Obsessive Slowness Revisited

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Of 665 patients referred between 1969 and 1984 for behavioural treatment of obsessive–compulsive disorder, 22 had marked slowness not due to washing, which was secondary to mental or overt rituals or ruminations. Over 90% of the slowness cases were male, and over a quarter had pre-natal or delivery problems.
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In 1974, Rachman described ten in-patients with obsessive slowness which was "a primary dysfunction, not merely a secondary consequence of other difficulties". Soon afterwards, an editorial in the *British Medical Journal* (1974) queried whether the slowness was primary, although three subsequent books did not (Hodgson & Rachman, 1976; Kendell & Zealley, 1983; Marks, 1981). Later, two cases of slowness due to mental checking were described (Bilsbury & Morley, 1979; Bennun, 1980). In a third case of slowness, mental checking or ruminations were not excluded and a fourth case of extreme slowness, who had been called catatonic, disclosed mental checking on abreaction (Clark *et al*, 1982). This pilot study examined some features of obsessive slowness in a series of patients.

Method

A group of 665 in-patients and out-patients with obsessive–compulsive disorder, seen in this unit from 1969 to 1984 with slowness not clearly due to washing or fears of contamination with dirt or germs, had their hospital records examined. These cases should have included Rachman's ten in-patients with 'primary' slowness, but they could not be identified from the case notes, unit records and correspondence with staff who had known them.

Results

Of the 665 patients, 22 had slowness as a significant clinical problem. In all but one of these 22 patients the case notes described definite rituals, ruminations and/or washing that probably accounted for their slowness. The exceptional case was a man who was slow and habitually late without rituals or ruminations; his problem had begun at the age of 12, he was seen as an out-patient at the age of 37; and 13 years later his slowness continued but, as always, did not hamper his life, which his wife confirmed. He had never been an in-patient.

It is striking that 19 of the 21 cases with problem slowness were male and only 2 female. Mean age of onset was 19 years (range 5–37). Six patients (27%) had pre-natal or delivery problems, but only two of these had delayed milestones during development. There was a family history of psychiatric illness in nine patients (41%).

Discussion

This pilot work has the limitations of a retrospective case-note study. Conclusions need verification in prospective work with standardised analysis by interview of mental state and behaviour. Bearing this caveat in mind, careful search of the detailed case notes of 665 patients with obsessive–compulsive disorder (OCD) found no case of slowness as a primary and handicapping problem. Obsessive slowness seemed nearly always due to overt or covert rituals or indecision. Rachman (1974) noted that such patients are "fanatically meticulous. Each task has to be done in the correct manner . . . . Slow motion of the limbs seems to play no part in their slowness". Slow obsessive–compulsives seem to fear and avoid making mistakes or causing disorder. Their excessive orderliness is a ritual although actions within a sequence may not be repeated. If the sequence is disrupted, even near its end, the patient commonly feels compelled to start the entire sequence again and complete it perfectly.

Following the exposure principle, behavioural treatment of obsessive slowness consists of persuading the patient to systematically speed up and take the risk of making mistakes and causing disorder. We have no outcome data, although marked slowness gives the impression of being more difficult to treat than most OCDs. This need not, however, reflect slowness *per se*. It could instead reflect an association of slowness with severity, which predicts fewer gains with exposure therapy (Basoglu *et al*, 1988).

Two points were notable in our cases of marked slowness. First, 27% of our slowness cases had a history of pre-natal or delivery problems, more than is usual in OCD. The second remarkable point is that 92% of our slowness patients were male, whereas OCD as a whole tends to occur about equally in men and women. Males predominated among 16 cases of OCD concerning symmetry and exactness (Rasmussen & Tsuang, 1986). Early-onset cases of OCD predominate among males (Noshirvani *et al*, 1991), but our slowness cases had no particularly early onset,

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having begun on average at the age of 19, fairly close to the mean onset age of early twenties in most series of OCD (Marks, 1987). It is unclear why there is such a marked male preponderance in slowness cases, nor whether it is relevant that another syndrome in which slowness features – Parkinsonism – is seen slightly more often in men than in women. Parkinsonism tends to start far later than OCD and is associated with obvious pathology in the basal ganglia and substantia nigra, which is uncommon in OCD.

Perhaps the above two points suggest that neural circuits concerned with acting on decisions and completing the ensuing behavioural sequences may be more sensitive to damage in males than in females.

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The Fregoli Syndrome and Puerperal Psychosis

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Four cases of the Fregoli syndrome occurring in the setting of puerperal psychosis are described. They are discussed in relation to previously reported cases and it is proposed that the acute onset of the psychosis and ambivalence arising with childbirth are important factors in the pathogenesis.

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The Fregoli syndrome is a rare psychopathological manifestation first described by Courbon & Fail in 1927. It is usually classified as one of the delusional misidentification syndromes together with the more frequently occurring Capgras syndrome (Capgras & Reboul-Lachaux, 1923), the rarer syndrome of intermetamorphosis (Courbon & Tusques, 1932) and the syndrome of subjective doubles (Christodoulou, 1978). The syndrome derives its title from a famous actor, Fregoli, who had an exceptional ability to change his appearance, and is characterised by the patient identifying a familiar person in various strangers claiming that, although these strangers and his/her familiar person bear no physical resemblance to each other, they are in fact psychologically identical.

Although the original 1927 case occurred in a female patient, Christodoulou (1976), suggests that it is primarily a male manifestation with all patients being psychotic, and in most cases schizophrenia constitutes the nosological setting. There is usually a marked paranoid element with a strong organic component contributing to the pathogenesis.

We report here four cases of the Fregoli syndrome occurring in the setting of puerperal psychosis.

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