Psychogenic pseudo-Tourette syndrome: one of Dr Johnson’s maladies?

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It has been suggested that Dr Samuel Johnson was a sufferer of Tourette’s Disorder, now regarded as a distinct syndrome of tics and vocalizations consequent on a neurological abnormality. We describe here a superficially similar syndrome of apparently psychogenic origin that may have underlain some of Dr Johnson’s oddities.

Case history
JKS (not his true initials) was a 45-year-old science professor at a provincial British university who would from time to time surprise family or colleagues by twitching, wincing and pronouncing, usually in a normally loud speaking voice, words or short phrases irrelevant to the social context. This was a phenomenon that had developed from adolescence (he was uncertain about the precise age of onset) and by early middle-age had become liable to erupt, even when in company, if his concentration lapsed. There was no family history of neurological disorder. He described his childhood as having been lonely and unhappy and oppressed by an emotionally unstable and domineering mother. An early habit of conducting conversations with imaginary companions had continued through life as a tendency to speak his thoughts aloud when alone. Driven by parental pressure, he won scholarships to grammar school and university, but at the price of a perfectionism that subsumed constant anxiety that he was falling short of potential and expectation. From childhood and adolescence he showed minor obsessional traits, particularly relating to closing and locking doors, and he also had an abnormally intense distaste for the telephone. Episodes of depression from early life led to periodic bad behaviour in childhood and binge drinking as an undergraduate. At the age of 27 years, he had suffered a serious depressive illness that led to a serious attempt at suicide and some weeks of institutionalization with electroconvulsive therapy (ECT). Thereafter, minor and short-lived depressive episodes continued, but in the context of a happy and well-ordered marriage, alcohol intake had settled to a regular social pattern with a weekly intake of around 30 units. Tobacco use was limited to an occasional pipe.

Subjectively, the origin of his tics and vocalizations lay in a fear of particular thoughts that if uninhibited were liable to induce unhappy rumination and impulsively suicidal ideation. He described his mental landscape as resembling a relativistic space-time continuum pitted with the deep concavities of black holes into which his consciousness, unless firmly orbiting some professional or social interest, would inevitably roll. At the centre of each black hole was the memory of some unpleasant, embarrassing or humiliating event from his sometimes socially ill-tuned past. The problem became worse during periods of low mood or overwork. Once his consciousness started to roll towards one of the black holes he had found he could change its direction by the distraction of a tic and vocalization. The tics were most commonly a symmetrical or unilateral facial wincing with or without spasmodic flexion of the upper limbs, but sometimes repetitive wiping of a hand over the forehead and eyes. The vocalizations were from a limited but evolving repertoire of ritualized phrases, such as lines from poems (e.g. ‘Lars Porsena of Clusium . . .’), or songs (e.g. ‘Death, where is thy sting-a-ling-a-ling?’). Other phrases were more closely connected to their purpose – ‘have done with it’ and ‘shove it away’ reflected the effort to interrupt or re-direct his thoughts away from a threatening black hole. Some phrases, drawing on school-day memories and early Tractarian sympathies, were from Latin hymns or
the Anglican liturgy but uttered without prayerful intent. None was obscene although, as an experienced domestic handyman, JKS could be fluent in a relevant vocabulary. When alone he did not bother to inhibit the tics and verbalizations but was always able to suppress them when in company if his mind did not wander. His attempts to cover lapses included pleading neuralgia as the cause of the tics and he would continue verbalization into humming or singing as tunefully as he could manage on the spur of the moment.

Examination

On examination the only physical abnormality was a mild essential tremor.

Management

No treatment was sought. ‘No one is going to be seriously disturbed by meaningless vocalizations from a professor. My only interest is whether my condition is Tourette’s Disorder and its relation to what Dr Samuel Johnson called his “bad habit”.’

Discussion

Tourette’s Disorder is now generally accepted as being a neurological rather than psychological condition. The diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM) of 1994 comprise both multiple motor and one or more vocal tics occurring nearly everyday or intermittently over more than one year, onset before age 18 years and there not being any other identified cause. The criteria also included a requirement that the disturbance should cause marked distress or significant impairment in functioning but this was omitted from the 2000 revised text. Setting aside the uncertainty about age of onset, JKS’s tics and vocalizations could qualify for a label of Tourette’s Disorder and its relation to what Dr Samuel Johnson called his “bad habit”.

Dr Samuel Johnson had a number of diseases and features of medical interest that have been exhaustively documented. He certainly had scrofula, a right-sided fourth cranial nerve palsy, had been prone to depression since the age of 20, and ultimately suffered heart failure and a stroke. More enigmatic were the repetitive movements, tics, vocalizations and ritualisms recorded by friends and admirers and described in most collections of “Johnsoniana”. These have aroused much medical interest and speculation and seem to fall into three groups. Some were clearly obsessive-compulsive in nature, such as touching posts in the street, careful positioning of feet and counting of steps in order to enter rooms with a particular foot. Others involved continuous rocking of the body and, in particular, rotational movements of his hands apparently as an aid to his thoughts and rather resembling, it seems from descriptions and portraiture, the ‘unpacking’ gesture so characteristic of modern social scientists.

It is Johnson’s tics and apparently involuntary vocalizations that have raised the question of Tourette’s Disorder and are of relevance to JKS. James Boswell thought that all Johnson’s movements occurred both when actively engaged socially and when alone or in thought. Joshua Reynolds, Johnson’s ‘oldest and kindest’ friend, disagreed and wrote to Boswell: Dr Johnson ‘... could sit motionless, when he was told to do so, as well as any other man’. Mrs Thrale, another close friend, also noted that Johnson’s unusual movements vanished when he was in church. These descriptions by Johnson’s intimate friends are probably more reliable than Boswell’s. Reynolds’ opinion was that the abnormal movements ‘... proceeded from a habit which he had indulged himself in, of accompanying his thoughts with certain untoward actions, and those actions always appeared to me as if they were meant to reprobate some part of his past conduct. Whenever he was not engaged in conversation, such thoughts were sure to rush to his mind, and for this reason, any company, any employment whatever, he preferred to being alone.’ There is abundant evidence that Johnson was constantly fearful of a return of

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his depressions and of possible insanity, and company and conversation could distract him from such fears. There is also evidence that Johnson was much troubled by, and actively resisted, urgings from what he called his ‘amorous propensities’. According to Reynolds, Johnson himself said that the ‘great business’ of his life was to ‘escape from himself’.7 He would recite the Lord’s Prayer and the Apostles’ Creed to himself but ‘sometimes some words would emphatically escape him in his usual tone of voice’. There is no record of any obscene utterances. In reply to a child’s enquiry about his ‘strange gestures’ Johnson ascribed it to ‘...a bad habit. You must, my dear, take care to guard against bad habits.’7

It has recently become common to attribute Johnson’s oddities to Tourette’s Disorder but this is not a unanimous view. Earlier authorities, before Tourette’s Disorder became better recognized, considered them to be habit spasms or to reflect, in some unspecified way, emotional rather than neurological disturbance. Without any pathognomonic features or pathology, Tourette’s Disorder as currently defined is a commodious concept into which can be fitted almost anyone with a tic or two dating from adolescence. Coprolalia, widely regarded as characteristic of the condition, was exhibited by neither Johnson nor JKS, but is absent from a large minority, or even majority of diagnosable cases of Tourette’s Disorder. The obsessive-compulsive traits exhibited by Johnson, and to a minor extent by JKS, are often observed in sufferers and some writers consider them part of the full syndrome but in themselves can carry little diagnostic weight.

Relevant in linking the tics and vocalizations of JKS to some of the similar oddities of Johnson are: the history of depression; the conscious efforts to prevent a recurrence by suppressing particular thoughts; the sense of personal imperfections and guilt; and the fact that both Johnson and JKS could inhibit them. The greater prominence of Johnson’s tics and vocalizations, in comparison with those of JKS, presumably reflects in part a greater intensity of emotional and psychological disturbance. As a robust widower Johnson may also have had more trouble than JKS from his ‘amorous propensities’. In addition, a greater self-absorption and unawareness of, or unconcern for, the effect of his behaviour on other people may have contributed. Johnson was certainly fortunate in being surrounded by loyal friends rendered tolerant by their admiration for his formidable intellect and accomplishments.

Conclusion

Although potentially fulfilling a strict interpretation of the DSM criteria for Tourette’s Disorder as a neurological affliction, the psychological origin of JKS’s tics and vocalizations are inappropriate to that diagnosis. Psychogenic pseudo-Tourette syndrome, therefore, seems a better label. Perhaps this condition is more common than currently recognized and should be included in the differential diagnosis of Tourette’s Disorder. It also seems to offer a plausible explanation for some – not all – of Dr Samuel Johnson’s oddities.

References

3 Bliss J. Sensory experiences of Gilles de la Tourette syndrome. Arch Gen Psychiatry 1980;37:1343–7