital), nor of the fear states masquerading as obsessions and of hysterical origin. Patients with obsessional neurosis have *not* broken down under stress, but tend rather to have stood strain well. Of men who have broken down to reactions of anxiety type it has frequently been noted that in their personal histories they have had what might well be termed obsessional features, but in no case was the breakdown a recurrence of, nor an increase in, such obsessional features.

Discussion.

The patient in the case described was a particularly good witness, and in spite of the somewhat bizarre flavour of his doubts, there was nothing revealed in his personality nor on history taking nor on examination to contradict the feeling that

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this was, in fact, a genuine obsessional compulsive state; certainly the patient himself regarded his difficulties as unreasonable and stupid, and he never gave any suggestion that there was any doubt in his own mind as to his individual integrity, i.e. he never felt unreal or split up in himself, and he denied any feelings of Doppelganger type. Although he would return to a spot it was to identify it as such, and see that he had left it, rather than to collect any part of himself which he felt he had left there. We could find no evidence of a disorder of the schizophrenic type, and although he could " feel " that he had retained contact with objects, e.g. football, and would look to convince himself that the idea was only an illusion, he was quite clear that it was " an idea that it might be there " rather than an apparent peripheral sensation.

The contents of obsessional neuroses are many and varied, but in the literature to which we have had access we can find no reference to a case showing such clear cut or bizarre features, nor relating only to tactile and spatial relationships, such as the one which we have described, though Straus is quoted by Schilder (4) to have drawn attention to space disturbances in the symptomatology of obsessions.

Naval life and routine, with its insistence, from the earliest days of training, on exactness and neatness may be considered to foster any obsessional traits, and may actually tend to produce a condition, superficially mildly obsessional in its striving for perfection and exactitude and in a never ending check up—a fact particularly well seen in many long-service ratings and older Warrant Officers. This condition cannot be classed as an obsessional neurosis, for its non-achievement does not make the person unhappy, nor does he recognize the condition as one of which he would gladly be rid. This is well described by a Wren patient—herself grossly obsessional—in referring to a Pensioner Chief Petty Officer " . . . is so maddening in his deliberation and exactitude that I could scream."

It might, therefore, be thought that ordered Naval life and training would suit such patients, but it must be remembered that they tend to be rigid, non-adaptable people who cannot mould to a routine unless it be one of their own construction and not one to which they are required to conform.

Lewis (2) and Dawson both remark on the rarity of criminal tendencies in these cases, the patients always resisting compulsive acts towards crime. In the case we describe, one particularly unfortunate feature was the disciplinary trouble into which this man's compulsions led him, for though his actions in themselves were not wrong and involved him in no offence, he was severely penalized for sleeping as a result of exhaustion produced through his disability. This can only stress the added difficulty with which such patients may have to contend in the Service, and the care which Service medical officers must exercise in order to ensure that men are not punished merely because their disorders are not accompanied by grossly abnormal physical or mental signs, and because the man himself makes no complaints.

Summary.

(1) An interesting case of obsessional state with unusual content is described.

(2) Definition and diagnosis are discussed.

(3) The incidence of obsessional state as a primary disability in the Royal Navy is shown.

(4) The aetiology is briefly discussed. The incidence of the condition in a disciplined Service under considerable stress lends support to a belief that the disorder is endogenous in origin.

We wish to thank Surgeon-Captain Desmond Curran, R.N.V.R., for much encouragement, helpful criticism and advice.

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https://doi.org/10.1192/bjp.91.385.495 Published online by Cambridge University Press