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Obsessive-compulsive symptoms and endogenous psychoses

ARTICLE

Igor Studart

Abstract

The nonspecific nature of obsessive-compulsive symptoms (OCSs) has been recognized since the era of classical psychopathology, whether due to their presence during the course of endogenous psychoses or their episodic/chronic manifestation in severe non-psychotic disorders. Adopting a phenomenological-dialectical perspective, this study aims to highlight the structural significance of OCSs within the context of endogenous psychoses, limiting the scope to clinical-psychopathological observations. Initially, the relationship between OCSs and manic-depressive illness is discussed. In melancholia, temporal retroversion and the objectification of time foster the emergence of obsessive phenomena; conversely, in mania, the expansion of the "Self" pole dissolves the obsessive impasse, pointing to opposing structural relationships. Next, schizophrenia is examined through the classic case of Lola Voss (Binswanger). Lola develops complex superstitions, a "compulsion to read," and a "phobia of clothing," eventually progressing to persecutory delusions. Binswanger questions whether delusional ideas can emerge from obsessive ideas or if both are expressions of the same "Delusional Mood." In this case, obsession and delusion intertwine, forming "graded shades of psychic structures." A diachronic analysis of the case allows for bridging classical clinical practice with contemporary research—such as the study by Egea-Fernandez et al. (2024), which identifies two phases of OCSs in patients taking clozapine: a first phase correlated with psychotic severity, and a second linked to the drug's serum concentration. The first phase finds a parallel in the Lola case, while the second prompts investigations into "body memory" and corporeality as dimensions involved in antipsychotic action. It is concluded that the integration of a phenomenological reading with contemporary empirical data broadens the understanding of SOCs in endogenous psychoses, shifting the focus from isolated symptoms to phenomena rooted in the totality of the psychopathological experience, and enabling an examination of the interface between diagnosis, structure, and therapeutic intervention.

Keywords: Diagnosis; Endogenous psychoses; Obsessive-compulsive disorder; History of psychiatry.

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Sintomas Obsessivo-Compulsivos e Psicoses Endógenas

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ARTICLE

Resumo

A inespecificidade dos sintomas obsessivo-compulsivos (SOCs) é reconhecida desde a psicopatologia clássica, seja pela sua presença no curso de psicoses endógenas ou de forma episódica/crônica em afecções não psicóticas graves. A partir da perspectiva fenomenológica-dialética, este trabalho busca evidenciar o significado estrutural dos SOCs no contexto das psicoses endógenas, restringindo-se a comentários clínico-psicopatológicos. Inicialmente, discute-se a relação entre SOCs e doença maníaco-depressiva. Na melancolia, a retroversão temporal e a objetivação do tempo favorecem a emergência de fenômenos obsessivos, enquanto na mania, a expansão do polo do Eu dissolve o impasse obsessivo, indicando relações estruturais opostas. Em seguida, examina-se a esquizofrenia por meio do caso clássico de Lola Voss (Binswanger). Lola desenvolve superstições complexas, "compulsão de leitura" e "fobia de roupas", evoluindo para delírios persecutórios. Binswanger questiona se ideias delirantes podem emergir de ideias obsessivas ou se ambas seriam expressões de um mesmo Humor Delirante. No caso, obsessão e delírio se entrelaçam, formando "tons graduados de estruturas psíquicas". A análise diacrônica do caso permite articular a clínica clássica com pesquisas atuais, como o estudo de Egea-Fernandez et al. (2024), que identifica duas fases dos SOCs em pacientes em uso de clozapina: uma primeira, correlacionada à gravidade psicótica, e uma segunda, à concentração sérica do fármaco. A primeira fase encontra paralelo no caso Lola; a segunda suscita investigações sobre a "memória corporal" e a corporeidade como dimensão implicada na ação antipsicótica. Conclui-se que a articulação entre leitura fenomenológica e dados empíricos contemporâneos amplia a compreensão dos SOCs nas psicoses endógenas, deslocando o foco de sintomas isolados para fenômenos enraizados na totalidade da experiência psicopatológica, e permitindo pensar a interface entre diagnóstico, estrutura e intervenção terapêutica.

Palavras-chave: Diagnóstico; Psicoses endógenas; Transtorno obsessivo-compulsivo; História da psiquiatria.

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The[1] nonspecificity of obsessive-compulsive symptoms (OCSs) had already been recognized by classical authors of descriptive psychopathology, whether because of their appearance in the course of endogenous psychoses (Bleuler 1924), or in episodic or chronic form in severe cases of non-psychotic affections (Kernberg 1967; Hoch and Polatin 1949). Within the phenomenological-dialectical sense, we could situate these occurrences as anthropological disproportions (Messas 2021). Starting from this observation, my aim will be to evidence the meaning of OCSs from their structural relation with the group of endogenous psychoses, taking as a point of departure the phenomenological-dialectical perspective of these structures. Knowing, however, that all structures could be submitted to such scrutiny, I chose to exemplify this with Schizophrenia, starting from a classic case in the literature.

Due to limitations of time and space for the present discussion, we will make strictly clinical-psychopathological comments, without dwelling on hermeneutic-biographical analyses. It is important to recognize, however, that this choice leaves out one dimension of the phenomenon: its relation with the internal history of the patient's life. Even so, this delimitation will allow us to shift the focus from symptoms — taken in isolation — to phenomena, in which the relation to the totality of psychopathological experience is already embedded in the very perception of these manifestations (Tatossian 2024).

Obsessive phenomena are ambiguous (Tatossian 2024). The typical alteration of "pure" obsessive disorder already reveals a modification of the sympathetic union

[1] **Translator's Note:** This translation was produced with the assistance of artificial intelligence, specifically ChatGPT, model GPT-5.5 Thinking, developed by OpenAI. The model belongs to the family of large language models and features advanced natural language understanding and generation capabilities, with particular proficiency in academic, technical, and humanistic registers across multiple languages.
The translation was carried out from Brazilian Portuguese into English, following a section-by-section methodology, with systematic review of terminological consistency, preservation of the author's stylistic choices, and faithful rendering of the conceptual vocabulary proper to the semantic field of the text. Every effort was made to neither omit nor add ideas to the original text, respecting as closely as possible its argumentative organization, linguistic style, and conceptual density.
All quotations incorporated into the body of the text were translated directly from the version of the article provided for this activity, without independent consultation of source texts or alternative editions of the cited works.
The AI-assisted translation was conducted on May 23, 2026, and supervised by Fábio Luiz Socreppa da Fonseca. The translated version was subsequently submitted to the author for review, consideration, and approval, which was granted on June 18, 2026.
Readers are advised to consider that, while every effort has been made to ensure accuracy and fidelity to the original text, AI-assisted translations may present limitations in capturing highly context-dependent expressions, stylistic nuances, or culturally situated meanings. Any queries regarding the translation may be directed to the supervisor.

with the world (Straus 1948), very well captured in Fukuda's expression "psychic autoimmunity" (see Fukuda et al. 2023 for a recent and comprehensive review). In summary, spatially, this condition is characterized by the "stalling" of the structure through a kind of vision of the total world, due to the adoption of multiple perspectives, in which a leveling-down toward action thus becomes impossible. From the temporal point of view, it would be precisely the triumph of the anti-eidos over the eidos, of the characteristics of permanence over those of transformation. This global configuration of subjectivity bears resemblance to typical alterations of the classical psychotic structures, due to its processual, incomprehensible aspect, in certain cases (Daker 2014).

We thus arrive at the central point of this meeting: the relation between OCSs and endogenous psychoses. I choose this specific focus in the hope that a gaze by contrast between manic-melancholic and schizophrenic experiences may highlight the similarities and differences of obsessive phenomena in different structural senses.

The proximity between OCSs and affective psychoses had already been recognized by Kraepelin (1907). In the phenomenological tradition, von Gebsattel (1966) points to the similarity between melancholic and obsessive temporal experience. In melancholia, the temporal retroversion that characterizes vital inhibition leads to a spatial condensation resulting from the objectification of time. How does this relate to OCSs? The patient, a desperate spectator of his vital inhibition, manifests contents with a compulsive veneer precisely through this temporal objectification. Thus, obsessive phenomena become, as von Gebsattel beautifully puts it, "wave crests that render visible and empathic the inexorable flow of time."

If melancholic temporal experience bears a great similarity to the emergence of obsessive phenomena, in mania we observe the opposite. The formula of the "manic leap" (Binswanger 1971) is especially elucidating: with the lightness and expansion of the pole of the I, mania dissolves the impasse characteristic of obsessive phenomena. In sum, melancholia acts synergistically with OCSs, whereas mania establishes an antagonistic relation. This observation offers us a therapeutic lesson: interventions indicated in the treatment of OCD, such as exposure and response prevention (ERP), antidepressants, and psychosurgery, share

characteristics analogous to those of manic conditions, insofar as they produce an unevening of experience that breaks the perspectivist impasse of this structure.

Let us now turn to schizophrenia. To compare the field of schizophrenic experiences requires some prior precautions. The first of these is the very delimitation of the concept. The problem of the inappropriate blurring between psychotic and non-psychotic alterations — through the simplistic equation of illness with the refusal of self-realization (Tatossian 2024, Conrad 1958) — is here avoided by adhering to a clinical-psychopathological approach, without hermeneutic ambitions. Another delicate point is the definition of cases of schizophrenia. As Schneider said, we could fall into the maxim that it is impossible to speak of "schizophrenia" itself, only of "what I call schizophrenia." In order to avoid entering the fertile, yet labyrinthine, "nosological Babel" that surrounds these cases, I have chosen to follow a classic clinical account: the case of Lola Voss, published by Ludwig Binswanger in Schizophrenie (1963). The choice of this case is justified for two reasons: first, because it offers clinical material sufficiently rich to examine the intersection between obsessive-compulsive symptoms and schizophrenia; second, because it allows us to articulate the classical canon of phenomenological psychopathology with possible dialogues with more recent research — remembering that Schizophrenie was already conversing, in its own way, with the psychiatry of its time. I therefore make a brief digression to present the case in general terms, highlighting the aspects most relevant to our question: the relation between so-called obsessive-compulsive symptoms and schizophrenia.

Lola Voss was born in South America, the daughter of a German father and a mixed-race mother. In childhood, she had a stubborn temperament, was very spoiled, and was considered somewhat "masculine" by the standards of the time. Her intelligence was average. In adolescence, she studied in boarding schools in Switzerland, maintaining a tendency toward isolation. At the age of 20, she met a Spanish physician who would become her fiancé. Until then, there had been no clear signs of mental disturbance. At the age of 22, during a trip to a spa in Germany with her mother, Lola began to present what seemed to be superstitions. Initially, she demanded that a certain item of clothing be removed from her luggage. She then began to interpret the sight of a hunchbacked man as a sign of good luck, while the sight of a hunchbacked woman meant a bad omen. The following year, she remained in Europe while her fiancé sought to establish himself professionally. During a stay

with relatives in Germany, she came to believe that everything that came from her mother was "bewitched" and began to get rid of pieces of clothing, underwear, and even hairbrushes that had any connection with her. She saw several physicians and received all manner of treatment proposals, always strongly resisting speaking about her superstitions. At the age of 25, she was admitted by her family to the Bellevue Sanatorium. Binswanger begins his notes on the case by emphasizing that Lola was a skillful liar, something that, added to her resistance, escapes, affective indifference, emotional coldness, the already mentioned "childish stubbornness," and unpredictable behavior, evidenced an asymmetry between her age and her psychic development. In addition, Lola showed great fear of being inadvertently hypnotized by the nurses, requiring constant reassurance, possibly a first indication of experiences of passivity. She always wore the same clothes, and her superstitions broke through even when she tried to conceal them. After a change of physicians, she began to feel more comfortable and revealed that the superstitions had begun six years earlier. She reported that they had started during a stay in New York with her grandmother and other relatives, including the fear related to clothes and the superstition concerning hunchbacks, both men and women. In general, Lola lived seized by the constant fear that something bad might happen. After meeting her fiancé, these ideas worsened and gradually extended to countless situations. For example: upon seeing four pigeons, she interpreted this as a sign that she would receive a letter—since the number "cuatro" contained the letters c-a-r-t, as in "carta." Her tendency to interpret everything exhausted her, especially in social contexts. The associations were almost infinite, extending across several languages. The condition worsened about eight months after her admission, when a nurse appeared with an umbrella similar to Lola's father's. From that point on, through complex chains of connections, she constructed the idea that everything was interconnected among the staff members, her family members, and her fiancé, bringing bad luck to the future marriage. Accompanying her on walks was difficult: she saw "yes" and "no" in everything, as though she fitted signs into the environment. When she needed to go out shopping, for example, she would go with her eyes closed, because of the force with which the environment imposed meanings upon her. The case was so severe that Binswanger recorded that there were no conditions for exercising a "counter-compulsion," something that partly recalls contemporary exposure therapies. Lola alternated between moments of trust in the physician, asking for help, and active

resistance, driven by what she called an “indescribable fear.” After approximately 14 months at Bellevue, the family decided to allow the marriage and arranged a meeting with her fiancé in Paris.

There followed a four-year catamnestic period, accessed by Binswanger through correspondence with Lola, her family, and the physicians who cared for her. In the first weeks in Paris, she felt joyful and hopeful, although superficially so. She still maintained the idea that the nurse could harm her and began to have greater difficulty writing to her fiancé. Soon, she began to feel “infected with what we know.” She tried to distract herself with theater and other activities, without success, until, two months later, she asked Binswanger to recommend another sanatorium in the outskirts of Paris. She was then admitted under the care of Prof. Pierre Janet. According to reports from the family, she entered a hallucinatory-agitated state, avoided interpersonal contact, and remained almost always in her room, with rare moments of improvement. The physician responsible informed Binswanger: “She is not improving; the mania of doubts, the phobias, and the superstitious ideas persist, aggravated by hallucinations, ideas of influence, and a true persecutory delusion. This delusional psychasthenia threatens to evolve into chronicity.” Back in South America, Lola writes to Binswanger:

> Unfortunately, I did not write earlier to tell you that horrible people were after me and were spreading all kinds of bad things about me. I knew that they entered my room and watched me from outside with a greedy curiosity. I do not know them. I will tell you about them. (...) I feel very sad to be seen and observed for so long by these strangers. My family is influenced by them to believe that I am ill. Perhaps I may tell you more about this on another occasion. I would never have believed the things I discovered about these people.

Binswanger organizes the case psychopathologically into three stages. In the first two, the “reading compulsion” and the “clothing phobia,” Lola still moved within the field of the superstitious. The question he raises is: to what extent would we be dealing with an obsessional neurosis, and to what extent would these ideas already be delusional? The simple diagnosis of schizophrenia does not resolve this question, since the course of the illness may present a variety of psychopathological manifestations. Moreover, as Binswanger observes, there is no mental symptom that, at some point, could not be called “obsessive.” The fundamental question then becomes: can delusional ideas emerge from obsessive ideas? And, if so, to what extent would delusion and obsession be different stages — and in what way — of the same formal transformation on the anthropological plane?

Lola's "reading compulsion" presents a character distinct from "pure" obsessions: she resorts to the "meaninglessness" of superstitions in order to decide upon everyday life, extracting a "yes" or "no" from the objects around her. This differs from the typical obsessive patient, harassed by meaningless ideas that he seeks to neutralize. For Lola, the meaning of the world depended essentially on a higher sphere, transmitted by this "oracle." Behind the reading, there was also a possibly delusional system of interpretation that sustained this very possibility. However, the compulsory character of the experience, the "must" that accompanied it, remained present. This led Binswanger to consider the condition as a mixture of delusion and obsession, configuring "gradual shades of psychic structures." The "clothing phobia" raises the same question. What brings Binswanger closer to the recognition of a delusion is the feeling of exposure to a powerful "oracle of destiny" — Lola's system of interpretations — even though the lack of information about varied hallucinatory experiences, transitivism, and experiences of influence leaves the analysis incomplete. Finally, in the multiple persecutory delusions, Binswanger observes that the diachronic interpretation would not be that the delusions originated from the phobias and obsessions, but rather that these were already the expression of a fundamental Delusional Mood, that is, a profound transformation of the physiognomy of the world. Thus, Binswanger's reading shifts from the manifest symptomatic groupings — OCSs and delusions — toward the phenomena. This is the phenomenological mode of operation in psychopathology: a "new" experience of what is already known, seeking to reveal the underlying structure that formats "how" its objects appear to consciousness (Tatossian 2024).

It would still be worth asking whether delusions could function as a "cure" for an intense state of anguish. However, Binswanger dismisses this possibility:

> Lola, in her persecutory delusions, did not suffer as terribly as she had in the superstitious stage. But she did not herself cause these delusions, nor did she experience them as completion, strengthening, or consolation. In this case, we are thinking strictly in terms of 'normal psychology.' (...) Where there is delusion, there can no longer be any genuine I.

He criticizes two approaches that, according to him, account for the failure of psychopathology in this field: (1) attempting to understand and explain delusions in terms of normal psychology, and (2) declaring them scientifically "incomprehensible" and treating them as an enigma that, at most, could be explained by brain pathology.

The question then remains: why is the case of Lola Voss relevant when

contrasted with the contemporary literature on OCSs and schizophrenia? The first point is that it offers a way out of the endless debate over whether these symptoms function as risk or protective factors. By shifting our gaze to the fundamental organization of these manifestations in the pre-reflective stratum of consciousness, we open the possibility of viewing the question from the standpoint of a phenomenon of parallax, an apparent displacement of an object when we change the point of observation. What we observe here is schizophrenic autism, not in the sense of extreme introversion or of a "very vivid inner world," but as a fragmentation of the pole of the I on increasing scales of worlding. This leads us both to phenomenological readings of synchronic relations — phenomenological implication — and to those of diachronic relations — phenomenological causality (Sass 2014).

Through its diachronic exploration, the case of Lola Voss and Binswanger's observation regarding the possibility of obsessive-compulsive symptoms already implicated in a Delusional Mood allow, albeit diagonally and while respecting the epistemological limits of each method, an approximation with contemporary empirical research. For example, Egea-Fernandez and collaborators (2024) published, in 2024, in the British Journal of Psychiatry, a study showing that OCSs in patients using clozapine — a clinical problem that affects the most severe portion of these cases — present two phases: a first, obsessive phase, which correlates with the severity of psychotic conditions, and a second, compulsive phase, after the resolution of psychotic symptoms, which correlates with serum levels of the drug. The first phase finds a parallel in the unfolding of Lola Voss's condition. The second, however, would represent fertile ground for new investigations, since, even with the remission of positive symptoms — delusions and hallucinations — patients persist with verifications and checking behaviors, in a dynamic of habituation that would lead us toward the path of a "body memory" (Fuchs 2012). Corporeality, in this case, is one of the dimensions most implicated in the antipsychotic action of these drugs, through a process of opacification and increased preponderance within experience, which would be well metaphorized as a process of psychopharmacological grounding (Tamelini and Messas 2019). This is a question that Lola's case, due to historical contingencies, cannot answer. It will be up to us to investigate the relations between the specific actions of pharmacotherapy and psychopathological alterations. Not as isolated entities — e.g., the action of antipsychotics, the action of antidepressants — but by including the structural dynamic that receives the action of the drug. In other

words, a phenomenological analysis of the actions of pharmacotherapy that also considers the implications between diagnosis and therapy. I quote Petrilowitsch (1968):

> It is necessary to exercise great caution when assuming that certain psychic phenomena always possess a constant and clearly defined degree of significance. In psychiatry, we do not deal with units of monolithic simplicity, but with units characterized by a vast number of differentiable factors. Since the relative value of any component can only be determined in its relation to the others, we gradually observe a change of attitude tending toward the creation of systems of interrelation, which to some extent meet our need for an integrative and correlational view. This does not limit, as is often supposed, the value of psychiatric diagnosis, but rather increases it.

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