Obsessive-Compulsive Disorder: Its Conceptual History in France During the 19th Century

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Until the 1850s, obsessive-compulsive phenomena were considered to be a variant of the old notion of insanity. Around this time they became a separate disease: first, as a member of the old class of the neuroses; then, briefly, as a variant of the newly formed notion of psychosis; and finally, as a neurosis proper (in the post-1880s sense). These changes reflected theoretical shifts in the definition of the grand psychiatric categories. After 1860, organic causal hypotheses for OCD included dysfunctions of the autonomic nervous system and cortical blood supply. Psychological hypotheses suggested the OCD might result from volitional, intellectual, or emotional impairment, the last of which predominated after 1890. Issues relating OCD to personality types and hereditability were dealt with in terms of the degeneration theory. By the late 1880s, OCD achieved full clinical and nosological definition.

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OBSESSIVE COMPULSIVE DISORDER (OCD) includes interloping and iterative thoughts and/or actions that may interfere with or paralyze behavior. OCD may be accompanied by declarations of distress, characterized by resistance, interference, and the presence of insight. In spite of revived interest in OCD, its nosological status, natural history, and classification remain unclear.

Assuming that OCD-like behavior phenomena existed before the 19th century, it is plausible to expect that words and concepts were marshalled to define them. If so, the history of the words (historical semantics) and concepts (conceptual history) require separate analysis. They were affected differently by the epistemological break that changed the psychiatric discourse during the early 19th century.

The concepts involved in the current definition of OCD were tooled during the 19th century. This review focuses on the French psychiatrists responsible for its formation. German and British work is comparatively less important, and has been dealt with elsewhere.

HISTORY OF THE WORDS

Since the Medieval period, Latin terms such as obsessio, compulsio, impulsio, and scrupulus were adopted by the European medical community to deal with OCD-like phenomena. A number of vernacular terms served a similar function in ordinary language.

As part of the 19th-century drive for description, French psychiatrists coined the following noun and adjectival phrases to name clinical phenomena, which included OCD: manie sans délitre, folie raisonnante, monomanie raisonnante, kleptomanie, idées fixes, idée irresistible, délire avec conscience and délire sans délitre, idées restrictives or mobiles, pseudomonomanie, folie lucide, folie or monomanie avec conscience, délire de toucher, folie de doute, délire
emotif,25 obsessions pathologiques,26 folie des héréditaires dégénérées,27 and crainte de souillure.28

These categories also referred to clinical phenomena other than OCD. Since Pinel, manie sans délire and folie raisonnante described forms of insanity unaccompanied by delusions (i.e., that escaped the conventional intellectual definition of insanity).29 Prichard’s concept of moral insanity was but an Anglicized version of this category.30

The inclusion of OCD under folie raisonnante proved unsuccessful. This category had no conceptual machinery to explain the presence of thoughts which, although persistent and disturbing, did not qualify as delusions (clinical observations demonstrated that some sort of insight seemed to be present).31

After the 1850s, OCD was redefined within a new category, “folie avec conscience” (insanity with insight). The transfer was dealt with in a famous debate in the Société Médico-Psychologique.32 By temporarily surrendering the lack-of-insight criterion (central to the concept of delusion), psychiatrists supporting this category allowed a number of disorders such as OCD, agoraphobia and panic disorder, and hypochondriacal and homicidal monomanias to be classified as insanities. Folie avec conscience disintegrated by the end of the century under the pressure of the advancing (and narrower) Kraepelinian view of psychosis33; by then, OCD was also given an alternative clinical and etiological interpretation.

HISTORY OF THE CONCEPT

The First Half of the 19th Century: Esquirol (1772-1840)

Esquirol14 opened a new clinical space for OCD when he classified the disease of Mlle. F as a form of volitional monomania (délire partiel). He defined this category as “involuntary, irresistible, and instinctive activity”; the patient is “chained to actions that neither his reason or emotion have originated, that his conscience rejects and his will cannot suppress.” Esquirol noticed that Mlle. F described her thoughts as irresistible and hence seemed to have insight. He concluded that such irresistibility reflected a weakness in the volitional faculty. Diseases of the will remained a popular subject in French psychiatry until the end of the century.34,35

The view that the OCD was a partial insanity or monomania did not last long. The concept of monomania, never very popular, declined in the 1850s.36 Critics claimed the following faults (1) it had resulted from a mechanical application of Faculty Psychology37; (2) it encompassed too many clinical states and hence had little or nothing to say about individual phenomenology38; (3) it was based on cross-sectional observation and had no conceptual machinery to handle longitudinal symptom-changes39; (4) it handled subjective symptomatology poorly which, since the 1840s, had become an important aspect of the definition of mental disorder29; and (5) it created legal difficulties.40 The category was sounded its death knell41 at the 1853-1854 debate of the Société Médico-Psychologique in Paris. Its disappearance set the category of OCD asunder.

The Second Half of the Century: Morel (1809-1873)

Morel25 described OCD as a member of a category he called délire emotif, and which he considered not as “an insanity but as a neurosis, that is, a disease of the emotions.”25 He wrote: “what I call ‘délire emotif’ corresponds to a particular type
of fixed idea and abnormal act whose existence, however, does not entail an involvement of intellectual faculties." For example, the drive leading to the compulsion resulted from a heightened affective state. Morel's use of the word délire was unconventional in that it allowed for the presence of insight. 42

Analysis of his seven cases confirms the broad nature of the category that also included vasomotor and digestive symptomatology, phobias, dysphoria, unmotivated fears, fixed ideas, and impulsions, as long as there was no cognitive impairment. Janet's concept of psychasthenia 43, 44 followed this grouping very closely.

Three reasons explain the success of délire emotif: first, the towering reputation of Morel; second, it provided an alternative to the German view that OCD was a thinking disorder similar to paranoia 45; and third, it allowed for the classification of a variety of anxiety-equivalents. 46 Luys 47 suggested that since ideas, emotions, and actions had separate cortical localization, nervous excitation might give rise to bizarre ideas, involuntary emotions, or compulsive acts. Luys disagreed with Morel's view that all vegetative functions were localized in the ganglionar system. 47

Reclassification of the OCDs as a form of neuroses reopened the possibility that they might result from nervous involvement of areas of the brain related to cognition, emotions, or volition. Once again, it must be remembered that in 1866 the word "neurosis" was only half-way through its long development. 48

Morel's view has been echoed in the history of psychiatry, particularly in the 1960s by Beech and Perigault, 3 and later by DSM-III-R, 49 where OCD is classified as an emotional disorder. However, neither of these efforts has solved the objection raised at the time against Morel's view: why the so-called insanities with insight, in spite of their common origin, are so clinically dissimilar. The belief that there was no need for a generic name for such a heterogeneous group of disorders won the day and the concept of folie avec conscience faded way.

Dagonet (1823-1902) and the Concept of Impulsion

While obsessions were defined vis-a-vis the concept of delusion, compulsions required separation from impulsions, a class of symptoms including all manner of paroxysmal, stereotyped, and (apparently) involuntary actions.

The explanatory force of the term "impulsion," (imported from the science of Mechanics), 50 resulted from its analogical use that alluded to vestigial behaviors, drives, cravings, and appetites. This helped psychiatrists to explain apparently unmotivated seizural and episodic behavioral phenomena. In addition to OCD, impulsive insanity also included phobias, homicidal and suicidal tendencies, manic behavior, hypochondriacal preoccupations, and even epileptic seizures. 51, 52

The concept of impulse was ambiguous poised in two different dimensions. In one, it was used both as a description and as an explanation; in the other, it was considered as either reactive or endogenous. From a historical viewpoint, the earliest view was that it was of inner origin. 52, 53

Versions of impulsive or instinctive insanity, based on Faculty Psychology, 30 were in circulation in European psychiatry as early as 1810. According to Faculty Psychology, the will was a separate mental function, and hence susceptible to independent impairment. 30 Pinel 12 and Georget 54 included cases with impétuosité de penchans in this category of manie sans délire or non délirante. Esquirol's 14, 55
notion of monomania\textsuperscript{56} brought the disorders of the will into the mainstream of psychiatry.

After the decline of the notion of monomania, the monomaniac impulsive syndromes were included in the category of impulsive insanity, thus named by Marcé and Foville.\textsuperscript{52} Dagonet offered a clinical and taxonomic analysis and concluded that any patient suffering from insanity might display "impulsions violentes, irresistibles." The latter could be primary or secondary to delusion, pathological affect, or hallucinations. They could be of short duration or chronic.\textsuperscript{52} They "resulted from a failure of the will." Dagonet included in this category clinical phenomena in which "the more one tries to discard an idea, the more it becomes imposed upon the mind, the more one tries to get rid of an emotion or tendency, the more energetic it becomes."

\textit{Legrand du Saulle (1830-1886)}

Consolidation of the clinical description of the OCDs was achieved in the work of Legrand du Saulle,\textsuperscript{57} who reported 27 cases (11 his own) in 1875. He recognized that OCD patients were admitted to the hospital only when severely ill or complicated by psychotic symptoms or depression. He was aware of OCD's fluctuating course, insidious onset, and tendency to symptom-change with time. He classified OCD as one of the varieties of insanity with insight, reporting that it had early onset, occurred more frequently in women, affected individuals from higher social classes, and occurred more frequently in fastidious and rigid personalities.

A believer in longitudinal analysis, he identified three stages in OCD. In the first there were "involuntary, spontaneous and irresistible thoughts on various subjects without illusions or hallucinations"; with a "feeling of doubt, of brooding," and occasionally, "mental representations and images" of the repetitive thoughts. These symptoms engendered fears and anxieties and led to the establishment of rituals.

In the second the condition was characterized by unexpected revelations made to relatives or friends of the presence of symptoms often kept secret for years. Depression, anxiety, agitation, and suicidal ideas might also appear together with suicidal brooding, but rarely led to self-harm. Patients could also develop animal phobias, somatic (e.g., vasomotor) symptoms, rituals, fear of touching objects, abnormal cleanliness, hand washing, and eccentric behaviour. Insight was not lost and doubt became less bothersome. Symptoms followed a fluctuating pattern with a course punctuated by attenuations and remissions.

The third stage included major compromise of psychosocial competence, rituals, and obsessional paralysis. On follow-up, (often longer than 20 years), some patients had become house-bound and maintained only a semblance of insight; they showed a typical "double book-keeping" type of behavior and examination revealed a darker, almost psychotic side. There was no evolution towards dementia.

Although his work transits the old and new concepts of insanity, some confusion may be caused by Legrand du Saulle's quaint usage of the terms \textit{neuroses} (in its pre-Morel meaning), and \textit{déliire}, (one of whose renditions is delusion), to refer to obsessions.\textsuperscript{42} Legrand du Saulle wrote this book 9 years after Morel's paper,\textsuperscript{35} and he accepted the latter's view that OCD was primarily a problem of emotions. But, his great clinical acumen, applied to the analysis of 27 cases (the largest series published up to that period), led him to identify forms of behavior that went beyond what was considered acceptable for the neuroses of his time. So, although paying lip
service to the neurosis theory, the book suggests something that has since become an important issue, i.e., the presence of psychotic symptoms in OCD.

There is yet another point that may confuse the reader; it relates to his inclusion of animal phobias, agoraphobia, vasomotor phenomena and other somatic symptoms, panic disorder, and probably some cases of partial epilepsy with complex seizures. With regard to this, remember that Legrand du Saulle was writing in 1875, that these clinical states had not yet been separated from the nosological viewpoint, and that during this period somatic symptoms were freely included as part of the definition of mental disease.

This attitude vis-à-vis somatic symptoms changed when Freud's theories became available. Psychiatrists then felt unable to include somatic symptoms among the primary symptoms of psychosis (e.g., the vasomotor changes of catatonia), and either ignored them or regarded them as secondary and accidental. Those who have studied Janet’s work have realized that he maintained the boundaries for OCD exactly where Legrand du Saulle had drawn them 30 years earlier, i.e., including phobias and epileptic states in OCD.

Ball (1834-1893)

Ball suggested eight operational criteria for OCD: insight; sudden onset (patients may remember the very day the disease started); paroxysmal nature (severity increases in certain periods, and winter is a period of calm); fluctuating course (there are long periods of remission); no cognitive impairment; release of tension after the compulsion has been carried out; high frequency of somatic and anxiety symptoms; and family history, although acquired obsessions are common.

Ball classified OCD according to the following states: minor (obsession only), moderate (additional presence of anxiety and major hesitations), and major (compulsions also). As precipitants he listed tiredness and fatigue, major life events, puberty, sexual problems, pregnancy, puerperium, and menopause. Ball's view was that OCD resulted from impaired brain circulation, but strongly advised against the use of morphine. Ball's criteria became popular.

Magnan (1835-1916)

Magnan classified mental disorders into organic, psychosis proper, and states of mental retardation. The second group he subdivided into mania, melancholia, chronic delusional state, intermittent psychosis, and psychosis of degeneration (folie des dégénérés). OCD was included in the latter category together with phobias, agoraphobia, sexual perversions, and hypochondriacal states. OCD and its variants, onomatomanie (repeating obsession) and erythromanie (facilité extrême à rougir, i.e., blushing), together with the other disorders, were assumed to result from cerebrospinal pathology. They were also assumed to “develop only in subjects affected by degeneration . . . and merit to be considered as the psychological stigmata of degeneration psychosis. . . .” Following the same model, Ameline suggested cerebral entropy as an explanation for the disorder.

Ladame summarized Magnan’s contribution well:

“The majority of authors, following Morel, have considered heredity as an important factor in obsessions. None of them had, however, considered the symptoms themselves as a direct sign of pathological heredity. This is what, with great success, has been done by Magnan. The various
clinical presentations of obsessions and impulses are for this distinguished alienist episodic syndromes of the psychosis of degeneration. They are true psychological stigmata. . . ."

**ETIOLOGICAL DISPUTES**

As mentioned previously, there were three psychological hypotheses that accounted for OCD. The emotive and volitional views were more popular in France while the intellectual view predominated in Germany,62 where Westphal63 suggested that *Zwangvorstellungen* (obsessional presentations) resulted from a primary dysfunction of intellect.8 However, his operational definition of obsessions differed from that of the French; he refused to give up the lack-of-insight criterion for delusions (Wahn).8 Instead, he asserted that obsessions were an ego-dystonic variant of fixed ideas. Westphal's intellectual view received varying degrees of support from Tuke, Magnan, Cramer, Wernicke, Ziehen, and Darnbluth.

The emotive view remained popular among the French, and toward the end of the century began to spread. (It was supported by Aschaffenburg, Kraepelin, Freud, Hartenberg, Bleuler, and Stocker.)

The volitional theory, started by Esquirol and Billod, decreased in popularity during the third quarter of the century, only to undergo limited revival in the work of Ribot, Arnaud, and Legrain. Thus, Arnaud64 suggested that aboulia, a severe volitional deficit, was the primary impairment in OCD:

"Amongst obsessives, whatever their severity, aboulia is always present and always precedes the disease; its permanence explains the obsessional state . . . emotional accompaniments, and ideas play an important role but are secondary in the pathogenesis of obsessions. . . ."

He stated that the error of the intellectual view resulted from the belief that ideas were primary ingredients in any form of behavior.29 Legrain,65 a follower of the physiological views of Luys,26,66,67 also proposed a version of the volitional hypothesis.

On the other hand, Haskovec,68 better known for his description of pre-neuroleptic akatisia, considered the emotional aspects of OCD to be secondary and argued in favor of a version of the intellectual view. He believed that the emotive view resulted from the analysis of samples that had been contaminated by phobic and anxious patients. He proved his point by analyzing a sample of OCD patients (n = 100) that contained such confusing symptoms,69 concluding that

"sometimes the visual image of the phobic object triggers the obsessional idea, and this, in turn, heightens the emotion; the patient may, for example, see an axe, and this will trigger the obsession of killing a loved one."68

Among psychiatrists writing in French, Haskovec was the exception. By the turn of the century, when Janet was collecting both cases and hypotheses to write his book *L'Obsession et la Psychasthénie*,43 practically everyone supported the emotive hypothesis.

**CONSOLIDATION OF THE EMOTIVE VIEW**

The emotive view proved popular not only in relation to OCD, but also to clinical states such as abulia69 which, during the first half of the century, had been considered as a form of volitional disorder. Anxiety-based explanations became acceptable not only because great men were espousing them, but because the second
half of the century was a period of revival for all the aspects of affectivity and emotion, and their relationship to the autonomic nervous system. This shift was encouraged not only by the internal logic of research in psychology and psychiatry, but also by the fact that the non-emotive explanations were found lacking. In addition, there was the Zeitgeist factor: in France this was a period of heightened social anxiety. Zeldin suggested that anxiety increased

"... in the sense that traditional supports of behaviour were weakened, that people were left facing a larger world and a vastly greater range of problems, with far less certainty as to how they should treat them, and often with sharper sensibilities."

In turn, this seems to have put a great deal of clinical pressure on physicians, as the type of complaints brought to them fell well outside the range of traditional insanity concepts. Related explanatory concepts such as neurasthenia, psychasthenia, surmenage, and phosphate deficiency thus became very popular.

Therefore, research by psychologists (who were often philosophers, also) took place against a background of emotivité and was encouraged by changing philosophical winds blowing in favor of the emotive view. Conditions in which affective symptoms featured prominently were a natural target for this change. From the methodological viewpoint, the following belief started during this period: The best way to learn about normal function was to study it during disease. Towering among researchers during this period were Luys, Ribot, Féré, and the other members of the School of Paris (Paulhan, Janet, and Binet).

There soon developed a philosophical reaction against the materialism and intellectualism propounded by psychiatrists such as Baillarger and Morel. This reaction, in a country that, despite Pasteur and Bernard, never ceased to worry about its spiritual needs, was strong, and the emotive hypothesis rode high on this yearning. The reaction was led by Lemoine and Janet (1823-1899) in particular. It began in 1867 with the publication of the latter's Le Cerveau et la Pensée. Janet, who greatly influenced the work of his nephew, Pierre, was the standard-bearer of the emotive tradition in French philosophical psychology, started by Maine de Biran, and kept alive by illustrious philosophers such as Royer-Collard (whose brother was a psychiatrist), Cousin, Jouffroy, and Ravaissone. In his popular Paris lectures, Janet insisted that feelings and emotions were at the center of psychological organization.

ISSUES OF CLASSIFICATION

The clinical phenomena covered by the French categories délire emotif and folie avec conscience were the same as those presently covered by the sections "Anxiety Disorders" (or "Anxiety and Phobic Neuroses") and "Impulse Control Disorders Not Otherwise Specified" in DSM-III-R, except that they also included vasomotor phenomena (e.g., Reynaud's disease). After the 1860s, these two categories absorbed most of the clinical states included under folie raisonnante, which was consequently narrowed down until it reached its final definition in the work of Serieux and Capgras.

After 1900, the gradual teasing out of folie avec conscience into OCD, panic disorder, anxiety disorder, phobic anxiety, and vasomotor phenomena, took place in France under the influence of historical factors such as the narrowing and psychologization of the neuroses (à la Freud), and relentless clinical research.
The analysis of the process of disintegration of *folie avec conscience* is beyond the scope of this review, but can be followed in the work of Brissaud, Souques, Devaux, Logrée, Guede, Claude, and Levy-Valensi.79-84

**PSYCHOLOGICAL BACKGROUND**

*Ribot (1839-1916), Féré, and Paulhan*

Of the French psychologists of the second half of the 19th century, Théodule Ribot is probably the best known and certainly the most influential.85,86 With regard to OCD he wrote:

"The mental state called 'insanity of doubt' or ruminative mania is to the irresolute character, what abulia is to the apathetic character. It consists in hesitation over futile issues, and incapacity to make decisions. The hesitation affects the intellectual sphere and the patient faces endless self-questioning . . . If 'psychological rumination' (as Legrand du Saulle states) was all that there is, we should have nothing else to say; but the perturbation of intellect translates itself into acts. The patient dares not do anything without taking endless precautions. If he writes a letter, he reads it many times, egged on by the fear of having forgotten or misspelt a word . . . This is a disease of the will resulting from weakness of character and accompanied by pathology of the intellect. In a way, it is to be expected that obsessional ideas will become translated into empty acts, not adapted to reality; in this process, however, individual factors play a role; and we have found a decrease in vitality ('abaissement du ton vital'). Evidence for this factor is to be found in the nature of the diseases which may cause it (hereditary neuropathies, debilitating illnesses), and in the fainting that may follow efforts to overcome the problem etc. . . .35"

In his *La Pathologie des Emotions*,87 written under the influence of Ribot, Charles Féré (1852-1907) undertook the description of all clinical phenomena related to morbid affectivity, including OCD. His list was large, as he believed that "there existed no mental activity unaccompanied by sentiment of some kind." However, he used the term "emotion" in a general sense to name all affective states.88 His central claim was that, generally, intellectual and volitional symptomatology were secondary to primary morbid affect.

He offered a fourfold classification of clinical phenomena falling within the category of morbid emotivity, according to whether or not arousal and emotivity were diffuse or systematic (focused on a particular trigger or area), and whether or not the functions were increased or decreased.87 In the first group (diffuse and increased), he included all general or free-floating anxiety states; in the second (diffuse and decreased), the stupors; in the third (systematic and increased), specific phobias and OCD; and in the fourth (systematic and decreased), sexual deficits. He reported a number of cases that demonstrated frequent overlapping of symptomatology. He parried the obvious criticism that his systematic and increased group was resurrecting the affective monomanias by claiming that patients in this category always present intellectual pathology, i.e., abnormal mental contents acting as triggers for the emotional response. This was not the case for the monomanias.

Frederic Paulhan's main work includes an analysis of the concept of character89 (on which Ribot based the chapter on the same topic in his book on emotions), and of the emotions.90 On the latter, like Ribot, he espoused an epiphenomenic view and conceived of the emotions as psychophysiological phenomena subject to the laws of evolution.70 As Höföding91 showed, Paulhan's hypothesis that elementary feelings can be combined into composite ones, could also be used to account for the phenomenon of doubt. For example, when hope and fear are present in equal
strength, he believed that “doubt results, whose central feature is anxious restlessness that may lead to rash decisions to stop the anxiety caused by the hesitation. . .”

Féré and Paulhan, with their enthusiastic support for the psychological and physiological analysis of the emotions, spoke a language that psychiatrists could understand. They made sure that the emotive view of OCD reigned supreme.

Pitres (1848-1928) and Régis (1855-1918)

Pitres and Régis\(^2\) defined obsessions as

> “a morbid syndrome characterised by the anxious experiencing of parasitical thoughts and feelings which force themselves upon the self and lead to a form of psychical dissociation whose final stage is a splitting of the conscious personality . . . we do not hesitate to consider emotions as the primitive and fundamental element of the obsession.”

They defended the emotive view at the Twelfth International Congress of Medicine in Moscow in 1897, but rejected the Freudian sexual hypothesis.

In their book, which deals with obsessions, impulsions, phobias, and panic disorder, Pitres and Regis rejected the view that panic disorder (névrose d’angoisse) was a separate entity; instead, they considered it as a syndrome that could become grafted upon OCD, anxiety disorder, or depression. They reported 110 cases (the largest series until then) in which 63% had clear emotional precipitants, and 80% had relatives suffering from some form of mental disorder. Age of onset was before 30 years, and the disease, more common in women, was divided in ideational and compulsive varieties.

The Aftermath: Janet (1859-1947)

Janet owes much to the work of his predecessors, including Pitres and Régis. His contribution, as his coworker Raymond\(^3\) once said,\(^4\) must be considered to be more theoretical than clinical. For Janet, OCD resulted from a dislocation of function; they were an engourdissement of the mind that required no anatomical substratum.\(^5\) Obsessions were but the experiential or subjective concomitant of a feeling of incompleteness that resulted from a defect in the “function of the real.” This amounts to no more than a metaphorical redescription of how patients often respond in relation to their inability to bring tasks to completion. Janet carved out psychasthenia from the already inflated category of neurasthenia.\(^6\)\(^,\)\(^7\)

Psychasthenia, itself an over-inclusive category, soon became the new giant of neuropathology.\(^8\) In l’Automatisme Psychologique,\(^9\) Janet considered obsession as an idée fixe which, together with hallucinations, constituted “simple and rudimentary forms of mental activity.”\(^10\) Psychasthenia was essentially an etiological term and hence could not have clear-cut descriptive clinical boundaries.\(^11\) Rather, it relied on theoretical mechanisms such as a reduction of psychological tension and incompleteness (inachèvement).\(^12\)\(^,\)\(^13\) Schwartz\(^14\) was right in referring to it as “a cluster of symptoms artificially demarcated to which the predominance of a ‘typical (causal) mechanism’ conferred a particular aspect.”

Indeed, analysis of the 236 cases reported by Janet shows that psychasthenia included, in addition to OCD, panic, phobic and tic disorders, hypochondriacal and confusional states, and some forms of epilepsy. Janet’s psychological approach firmly placed OCD in the territory of the neuroses, which also included at the time
neurasthenia, hysteria, and psychasthenia. This was to be reinforced by Freud. (See references 10 and 103 for a history of the psychodynamic hypothesis with regard to OCD.)

SUMMARY AND CONCLUSIONS

In conclusion, this review has demonstrated the following:

1. Between the 1830s and 1900, OCD was successively classified as insanity (monomania), neurosis (old definition), psychosis (new definition), and, finally, as a member of the newly formed class of neuroses.

2. The component symptoms of OCD also went through changes. Obsession had to be separated from delusion (délire), and both of them from their common ancestor, idée fixe. This process was completed by the 1870s. However, it must be remembered that the French word délire means more than the English term “delusion.” Compulsion, in turn, had to be separated from the term “impulsion,” i.e., the name for a parent class constituted by all forms of paroxysmal, episodic, stereotyped, and irresistible behavior. This second process took longer to be completed.

3. Three theories accounted for the psychogenesis of OCD: volitional, emotive, and intellectual. The former two were more popular in France, and eventually the emotive hypothesis predominated. By considering OCD to be a form of pathological or distorted emotion, it was possible to retain it as a functional disorder, at the same time maintaining its relationship to the autonomic nervous system. Very importantly, it was also possible to satisfy the ongoing fashion (which also influenced Freud) of interpreting most mental disorders as an impairment of emotional mechanisms.

4. The natural history of OCD, with its episodic course and varied symptomatology, was fully worked out before the turn of the century. Janet confirmed rather than created these findings.

5. The concept of degeneration played an important role in the formation of OCD. It provided a basis for the claim that a form of pathological personality might underlie OCD. It also provided a mechanism for the biological transmission of the disease. In the work of Magnan, OCD even became a psychological stigma of degeneration.

6. OCD, agoraphobia, panic disorder, and other anxiety disorders were traveling companions up to the end of the century. Their final teasing out was made more on theoretical (etiological) than clinical or epidemiological grounds.

7. The historical problem posed by OCD seems to have been that, although recognized since the 1830s as a sui generis cluster of symptoms, it did not elicit an imaginative response from psychiatrists; most tried to pigeonhole it into one of the ongoing clinical categories. This Occamian attitude might have encouraged great economy of thought, but has probably done little to increase the understanding of this fascinating and elusive condition.

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OBSESSIONS IN THE 19TH CENTURY

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