Obsessions. By JAMES SHAW, M.D., Liverpool.

REVIEWS, abstracts, and papers concerning this subject having appeared from time to time in the *Journal of Mental Science*, I shall, with the exception of making a few incidental explanatory quotations, confine myself to an account, more or less brief, of some of my own cases and to the remarks suggested by them.

Obsessions are much more frequently met with in private than in asylum practice, and when they do occur in the latter they are often so masked by other symptoms as to be nearly, if not altogether, unrecognisable, except with the help of the history. They may be physiological, as instanced by the catchwords or refrains which haunt the mind for hours or days and then vanish. Like hallucinations, they may be induced by drugs—at all events by one drug.

A diabetic patient of mine, who was recently taking sodium salicylate in moderate dosage, became obsessed by the song "Annie Laurie." This besetment was not unpleasant at first, and the patient would occasionally burst out singing the song just at the point in the wording at which she had mentally arrived at that particular moment. After a few days, however, the melody became monotonous, the salicylate was discontinued, and the obsession gradually disappeared. There was a hallucinatory element in the case, as from the patient's description one could gather that the music was merely a modification of the ordinary salicylic "singing." But the words of the song rose in her mind imperatively like those of a very catchy refrain. In childhood she had sustained fracture of the back of the skull.

Morbid obsessions may be either essential or symptomatic, and in any case they arise, initially at all events, in a state of clear consciousness, and are then, as a rule, easily distinguished from delusions, ordinary psycho-sensory hallucinations, and illusions.

The patient suffering from obsessions is usually able to describe his symptoms fairly well. He is quite aware that his besetments are entirely subjective ; is capable of being reasoned, temporarily at least, or at times, out of his morbid fears ; recognises any criminal tendency of the inciting thoughts, and

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is able, for a time at all events, to resist their promptings; and, finally, is quite alive to the obscenity, blasphemousness, or absurdity of his besetting words or thoughts. The first criterion in the above sentence excludes hallucinations, except psychical and perhaps psychomotor, of which more will be said later on; the second and fourth shut out delusions; and the third eliminates morbid impulses, properly so called.

But obsessions sometimes develop into delusions or psychical hallucinations, or originate active and irresistible morbid impulses. Obsessions, where only symptomatic, may, as the disease progresses, become obscured by the blurring of consciousness and other symptoms. This is exemplified in agitated melancholia of obsidional origin (obsessive or obsessional melancholia). It is also exemplified in some cases of dementia præcox.

Although it has been said that it is not possible to classify obsessions, Magnan's definition (1) that an obsession is a mode of cerebral activity in which a word, a thought, or an image forces itself involuntarily into consciousness, suggests a classification useful in practice. Thus there are besetting or obsessing words, besetting thoughts and besetting images. For although the first and last forms secondarily induce thoughts and emotions, the besetting words, generally obscene, and the obsessing images, commonly unpleasant, are yet the primary phenomena in the actual obsession, apart from any theory as to pathogenesis.

The besetting thoughts may be crystallized into sentences nearly always of an inciting nature—phrasal, sentential, or inciting obsessions; or they may be obscene or otherwise unpleasant thoughts or ideas not necessarily taking any verbal, phrasal, or sentential form—ideal obsessions; or they may precede, accompany, or follow an emotion, almost always of fear, which overshadows them—emotional or phobic obsessions, in which the painful emotion of fear is the real obsession. So that we have verbal, phrasal, ideal, emotional, and visional obsessions. Frequently an obsession can be referred equally well to either of two of these groups, and several forms of obsession may, and often do, co-exist, one, however, as a rule, being more prominent than the others.

Verbal obsessions are those in which isolated words—mostly obscene or blasphemous—constitute the morbid besetment.

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They differ from coprolalia, blasphematory mania, (2) and even onomatomania, (3) in that the words are not necessarily uttered.

Verbal obsessions may constitute the leading feature of a sort of obsessional aberration or an early symptom of a form of agitated melancholia which might be called obsessional, obsessive, or obsidional melancholia. An example of each of these has been given by me more at length in another journal. (4) It will suffice here to say that both patients presented marked neuropathic heredity, neurotic constitution, and extreme religiousness. So that the words, which were described by them as obscene, blasphemous, and unutterable, and which were in fact never uttered, caused them intense mental anguish. The case of melancholia seen by me in consultation with Dr. Clegg was removed to a private asylum, where she recovered in about a year, as I was informed; whereas the case almost purely obsessional obtained admission with difficulty into a workhouse hospital, where the patient was not considered insane enough to be sent to an asylum, and when I heard of him several years afterwards he was, although less agitated, still unfit for his work as a teacher and obsessed as strongly as ever by the obscene words. Both patients had suffered from influenza prior to the mental illness. Both presented motor agitation, especially of the arms.

Phrasal, sentential, or inciting obsessions are besetting thoughts which take the form of isolated sentences and prompt, incite, or impel the subject of them to do certain acts, often criminal, or occasionally to refrain from doing things which would be beneficial.

The following is a case of *folie du doute*, in which the initial doubts and fears were replaced by phrasal obsessions of a comparatively harmless description. A lady, æt. 23, had been married four years and had had three miscarriages, the last at twenty-two. She was little, spare, and pale, but healthy looking, bright, and intelligent. She had lobeless ears, prominent antihelices, and high palate with slight median ridge. Her pupils and discs were normal. She said her father and mother were "nervous" and excitable.

She had suffered more than two years from certain mental symptoms. At first, if she put down or dropped any article, even a pin, she thought it would do her some harm, and picked it up; then thought she was foolish and put it down again, once

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more lifted it, and so on, five or six times. If she touched anything the thought "jumped into her mind" that it might injure her (mysophobia); then she washed her hands. At first she thought anything she did would injure her heart, and, latterly, her womb (nosophobia).

She had got over these ideas and phobias when I saw her. But they had been replaced by symptoms which she termed "exciting thoughts," *e.g.*, her husband had gone down to breakfast before her in the hotel where they were staying, and then her inward mentor kept saying more and more rapidly and urgently, "Hurry up! Hurry up!" But she reasoned with and told herself there was no necessity to hurry. When coming to my house the mentor said, "You will be late; you will be late." But then she thought to herself there would be others waiting, and she could wait too. When she was reading the mentor told her it would injure her to continue to do so, and this thought became so urgent that she was compelled to desist. She knew this was all subjective. She did not speak of "voices," mental or other, and had never suffered from hallucinations in any form.

Sleep and appetite were normal. The patient complained of thrills in her body and flushings in her head and face when the thoughts arose, or when people looked at her in the street. In the latter case she almost fainted, so that she could hardly walk out of doors in the daytime. Her right hand and a portion of one of her legs had felt numb and lost sensation. She had pain in her spine at times, and in the sacral region frequently. She had an urgent desire to urinate even when the bladder was empty, as ascertained by the catheter. Although several medical men, who had examined her, had found her womb normal, a notorious "specialist" had recommended her to wear a pessary, and she had worn one, but without any good effect. She had run through the gamut of the nervine pharmacopœia—all without relief.

My suggestions were to have cold sponge baths, modified massage, and faradism, to live in the suburbs of the large town to which she belonged, to join in games, go to theatres, etc., to read, occupy herself lightly, and resist the obsessions with all her might when they incited her to work fast and fatigue herself, or prompted her to desist from reading. As her symptoms were aggravated at the menstrual periods she was to take, at

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these times, a bromide mixture, and, in the intervals, tonics. She was much relieved when assured she would not become worse or insane. Some months afterwards I ascertained she was greatly improved.

The following case is of a more serious type, the depression amounting to melancholia. The patient, a married man, æt. 32, presented stigmata of degeneracy; the face, and especially the ears, were markedly asymmetrical, the right ear being very abnormal, having no antihelix or crus superius and presenting a long, prominent, ridge-like crus inferius, running parallel with the incurved end of the helix, forming a large, deep fossa cymbæ, and leaving the fossa conchæ very small; Darwinian tubercle on both ears, larger on right, etc. The pupils, discs, vision, and knee-jerks were normal, except very slight variable inequality of the first. The patient had a feeling of pressure on the top of his head, and sometimes slight lumbar pain. There was no tremor or feeling of weakness, and the hand-grasps were, right eighty-five, left seventy-five. There was some insomnia. The patient masturbated from the age of fourteen to twenty-one. A "voice" told him, when a boy, that he was not the son of his father and mother. He neither drank nor smoked, and was very religious. Although married, he had seminal emissions at short intervals. All his brothers and sisters have suffered from temporary mental depression. His mother, a brother, and a sister had delusions, mostly of a hypochondriacal character, from which they recovered in two years or less.

The patient had been suffering for some months from symptoms which he himself termed "morbid impulses" to attack others and injure himself. Hitherto, he had resisted these and prevented them culminating in acts, but with great effort, he said. On closely questioning him at different times, it was elicited that vivid thoughts (phrasal obsessions) suddenly shot athwart his train of thought, just as if some one had spoken them. Sometimes these thoughts took the form of questions, *e.g.*, "What are you going to do to So-and-so?" He understood this meant what violence, and he replied mentally. On other occasions they told him to do violence to certain persons, and he resisted. He was well aware that these suggestive mental queries and promptings so foreign to his better nature were subjective. The inclination to strike sometimes arose suddenly without the thoughts or any provocation,

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on seeing a weapon and a person near each other. Occasionally, he was unduly irritated by a jest or contrary opinion, and had the inclination to strike. He was in constant dread (emotional obsession) of doing something violent. He picked up the terms " morbid impulses," " loud thoughts," and " voices in the head," when being examined, and would use them afterwards, but the above was the exact state of affairs as ascertained in one of his brightest and most communicative moods. When first asked if the internal voices or loud thoughts seemed ever to be in his mouth (so-called psycho-motor verbal hallucinations), he said, " No, never." Afterwards, when in one of his worst moods, he said they were in his head *and mouth*, but on being closely interrogated, he said they were never in his mouth, *only in his head*.

In addition to these symptoms, he had the fixed belief that his soul was lost; his mind was beset by evil sexual thoughts (ideational obsessions); he heard creakings and " clankings " in corners of rooms (rudimentary auditory hallucinations) and in railway carriages (auditory illusions); he saw flashes of light before his eyes (rudimentary visual hallucinations); and one night, when out driving, real objects took the shapes of people and terrifying forms (visual illusions). Once he asked me if I thought the devil put all the thoughts, etc., into his head, and this was his only hint at external agency. The patient's speech was slow and hesitant, his voice weak and low. He seemed to " fill up " with emotion so as to be unable to speak, and then burst into tears. He said his thoughts were never off himself and his troubles. He was very much afraid of having to go to an asylum, and his wife had a great objection to his being sent to one.

He was put on the combined bromides with belladonna, liquor arsenicalis, and cinchona, also cascara tabloids. He was advised to have rest and change, a hard bed, a reel on his back at night, a morning cold bath, and not much fluid after six p.m. Under this treatment the seminal emissions and sporadic impulses diminished, the inciting obsessions, the illusions and hallucinations disappeared, and the patient, in spite of his fixed belief as to his soul being lost, became comparatively cheerful. But when he had been two months in the country, a friend took him along the brink of a precipice and walked a short distance ahead of him. The patient felt a

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strong inclination to throw himself over. To avoid doing so, he flung himself on the ground, held on by the grass, and screamed for help. This incident caused a recrudescence of all his symptoms. He acquired in addition illusions of taste and smell—suggestive of masturbation. Shortly afterwards another friend kept the ball rolling by reading some "horrible tales" to him. The anxiety was increased by financial worries, and the necessity to resume duty, for which he felt unfit. His self-control failed, and he began to threaten violence to, and finally actually attacked his wife. He was sent to an asylum, whence he was discharged recovered in less than a year.

A married lady, æt. 28, whose maternal aunt had suffered from so-called religious mania, had, a year and a half before my first seeing her, much anxiety and loss of rest whilst nursing her child through a long and fatal illness. Five months after this prolonged nursing, she had a difficult labour lasting, she said, three days. Three months after this labour, she contracted acute rheumatism, which laid her up for ten weeks, during part of which time she continued to suckle the baby. A nurse told her that if the rheumatism got to her heart, it would kill her. She was much impressed by this at the time, and the impression was lasting. It developed into an inciting obsession to injure herself, and a dread that she would do so (emotional obsession). She suffered from weakness, flatulence, functional palpitation, and depression. But she could throw the depression off for a time and be cheerful with her friends.

About three months before she came under my care she fancied, on looking at her baby, which was lying in bed quite well, that its throat was cut. This visual illusion haunted her. It possessed her thoughts (visional obsession), and every baby she saw had apparently had its throat cut (visual illusions). She went to Buxton, stayed six weeks, and underwent treatment by electric baths and massage without benefit. Whilst there she had three teeth extracted under gas. She had left her child at home, and she seemed, so she said, to lose her previous motherly feeling for it. Her obsessions, which had hitherto incited her to kill herself, now prompted her to destroy her child instead. This worried her much more than the previous condition.

Her symptoms when I first saw her were:—The abovementioned visual illusions—she had seen her husband also with

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his throat cut ; phrasal or inciting obsessions—vivid thoughts persuading her to cut her child's throat—to which she replied mentally as if to a second person, thus carrying on a mental conversation ; the dread (emotional obsession) and unpleasant ideas engendered by the inciting thoughts. When she saw a knife or other sharp instrument she felt a strong inclination to say aloud, "That would do," and in order to prevent herself saying it she counted, sometimes aloud. The inciting thoughts, dreads, etc., came over her at intervals "like a cloud." Asked if the conversations in her head were like "loud thoughts," she said, "Something like that." Asked about voices, she said she heard "voices," but not outside her own head. In a subsequent consultation, when under bromide, she said she heard no "voices," but that in the midst of her unpleasant reflections a strange thought would often strike in, quite foreign to her own train of thought, just as if some person were advising or tempting her to injure her child. She said these inciting thoughts, although they were in her mind, were not her own, meaning that they were not her voluntary thoughts.

There were some hysterical symptoms, *e.g.*, an attack of silly laughter and talking ; a tendency to be contradictory ; anomalies of cutaneous sensibility—tested with a pin, touch and pain seemed to be normal and equal ; the temperature sense was acute and equal, yet two sharp points were not discriminated on back of right hand at 38 mm., left 18 mm., right palm 14 mm., left 11 mm., tip of right middle finger 4 mm., left 2 mm., right side of forehead 15 mm., left 11 mm. ; beyond these distances, transversely, they were felt as two. She said she could not feel a current which a nurse at Buxton could not bear. The right hand grasp was 50, the left 40.

Bromides, glycerophosphates, hypophosphites, arsenic, Jamaica dogwood in various combinations lessened the frequency and intensity of her symptoms, and she said she felt "braver against them." She said she did not feel depressed, and that in the intervals between the "clouds" life was worth living. As she did not advance beyond this stage, total isolation from her relatives was suggested, with, as I ascertained two years afterwards, satisfactory results.

Ideal obsessions—the paræsthesiæ and paralgesiæ of the mind—are those in which an idea or belief constitutes the morbid besetment.

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In a case sent to me by Dr. S. H. Shaw and reported by me in another publication ([5]) the patient, a man of neuropathic heredity who had suffered from seminal emissions, the result of masturbation, was so beset by obscene ideas that he said his thoughts "constantly revolved round" his penis. He showed no permanent improvement under any treatment, yet he was always able to follow his occupation.

Another patient, previously neurasthenic, was beset by erotic though not obscene ideas to such an extent as to diminish his business capacity. After several relapses he made a good recovery under hypophosphites, arsenic, bathing in an enclosed sea-water bath with others, and outdoor exercise. He attributed his first symptoms to fright whilst bathing in the open sea.

These cases sometimes make very sudden recoveries. A young lady who was for many months much troubled by "funny" and "queer" thoughts constantly "jumping into her head," recovered immediately after an interesting event, which took place in the home of the near relative with whom she resided, and gave her fresh occupation.

In another case the idea of non-recovery was combined with nosophobia, in the shape of fear of softening of the brain. After a duration of several months, the patient improved under tonic treatment sufficiently to commence business on her own account at a bracing seaside resort, and speedily made a good and lasting recovery.

In cases of a periodical nature these thoughts may exist, combined with nosophobia, for years and then disappear, often remaining absent for a long period; as in a case sent to me by Dr. Cregan and reported by me elsewhere, ([6]) in which the idea of non-recovery prevailed almost continuously for five years, yet vanished, with the other depressing mental and bodily symptoms, and has now continued absent nearly four years.

Emotional, *affective*, or *phobic obsessions* may constitute almost the whole disease in cases of obsessional aberration (rudimentary paranoia). They also occur as symptoms of melancholia and paranoia. Perhaps the most typical and one of the best known of these phobias is the fear of open spaces, which, in some cases at all events, proceeds from a sort of stammering of locomotion, analogous to stammering in writing, deglutition, or speech, but with much greater intensity and extent of emotion.

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One mode of the pathogenesis of agoraphobia was illustrated in a case of mine already published. ([7]) Here the syndrome was caused in a neurotic man by slight "seizures" in the street, arising from over-dosing with strychnine. The dread of repetition of these seizures and of being again stared at promoted their recurrence, and thus resulted in fear of crossing the streets and even of walking along them. He suffered from stammering writing. The pallor and subjective sensations pointed to angiospasm.

Some of these emotional obsessions, *e. g.*, thanatophobia and astraphobia, are merely exaggerations of a natural or common fear. A lady, æt. 69, who had recovered from an attack of melancholia, during which sudden startings and cries (probably spinal symptoms) were frequent, would, at the beginning of a thunderstorm, hide herself in a dark cellar which she was ordinarily afraid to enter.

A female patient, æt. 30 and married, suffered from various dreads, *e. g.*, that people, even her own child, would smother her if they came near her (a modification of anthropophobia and perhaps claustrophobia); dread of paralysis, strokes, insanity, and other diseases (nosophobia), and of death (thanatophobia); dread of going into the street (agoraphobia), so that she would stay indoors for weeks, always taking care to lock the doors after her husband went out in the morning. Her symptoms had existed more or less for ten years, but had been worse for four. At the former date she had had all her upper teeth extracted under ether, at the latter she had gone through a difficult labour lasting thirty-eight hours, and about the same time had received a severe wound on one of her wrists. To the dental operation she attributed her first symptoms, to the obstetric one and the injury, their exacerbation. She had fits of agitation at the menstrual periods, and all her symptoms were then aggravated. Latterly she had been indulging in strong tea and vi-cocoa.

Dietetic treatment, bromide of ammonium, and tonics relieved the urgent symptoms in a week or so, and I saw no more of her for a year. She then called and said she was just recovering from what she termed a "blue fit," in which she had a choking sensation and thought she was dying, as she fancied she had burst a blood-vessel. She was still somewhat cyanosed and said she felt the blood running all over her (angioparesis). This

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occurred during a menstrual period in the first two days of which she had been unusually well. Tested with a pin the cutaneous sensibility showed no anomalies; but the points of a pair of compasses were first felt as two beyond 35 mm. on the back of the right hand, beyond 6 mm. on the palm, 4 mm. on tip of middle finger, on back of left hand beyond 19 mm., palm 10 mm., tip of middle finger 3 mm., right side of forehead 6 mm., left 12 mm.; in all cases transversely.

I prescribed ammonium bromide, valerian, ammonia, and gentian, with cascara tablets, and have not heard of her since.

An unmarried lady, æt. 40, of neurotic heredity and presenting degenerative stigmata, having been for some time neurasthenic, acquired a morbid dread that some evil would befall her parents. This was much intensified when she was away from them. She also felt afraid in narrow confined spaces (claustrophobia). She fancied she heard burglars in the house at night when no one else heard anything. In addition to these auditory, she had olfactory hallucinations, as well as visual illusions. Her symptoms were worse at the menstrual periods, she then becoming troublesome and violent. She finally acquired the delusion that she was being poisoned by her relatives, and her attacks of excitement became more frequent and pronounced, so that she had to be removed to an asylum, whence within a year she was discharged relieved.

A married lady, æt. 47, of neurotic heredity, four years after the menopause and fifteen after the birth of her last child, had, in addition to various neurasthenic and climacteric symptoms, a constant great dread of some vague danger and a fear of walking alone in the street, lest she should fall or have one of her so-called "fits" of numbness and weakness of the whole of one side (probably vaso-motor).

Perchloride of iron with sodium bromide and mag. sulph., in addition to out-door life free from fatigue, together with some extra rest in bed, and the deletion of strong tea from the dietary gave much relief.

Fear of railway travelling (siderodromophobia) and fear of precipices (cremophobia) were presented by the second case under the head of phrasal obsessions.

Visional obsessions are exemplified in the case of obsidional aberration with verbal obsessions already mentioned. The

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patient said that when he looked at anything he could not get the image of it out of his mind.

In the third case of phrasal obsessions reported here the patient was beset by the vivid thought or mental image of a child with its throat cut when the visual illusion, the immediate cause of the obsession, was itself not present.

The above classification is not quite logical and may have other imperfections, but the divisions will perhaps serve to pigeon-hole most of the many and various cases which come under no heading so well as that of obsessions. Some of the phrasal obsessions will perhaps be looked upon as instances rather of pseudo-hallucinations—Baillarger's psychical hallucinations—than of obsessions. At first I thought they were psychical hallucinations, but on closely interrogating the patients I was convinced that, except during exacerbations, these phenomena could not be regarded as even pseudo-hallucinations without much perversion of the usually accepted meaning of the term hallucination.

The dictum that obsessions originate exclusively in the associative centres and psycho-sensory hallucinations in the sensory can hardly be maintained. It does not seem to hold in the common "catchy refrain" obsession, or where there are those auditory hallucinations in which the patient, to his surprise, hears total strangers not only repeat conversations which have taken place in his own home, but discuss events which have occurred there.

The symptoms most akin to or resembling obessions are impulses, psychical or psycho-motor hallucinations, and delusions as to matters of faith. Those obessions which only arise under certain circumstances, *e.g.*, agoraphobia, mysophobia, astraphobia, are perhaps most akin to such an impulse as that which causes persons to throw themselves from lofty structures or heights, and the less common one to use a weapon on a man who happens to be near it. But in obsessions the fear or dread is the motive of any action that may take place, whereas in impulses the dread, if there is any, is lest the suggested deed should be accomplished.

Although Magnan's definition of an impulse, *i.e.*, a morbid impulse, has been adversely criticised on the ground that the impulse should always include the act, it seems to me that his definition, (8) "A mode of cerebral activity which impels to

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acts which the will is *sometimes* powerless to prevent," meets the case better than any other.

The morbid impulse may follow the phrasal obsession, or it may arise suddenly from a physical or mental immediate cause as a sort of cerebral reflex without the intervention of an obsession; it may culminate in the imperative act, or it may not; but the obsession, the impulse, and the act are distinct and separate. Such minor quasi-physiological phenomena as the irresistible or almost irresistible tendencies to count, touch, remove, drop, or lift various objects are rather obsidional impulses than obsessions.

Responsibility is manifestly less in the reflex or quasi-reflex impulses than in those which are preceded by phrasal obsessions as their immediate cause. When the former impulses are strong enough to overpower the will there is no interval for thought as in the impulses arising directly out of obsessions. The patient, whose case is the second reported under the head of phrasal obsessions, was always at his worst when these reflex impulses were most in evidence.

That phrasal obsessions are totally different from verbal psycho-motor hallucinations a few examples will show. Marie (9) reports three good cases in which the patient either thought he himself spoke against his will, or that others borrowed his voice and spoke through his mouth. Marie refers to another patient whose persecutors made him talk against his will. Sérieux (10) also records a case in which the patient thought she spoke in her own throat and called herself "thief," and another (11) in which the patient heard people speaking in her mouth.

These phenomena are such as might be expected from excitation of the nervous elements which retain the motor residua of speech in the inferior frontal cortex, if excitation of those elements is capable of producing hallucinatory phenomena at all. I venture to think, however, that many so-called psycho-motor hallucinations are merely psycho-sensory, located by the patient in some part of his body. But the verbal and phrasal obsessions appear to be due to mild erethism of a few of the elements of the sensory word centre in the temporal region. In the third case under the head of phrasal obsessions the inciting thought first sprang into the patient's mind and was followed by the tendency to utter it—a tendency which the patient checked by counting, sometimes aloud. In verbal

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psycho-motor hallucinations or in any phenomena resulting from erethism of the posterior part of the inferior frontal cortex, speech, or the sensation of having spoken would be primary.

That these phrasal obsessions, due probably to mild erethism of isolated groups of psycho-sensory, and never, I venture to think, psycho-motor cortical elements, may, during exacerbations, become so intensified as to be described as "loud thoughts" or even "voices in the head," and to that extent become psychical hallucinations, is apparent from the cases reported under the head of phrasal obsessions. But the patients had never any doubt as to the subjective nature of the phenomena. They felt as if their thoughts had got out of hand, and they were ashamed of their nature, and half inclined to repudiate them.

It is quite conceivable that still more intense erethism, with perhaps some implication of elements belonging to a lower sensory level, would produce the effect of external sounds and so give rise to true psycho-sensory hallucinations, those called by the patients "communications" or "commands." Verbal obsessions may be a rudimentary stage of psycho-sensory hallucinations of foul epithets and be capable of development by intensification and downward extension. I cannot say, however, that I have yet seen these transformations.

Delusions as to matters of fact cannot be confounded with obsessions, but certain so-called delusions as to matters of faith, fixed ideas, only differ from such obsessions as nosophobia and belief in non-recovery in that the patient is capable, in his best moods, of being reasoned, temporarily at least, out of the latter. But during exacerbations the obsession differs no more from the faith delusion, *e.g.*, the soul being lost, than the fact delusion that the subject is a giant differs from the fact delusion that he is the Creator. If the incorporation ot the morbid idea with the ego is the only diagnostic criterion between obsessions and delusions then is the difference in many cases merely one of degree. On the other hand, morbid fixed ideas as to matters of faith, so-called delusions, are often, as in some of the cases here reported, associated with symptoms which are markedly obsidional.

Neuropathic heredity and neurotic constitution are almost invariably factors in the etiology. A sexual element in some form or other is nearly always present, and often there is a

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history of exhausting illness, prolonged vigils, fright or other emotional shock, or some striking utterance.

A condition of mental or nervous exhaustion is not by any means always a factor in the etiology. A medical man, æt. over 70, able, energetic, unselfish, by no means neurasthenic, is beset by the idea or dread that it might be thought his father, a fiery-tempered man who died of coarse brain disease supervening on morbus Brightii, was insane. Periodically he requires reassuring, and although he is fairly easily reassured, anything in the shape of an example or illustration only leads to further questionings. In replying to the lengthy communications in these cases, brevity is indeed the soul of wit.

There seems at times to be a toxic element in the etiology or in the development and transformation of symptoms, as in the case of obsession of salicylic origin already mentioned. A small, pale, nervous-looking man, æt. 22, suffered from various obsessions, *e.g.*, sudden apprehensions that something, even fatal, might happen to him, wondering if he was really in the place where he actually was, wondering for an instant if he was really talking to the person to whom he was actually talking, fear that he could not get up from a chair on which he was sitting although he said he knew he could get up if he tried, sense of impending suffocation in the early morning. This last sensation was relieved by alcohol first taken to excess some years previously to counteract an attack of anthropophobia which had prevented him going out of doors for three months. The alcohol relieved the anthropophobia and the choking sensation, but induced the apprehensive wondering state above described, together with clutching sensations at the back of the neck, and a state of general fidgety restlessness. In addition to alcohol he was taking a concoction of coca, kola, etc., described as cocoa.

Some of the symptoms would seem to point to a vaso-motor factor in the pathogenesis, as well as to erethism of isolated groups of neurons or whatever else the nervous elements may ultimately prove to be. In some of the cases, the association of verbal or phrasal, manual and visual symptoms suggests the affection more especially of the cortex round the Sylvian fissure, and of the angular gyrus or the occipital lobe.

Psychologically a species of devolution or dissolution appears to take place, the highest and last evolved form of control, that of

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the thoughts and emotions, being the first to be lost, then the control of the actions, and finally, if the case proceeds, more or less blurring of consciousness.

During exacerbations in cases where the obsessions are essential or in the later stages of cases in which they are merely symptomatic the phrasal obsessions approach a lower level—psychical hallucinations; dreams are prolonged into hypnogogic hallucinations; mere passing doubts and dreads become fixed and incorporated with the ego; attention and memory are weakened.

There is in some cases a state of puerility, and in *folie du doute* the interrogative condition of the mind often resembles, so far as certain matters are concerned, that of an inquisitive boy of four or five years of age. In other cases again, the doubts and dreads indicate a state of pusillanimity more or less extreme.

Therefore, where they can be carried out, therapeutic measures directed to the removal of the cause, to the correction of the vaso-motor defects, and to the subduing of the neuronic erethism, combined with a form of re-education suited to each patient individually, would seem, at present, to offer the best chance of amelioration or cure.

Hypnotism might, under favourable circumstances, fulfil some of the indications, where the obsessions are not too importunate or are at times in abeyance. It is most likely to be useful in those cases in which it is applied under circumstances necessarily excluding the obsession, as in agoraphobia, for example. My own experience of it has not hitherto been very favourable, but the cases were experimented on as a sort of *dernier ressort* and were necessarily bad, viz., severe cases of phrasal obsessions and of nosophobia.

It might be worth while to mention here the case of a neurotic youth, æt. 21, who was beset by the not uncommon idea, almost amounting to a delusion, that he had seminal emissions every night. Hypnotism and various drugs had not the slightest beneficial effect. But after a year's associated outdoor and indoor exercises with general hygienic measures he appears now to be on the fair way to recovery.

(1) *Ann. med.-psychol.*, Mar.—Avr., 1896, quoted by V. Bourdin.—(2) *Lancet*, April 20th, 1901.—(3) *Ann. med.-psychol.*, Mar.—Avr., 1896.—(4) *Lancet*, August 9th, 1902.—(5) *Med. Ann.*, 1902.—(6) *Ibid.*, 1902.—(7) *Ibid.*, 1902.—(8) *Ann. med.-psychol.*, Mar.—Avr., 1896, quoted by V. Bourdin.—(9) *Journ. Ment. Path.*, June, 1901.—(10) *Ibid.*, July, 1901.—(11) *Arch. de Neurol.*, 1894.

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