Clinical Notes and Cases.

Obsessional and Impulsive Insanity. By JOHN R. LORD, M.B., Medical Superintendent, Horton Asylum, Epsom, Surrey.

THE following notes on a case of marked pyromania following a previous attack of kleptomania may be of interest to the readers of the Journal:

E. F. B—, æt. 23, was admitted to the Acute Hospital of this Asylum on the 28th March, 1908. She was a housemaid, single, a brunette of attractive appearance, whose height was 4 ft. 1¼ in., and weight 7 st. 9 lbs. She was in good bodily health.

Physical examination revealed nothing specially noteworthy. Circumference of head was 52·5 c.m., and cranial index 80·5. Her eyes were somewhat widely separated (3·5 c.m.), but otherwise there were no anthropometric abnormalities. Her motor and sensory systems were quite normal. There were no signs of hysteria.

Family history.—Her grandfather (paternal) died insane, and her grandmother (paternal) was stated to have died at sixty from "softening of the brain." An uncle had also been insane. Patient's father died at forty-six from pneumonia, but her mother is still living and in good health.

Personal history.—She was born at full time. Her mother had three girls in succession, followed by two boys, a girl, a miscarriage, and then a girl, who only lived an hour. Afterwards she had another miscarriage, then the patient, followed by a miscarriage, and finally a boy. The patient cut her first tooth at seven months, commenced to talk at twelve months, and to walk at fourteen months. She was educated at an ordinary school, and learnt fairly quickly, leaving school at thirteen when in the seventh standard. She was, however, always a little weak-minded and emotional, which became more marked at adolescence and afterwards, but has never amounted to imbecility. She never had any fits or other nervous disorders, except violent periodic headaches. Morally, she has been quite good with the exception of a tendency to prevaricate. She menstruated when fifteen years of age, went to work at sixteen, and has had five situations up to the date of admission.

First attack—kleptomania.—Somewhere about in her twentieth year she took a situation as draper's assistant, and when there began to have irresistible impulses to steal small sums of money—pennies and small silver coins, also articles of wearing apparel. She had no particular need for the money, and the other articles she did not need, neither did she wear them. She had no voluntary wish to steal, but an involuntary feeling or idea she had to, and "nothing would help her." She did not feel, however, that she was doing anything particularly wrong. She had no feeling of pleasure in the acts nor any sense of relief afterwards. Often the idea would come one day that, on the

https://doi.org/10.1192/bjp.55.230.517 Published online by Cambridge University Press

next day, she would have to take something, and when the next day came she would be quite unable to resist the impulse to steal. Probably on the next day the opportunity was greater. Finally, she was suspected, caught, and discharged. The impulse to steal then disappeared, and has not returned since.

Second (present) attack—Pyromania.—During the three years following this she was employed as a housemaid, and had two situations, in both of which she apparently gave satisfaction, her mistresses being relatives of each other. She was recommended from one to the other, and left her last through no fault of her own. Curiously, when at these places, a fire occurred at both, but her employers are stated to be convinced that the patient was not the cause of either. The patient herself strongly denies that she was guilty, but I think it possible, even probable, that she was. However, about the end of November, 1908, she left her last situation, and went to live with her widowed sister, a dressmaker. Patient states that, after being there a few days, an uncontrollable feeling or persistent idea came over her that she would have to set fire to something. She had no longing for it, but she felt that, sooner or later, come what may, she would have to do it. She became anxious and miserable, but concealed her feelings and impulses. After about a week of this, during which she menstruated, she set fire secretly to a curtain covering a box on the staircase landing, and during a period of seven days she originated in her sister's house no less than eleven fires, which all occurred during the day, one of which was serious enough to necessitate the local fire-brigade being called in. She used matches on most occasions, but once she scattered burning cinders over the oilcloth covering the staircase. She deceived her sister during the whole time, but at last she was suspected, asked about it, and reluctantly confessed. She then threatened to drown herself, and was taken to the infirmary.

She states that she derived no pleasure from her incendiary acts, nor feeling of relief afterwards. She can give no reason for such impulses arising in her mind. Nothing prompted or told her to do them. She had never heard or read of such things happening to anyone else. It was an irresistible feeling over which she had no control. She had no strong sense that she was doing wrong, though she knew she was not doing right. She was very angry when found out, and has had no return of the impulses since.

Mental state on admission:

She had normal cognition of her surroundings without any defect of orientation.

Her attention tended to stray. She was a little dull and retarded, but coherent; of fair reasoning powers and judgment.

Her memory was really good, but she tried to conceal the facts regarding her pyromaniacal attacks.

Education was average. There were no hallucinations or delusions. Her impulses did not occupy much of her mental contents.

She was a little depressed and emotionally dull.

Morally she had not a deep affection for her relatives. Religious feeling was practically *nil.* Truthfulness poor, but sense of propriety was good. No defects or perversions sexually.

https://doi.org/10.1192/bjp.55.230.517 Published online by Cambridge University Press

After much pressing she finally admitted facts given in her personal history.

Progress.—She rapidly brightened up; soon began to employ herself and to interest herself in her surroundings.

She denies any return of impulses, and there has been no evidence of such. No other impulses have appeared. She continues well behaved, rational to talk to, and of nice manner and disposition.

Diagnosis.—The case illustrates the complicated psychology of obsessions, compulsive thoughts, and morbid impulses. Objection would be taken to classifying her as an obsessional case, yet she was clearly beset by a mental product prior to any outward manifestation or motor translation.

Most alienists would say that she was suffering from Impulsive or Aboulic Insanity. It depends what is understood by these terms. Impulsive or Aboulic Insanity is commonly taught to be a defect of the will or volition, the impulse being either too strong or the will power too weak. Impulsive Insanity should, in my opinion, only be applied to those cases in which occurs a sudden impelled act—a psycho-motor explosion—with little or no ascertainable regard to any idea or feeling.

An obsession is any morbid mental product which dominates the mind and cannot be relegated to sub-conscious spheres and absorbed into the personality, and which paralyses to a varying extent inhibition, from reason or instinct, of the motor or sensory counter-parts. The mentalization which allows of or produces the psychic product is primarily at fault and not the volitional spheres. This is in effect Bianchi's teaching.

An obsession may be either an idea, fear, desire, motor act, or an instinct. Each is, however, to some extent associated with one or more of the others. The chief point is the unwelcome prominence in the mind generally.

A division into Compulsive and Impulsive Insanities is unsatisfactory, there being so many cases which have characteristics of both.

I think those cases in which the obsession or succession of obsessions slowly invades the whole mentalization in spite of treatment, and which ultimately leads to disintegration of the personality, should have a special designation such as "Progressive Obsessional Insanity." Others, in which there is no such tendency might be called "Simple Obsessional Insanity," while those cases in which the predominating mental product

https://doi.org/10.1192/bjp.55.230.517 Published online by Cambridge University Press

is chiefly a psycho-motor excitation should be termed either "Impulsive Insanity" or better "Motor Obsessional Insanity."

Ætiology.—The chief factor was undoubtedly the psychopathic heredity which showed itself primarily in an unstable and somewhat weak mental development. Another factor of some importance must have been the physical exhaustion of the mother entailed by rapid and numerous pregnancies. Including the patient, she had eight children and two miscarriages within fourteen years. A miscarriage occurred both before and after the patient.

Prognosis.—It is extremely unlikely that this is the last attack, but it would be interesting to know the nature of the next impulse and how soon it will occur. The prognosis is very grave. An interesting question will eventually arise, unless further symptoms develop, as to whether she can legally be kept in an asylum.

Her secretiveness and deceitfulness almost suggest latent criminal tendencies, and the dividing line between obsession and criminality must often be very indistinct.

Clinical and Pathological Notes.—III. By Dr. M. J. NOLAN, Resident Medical Superintendent, Down District Asylum, Downpatrick.

CASE 8.—*Disseminated sclerosis; hydrocephalus; epilepsy; extreme tenuity of skull; dementia.*

W. M—, æt. 29, admitted to asylum October 28th, 1903; died January 6th, 1908. Patient had no family history of insanity or allied neuroses. He led a steady, regular life, married early, and worked mainly in coal-pits. About fifteen years ago—when he was fourteen years of age—he fell on his head and was unconscious for several days, and ever afterwards complained of pain in his back. Ten years later, and four years prior to his admission, he got a fit, and immediately preceding it he said to his wife that he felt the pit to be falling in on him. From that time to date of admission the fits recurred at irregular intervals, he became gradually spastic in gait, and his temperament varied from dulness to marked irritability, and his mental faculties became obscured. He was then treated in the Union Hospital, and finally became so violent that he was removed to the asylum.

On admission the following particulars were noted: Body well-nourished; weight 12 st. 4 lb. Expression fatuous. Pupils irregular and eccentric, reaction to light and accommodation normal; nystagmus. Exaggerated knee-jerks; gait spastic; volitional tremor. "Scanning" speech; mental state dull and confused; irritable when questioned.

https://doi.org/10.1192/bjp.55.230.517 Published online by Cambridge University Press