OBSESSIONAL STATES IN EPILEPTICS.

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THE association of obsessive compulsive states with organic disease is well known and a prolific and abundant literature dealing with it has accumulated in the last twenty years. The combination of obsessive compulsive states with epilepsy, however, has received very little attention and in some of the cases in which it has been reported it has been regarded as a coincidence. This may very well be so, but the case here described is of interest in showing the combination very clearly, and it would not perhaps be very odd if there were a small group of epileptics with obsessive compulsive states, in whom both manifestations were ascribable to a common pathology.

It is not proposed in this paper to survey the literature dealing with organic disease in obsessional states, but since so much of the work done on obsessional states has been of psychodynamic kind, attention may be directed to a few of the more common combinations. Schilder (1938) states that not less than one third, and possibly even two thirds of obsessional states have an organic background, and he draws attention to the necessity, when examining these cases, of looking for signs of chronic encephalitis. He mentions slight degrees of facial rigidity and of rigidity of the flexors of the arm and draws attention to the value of a sign described by himself with Hoff, namely, that when the arms are outstretched with the eyes closed they tend to come together owing to the increased tone in the flexor muscles. Impairment of the accommodation-convergence reaction, tremor, and certain motor urges, particularly an urge to talk, must be looked for. Goldstein (1942) describes obsessional symptoms after brain injury, especially the tidiness and meticulous orderliness of some patients, which he feels subserves a protective function in minimizing the effect of daily adaptation to changing events. Though he does not stress fully developed obsessional states, these sometimes occur after brain injury, and the writer saw such a case a few years ago, following directly upon a cerebral contusion.

Studies have been made of obsessional experience during oculo-gyric crises. These attacks are, it has been pointed out, very frequent in chronic encephalitis if they are sought for, and their character varies very widely. Some have the sudden and unheralded character of epilepsy, and are uncontrollable in their course, while in others the resemblance to a compulsion is considerable, for not only is there a feeling of being compelled to look upwards, but the patient can with an effort direct his gaze elsewhere, though when the

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effort is relaxed, the eyes return to their upturned position. Obsessional rumination may accompany the crises, and Wexberg (1937) describes a patient who, during his attacks, felt that two people stood behind him and discussed him, and felt as if he were trying to look upwards and backwards in order to see them. Another patient during his attack continually pondered the question of why an O was round. Creak and Guttmann (1935) have discussed the relationships of tics and compulsive utterances to chorea, stressing the fundamental nature of the motor verbal eruption and the relative unimportance of the words used. It has been thought that those cases of chorea destined later to develop tics, showed differences at an early stage, particularly a preponderance of involuntary movements around the face, and involvement of breathing, phonation and articulation. From these studies and many others the organic basis of many, though not necessarily all, obsessional and compulsive states is clear.

The relation of epilepsy to the obsessional state is, however, much less secure and evidence is of a much less direct kind. Aldren Turner (1907) and Crichton Browne (1895) both observed obsessional doubting states in epileptics between fits; and Jelliffe (1932) noted that convulsions might occur in obsessionals, developing the subject in somewhat the same way as Freud, who believed that epilepsy might represent a discharge through somatic channels of excitation too massive to be mastered in a psychic way. Recently Roubicek (1946) has made a careful study of five cases of compulsive laughter, surveying much of the literature, and drawing attention to the close link between this condition and epilepsy. Cappell and Dott (1938) recorded a case of tumour of the mammillary bodies in which subsequent examination showed that neither cortical involvement nor hydrocephalus was present. In this case frequent fits occurred after a long aura of uncontrollable and inappropriate laughter. Wilder described a case where compulsive laughter gradually merged into the aura of epileptic fits over a period of years. Wilder's case was especially interesting in that one brother of the patient suffered from epilepsy and another brother suffered from compulsive laughter, as also did the son of this brother. Electroencephalographic evidence is conflicting. Pacella (1944) has published observations on a small number of EEGs performed on cases of obsessional state. He examined 31 cases, being careful to exclude any who had had electro-convulsive therapy, or any form of brain injury or disease. 26 of the cases were psychoneurotic and 5 were schizophrenic, and it is interesting to note that two of the former suffered from *petit mal*. He records that 22 cases out of 31 had abnormal tracings and that of these 14 had convulsive type patterns, as shown by frequent runs of 2–4 c/s and potentials of high amplitude after hyper-ventilation. Rockwell and Simons (1947) divided a series of obsessive compulsives into three groups, the second of which, amounting to 10 cases, consisted of patients with severe obsessional symptoms and some affective features. These were inadequate, unstable psychopathic personalities characterized by immaturity and low ethical standards, and all had abnormal records with slow waves, which in two cases were paroxysmal. A further case in which an obsessional state and a tic were combined showed excessive production of waves at frequencies of 5–7 cycles per second. These findings

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are of interest, but difficult to assess and are not yet confirmed by other workers.

Literature in the general sense yields at least two notable cases where epilepsy and obsessional states have been combined. John Cowper Powys describes his own very severe obsessional state—handwashing, a fear of knives and forks being allowed to point at his breast which was linked up with an obsessional preoccupation with the possibility of changing sex, and an aversion to cotton fabrics so strong that he was averse to the sight of either himself or another person holding a cotton handkerchief. This author describes in his autobiography how his epilepsy began at the age of eighteen and mentions several attacks which occurred subsequently. Freud tells how Dostoievski had fears of his own death as a child with many compulsive rituals to protect against the fear. His father was murdered when he was eighteen years of age, and thereafter Dostoievski suffered from epilepsy. Freud regarded this as a dramatization of his own punishment or at least as a portrayal of his guilt, and it is interesting to note that while he was incarcerated in Omsk for four years for a political offence, the epilepsy ceased. Freud believed that the imprisonment in Siberia was in itself punishment enough, and it is related that when Dostoievski was freed the epilepsy returned and indeed was worse than before.

My own case, which aroused my interest in the matter, was as follows:

The patient was a poultry farmer, aged 51. He showed no outstanding features in his childhood, which was reasonably happy, though he was a little timid and fearful of the dark, and required a light in his bedroom as late as twelve years old. His father was a well-known county cricketer, and under his guidance the patient devoted much time to cricket and other sports. He passed a scholarship and after leaving his secondary school joined his father in a leather business. He joined the R.A.M.C. in 1915, being invalided seven months later for epilepsy together with recurrent dislocation of a shoulder because of the fits. When he was 32 his father died, and a few years later he sold the business, being at that time concerned about his epilepsy and anxious to work in the open air, which he felt might help him. He and his wife retired into the country to live on a farm with a young female cousin, rendering certain services to her in return for a small grant of land. He lived on the proceeds of some poultry, together with the income from a small estate left by his father. Despite increasing personality difficulties with the cousin, who was described as "somewhat neurotic," he has remained in the same employment for sixteen years.

The family history is as follows: His father was a rigid, strait-laced man, who ruled his household with an iron hand. His mother was a quiet little woman, who died of cancer when the patient was about 20. One brother died soon after the last war, in which he was gassed and is said to have suffered from faints. The other brother still lives and was an unstable and unscrupulous person, who made sustained efforts to defraud the patient during their business partnership. The patient, in relation to his obsessional symptoms described below, said quite spontaneously that he wondered whether his brother's character, of which he was very much ashamed, was the cause of his being so fearful of similar traits showing in himself.

The patient married when he was 27, and the marriage has been successful. His wife describes the patient as quiet and reserved, fond of his cricket, and of stable mood. He has been a strict teetotaller, not because of any prejudice, but because he had been told drinking would influence his epilepsy adversely. He was religious, but not ostentatiously so, and indeed was not a particularly regular attendant at church. Apart from his cricket, he had few outside interests and spent his evenings at home.

His epilepsy appeared at the age of 17, and thereafter he had about five or six

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fits each year. He was free from attacks for years before his marriage, but they returned subsequently. He had taken his condition seriously at all times and had taken bromides and barbiturates regularly at least for the last fifteen years. Two years ago his fits ceased and at about the same time he began to feel worried as to whether he had paid his debts. He would go into shops in the village and ask for confirmation that he had paid his bill of a week before, clearly aware that he had done so, but feeling impelled to confirm it. At first one confirmation would suffice, but later several visits might be necessary. At the same time he became fearful of leaving the gates of fields open, and despite the utmost care and repetition in closing a gate, would be tormented by the fear that the catch might have slipped, and he would sometimes return over several fields in order to confirm that the gate was secure. At night he worried lest a passing car should run over someone in the dark, and that the victim would be undiscovered until the morning. During one night he lay awake and on three occasions when he heard a car pass he got out of bed, dressed, and walked two hundred yards down the road looking for the body. His passage through the village was torment to him, for he had at least three separate compulsions to contend with. He had to go into every shop he passed and confirm that he owed no money there; he had to stop and kick every stone off the pavement lest someone should slip and be injured; and he had to pick up and examine any small piece of paper he saw lest someone might have lost something of value. Eventually his anxiety became intense and he felt unable to move out of doors and he was admitted to hospital. There he would ask repeatedly if he were entitled to the cigarettes and stamps with which he was issued, at the same time apologizing for his " stupid behaviour " and asking the nursing staff to be as tolerant of him as possible. When his temperature was taken he felt compelled to ask for confirmation that the thermometer had been properly removed and not allowed to slip down under his clothing. After washing his hands, which he did frequently, he returned repeatedly to be sure he had turned off the taps. He was troubled incessantly by rumination as to whether in a large hospital someone might be buried prematurely because a doctor was not available to confirm the fact of death.

No obsessional symptoms had ever occurred in his life before. He had been an orderly and tidy man, and somewhat " particular " but not to a degree which his family regarded as in any way abnormal. In hospital he was treated with sedatives —regular and slightly increased doses of barbiturates, and by simple psychotherapy. His anxiety disappeared and though not free of compulsions these were less and more in control at the time of discharge. In the short follow-up so far possible, he has remained static and with very little practical disability. Prefrontal leucotomy was considered, but deferred in view of his response to conservative treatment.

Summary.

The combination recorded above may perhaps be more frequent than has been reported, though it is unlikely to be very frequent. It seems at least possible that a single pathology may be responsible for both manifestations, and that from some affected extrapyramidal area, a discharge may spread to both hemispheres, producing a generalized seizure. To speculate further would be profitless. It appears certain now that generalized convulsions may ensue from subcortical disease apart altogether from cortical involvement, as shown for example in Cappell and Dott's case; and it is equally certain that obsessional states are associated with ascertained disease of the brain-stem in its upper part. Certain other conditions, such as Gilles de la Tourette's disease, compulsive utterances and tics, and compulsive laughter might be regarded as sharing some of the features of both. It is possible, therefore, that there is a pathological entity which may produce this quite unusual combination of symptoms.

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