Obsessional disorder and neurological illness

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Obsessions and compulsions are mental experiences with a compelling quality which persistently intrude into consciousness. Although recognized by the patient as an abnormal and irrational product of his own mind, and resisted by him, he is incapable of expelling them. They may take the form of thoughts, images, fears, urges, desires, or acts. An obsessional illness is one where such symptoms dominate the clinical picture and are not associated with any underlying psychotic process or phase.

Since the end of the last century, attempts have been made to understand obsessional disorder in neurological terms. Gadelius (1896), in Sweden, considered that obsessions were exaggerations of normal mental functioning and compared them with suggestibility and contrast thinking. He believed that every idea had a counter-idea, like an echo. Postulating an organic brain lesion, Gadelius suggested that the former had a cortical, the latter a subcortical, origin. Where there was a constitutional tendency for cortical weakness, subcortical centres were released from higher control and obsessional phenomena appeared clinically.

An organic explanation for obsessional symptoms was subsequently advanced by a number of writers, particularly Goldstein (1924), Wexberg (1929 and 1938), and Schilder (1938). This theory gained ground from the work of Mayer-Gross and Steiner in 1921. They found symptoms similar to obsessional in post-encephalitic Parkinsonism. Other observers confirmed this finding (Ewald, 1924; Falkiewicz and Rothfeld, 1925; Scharffetter, 1926; Stern, 1927; Skalweit, 1928).

The present study represents part of a clinical, social, and prognostic inquiry into obsessional disorder. In investigating the medical history of patients suffering from such an illness, an attempt was made to discover the incidence of previous neurological disorder. This, it was felt, might throw some light on the possible connexion between obsessional symptoms and disease of the central nervous system.

MATERIAL AND METHODS

The material for the investigation was drawn entirely from patients attending the University Department of Psychiatry of the Manchester Royal Infirmary between the years 1945 and 1959. The patients fulfilled the criteria for obsessional illness given above. One hundred and seven such patients had attended the department and their records were scrutinized. A detailed medical history was available in 103 cases.

A control group of patients with non-obsessional neuroses was set up, matched for age and sex, drawn at random from the same locality, and having attended the psychiatric clinic over the same period of time. They comprised 62 cases of anxiety state and 45 cases of hysteria. Relevant information was available in 105 cases. The differences regarding previous neurological illness in the two groups could then be subjected to the \( x^2 \) test of statistical significance.

Both groups of patients had been investigated with the same degree of thoroughness. The only difference between them was that, unlike many of the obsessive patients, the control series was not examined personally. Personal questioning of the obsessive patients did not reveal any further case of unrecorded neurological illness, but caused some cases to be discarded as doubtful. It seems reasonable to conclude that in the control series, which was written up to a similar standard, lack of personal examination would produce a bias, if any, in the right direction, for certain cases which might have been excluded as unreliable could not be assessed.

RESULTS

These are set out in Table I.

On the evidence available, 28 obsessive patients (27.2%) had suffered from one or more forms of neurological disorder. The clinical records of the patients concerned have been examined in detail in an attempt to assess the reliability of their information.

Three patients reported encephalitis, and two of these had had encephalitis lethargica. One patient said she had contracted it at the age of 3 during the great pandemic, and stated that her father had died from it. The other, also a woman, had developed it and recovered just before the onset of her compulsive symptoms. This woman was examined personally; there seemed little doubt from her clinical description and the statements of the physician attending her at the time that the diagnosis was correct. The third was a case of polio-encephalitis. The illness had occurred at the age of 11 years. Both
In the control group of other neurotic conditions, eight patients out of 105 (7.6%) reported important neurological illness. These comprised chorea (two cases), birth injury with hemiplegia (one case), porencephalic cyst and atrophy (one case), poliomyelitis (one case), convulsions (one case), meningitis (one case), and beri-beri (one case). This is to be
compared with the obsessional series with 269
patients out of 103 (19.4%) having had one or more
important neurological illnesses, i.e., excluding
diphtheria (for reasons mentioned), herpes zoster,
and Bell's palsy. The difference between the two
groups is statistically significant at the 5% level
with one degree of freedom, using Yates' correction ($\chi^2 = 5.24, P = <0.05 > 0.02$).

DISCUSSION

The association of epidemic encephalitis and com-
pulsive disorder has already been mentioned in this
introduction. Mayer-Gross and Steiner (1921) and
Schilder (1938) have made important studies of this
connexion. Lewis (1946) states that encephalitis
lethargica and other cerebral diseases may produce
typical obsessional symptoms in persons free from
demonstrable tendencies in this direction.

Schilder (1938) came to the conclusion that organic
changes were important aetiological factors in two-
thirds of his obsessional cases and psychogenic
factors in one-third. In the former group, organic
signs—toxic change, tremors, impairment of ocular
convergence, hyperkinesis, or akinesis—were to be
found in a third and a further third had symptoms
suggestive of an organic background. In the majority
of positive cases, he says, we do not deal with sequelae
of epidemic encephalitis but with organic changes
similar to those in encephalitis but of different
origin. These may be constitutional or due to lesions
of foetal life, birth trauma, or to toxic and infectious
processes of unknown origin. Schilder tries to link
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fantile experiences, he suggests, create a pattern
which is expressed as compulsions on an organic
basis. In obsessional disorder, the organic process
liberates motor impulses which reinforce sadistic
attitudes to appear in the mind as compulsions.
Wexberg (1929 and 1938) and Goldstein (1924) are
both quoted as seeing an organic nucleus in obses-
sional disorder. The part of the brain involved is
that affected in Parkinson's disease, i.e., the corpus
striatum.

A number of writers have commented on the rela-
tionship of obsessional illness and epilepsy (Fuchs,
1927; Jahrreiss, 1926). Aldren Turner (1907) and
Crichton-Browne (1895) described obsessional states
between fits. Garmany (1947) reported a case in

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Table 1: Previous Neurological Disorder

<table>
<thead>
<tr>
<th>Illness</th>
<th>No. of Obsessional Patients</th>
<th>No. of Non-obsessional Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sydenham's chorea</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Convulsions in infancy</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Encephalitis</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Herpes zoster</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>von Recklinghausen's disease</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Heat stroke</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Subacute combined degeneration of the cord</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Bell's palsy</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Anterior poliomyelitis</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Eclampsia with fits</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Birth injury with hemiplegia</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Porencephalic cyst and atrophy</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Beri-beri</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

parents were questioned closely as well as the patient;
little doubt remained of its factuality.

Two patients reported meningitis in childhood.
No confirmatory data were available in one case;
the other was described as a nearly fatal illness at
the age of 3 which the patient was told was meningitis.

One patient had suffered from poliomyelitis and
this was confirmed by neurological examination at
the time of consultation. Thus six patients (5.8%)
gave a previous history of serious infectious illness
of the central nervous system.

Eight patients (7.8%) gave a history of convulsive
disorders. Five patients reported convulsions in in-
fancy; it was impossible to verify this information.
They had not continued into later life. One woman
had suffered from eclampsia with fits leading to a
stillborn child. Two patients reported major epilepsy
which was present at the time of consultation.

Five patients gave a history of diphtheria. It was
difficult to assess the true state of affairs in these
cases. No supporting data were available in the clin-
cal records, let alone whether neurological complica-
tions were present. It is common experience in
clinical practice to find patients calling any serious
infection in the mouth and throat in childhood 'diphtheria'. No interpretation can be placed on this
information and it is dismissed from the writer's calculations.

The information regarding chorea merits attention.
Six cases (5.8%) were reported. It was, in most cases,
described as 'St. Vitus' dance'. Four patients gave
details of an illness with uncontrollable jerking
movements of the body, in three cases requiring
bed rest in hospital. One case was doubtful and may
have been, from the patient's description, a functional
disorder of childhood, possibly a tic. The other was
described in terms suggestive of chorea but prolonged
bed rest was not reported.

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between fits. Garmany (1947) reported a case in
which both epilepsy and obsessional symptoms were present. He speculated that a single pathology, of some extrapyramidal area, might be responsible for both manifestations.

The relationship of obsessional symptoms in patients with chorea has been investigated by Guttmann (1927) and by Creak and Guttmann (1935). Widespread histological changes are found throughout the cortex, basal ganglia, and cerebellum in chorea (Greenfield, 1958).

Objections have been raised against a relationship between obsessional disorder and neurological illness. Pollitt (1958), for example, has discussed changes in personality and conduct which may follow any disease or injury of the brain, especially encephalitis. These usually take the form of emotional instability of a childish nature often with antisocial trends. The aberrant behaviour described as commonly following encephalitis is not found in people who fall ill with obsessional illness, neither during the illness nor before it. In fact, the obsessional character is the antithesis of the uncontrolled, antisocial, and wayward disposition of the post-encephalitic patient. Hall (1939) has described the mental accompaniments of epidemic encephalitis in children and states that when adult age is reached it is not accompanied by appropriate emotional maturation: 'They remain, more or less, childish'. As Pollitt (1958) remarks, this is hardly like the obsessional patient.

In relating the findings of this study to those of other writers, it is important to emphasize that the previous illnesses reported by patients could not, in the majority of cases, be verified either clinically or by hospital records. Inferences, therefore, can only be tentative. It would appear that about a fifth of patients had had previously some sort of important neurological disturbance, excluding trauma. It is difficult to say that in these patients organic cerebral changes had occurred. All the patients were subjected to neurological examination but none of Schilder's signs were recorded. On the other hand, they were not specifically looked for and may have been missed. Furthermore, it is doubtful whether the incidence of infantile seizures is higher than in the general population since febrile convulsions are not infrequent in childhood. Lennox (1947), for example, reported that seizures occur in about 5% of children under the age of 5 years.

Nevertheless, the incidence of neurological disease in the histories of the present series of obsessional patients cannot be overlooked, although it is lower than that found by Schilder. It is difficult to say with any certainty whether structural cerebral damage occurred and what part the illness played in the predisposition to the development of obsessional disorder later in life. Goldstein's view is called to mind that obsessional behaviour is a general disposition which can be released by the breakdown of higher performances. One may speculate that previous neurological disease isolates, as Goldstein would say, subcortical perseveratory activity from higher cortical centres. This might facilitate the emergence of compulsive phenomena when reinforced later in life by somatic or psychogenic precipitating factors. It would seem that further research is indicated in this field.

**SUMMARY**

The incidence of previous neurological illness in 103 patients suffering from obsessional disorder was investigated. It was compared with that of a control group of patients with non-obsessional neuroses (105 cases). Twenty patients (19.4%) of the former group compared with eight (7.6%) of the latter reported previous important neurological disorder. This difference is statistically significant at the 5% level.

The role of organic neurological changes in the pathogenesis of obsessional illness is discussed.

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**REFERENCES**
