

Progression of Neurotic to Psychiatric Illness and its Management Strategies: A Case History

Vibha Singh¹, Akanksha Chaurasiya^{2,*}

¹Assistant Professor, Department of Clinical Psychology, Central India Institute of Mental Health and Neurosciences, Rajnandgaon, Chattisgarh, India

²Assistant Professor, Department of Psychology, Government Degree College, Dhindhui, Patti, Pratapgarh, Uttar Pradesh-230138, India

ABSTRACT

Purpose: The purpose of this case report is to demonstrate the case of progression illness and its management plan. **Client description:** A 42-year-old male patient with a “Specific phobia with Obsessive Compulsive Disorder with Moderate depressive episode with paranoid schizophrenia”. During the interview, the patient reported that he is having fear of crowded places, height & blood, low mood, low self-esteem, repetitive thoughts, Nightmares about a snake, excessive cleaning rituals, suspiciousness towards surrounding people, and hearing voices. **Measures and outcome:** The Psychological assessment TCI indicates “obsessive-compulsive personality disorder”, Rorschach fulfilled the ‘coping deficit index’, TAT indicates fear of the environment, people or negative judgment by others, felt the anxiety of disapproval and punishment, Y-BOCS indicates “Moderate category of Obsession” and “Mild category of compulsive symptoms”, BDI-II indicates “Moderate depressive symptoms”, HAM-A indicates “Mild anxiety symptoms” and BPRS indicates “Mildly ill”. The MSE revealed that the patient had checking & sexual obsession, dirt & contamination obsession and cleaning compulsions, Agoraphobia, claustrophobia, hemophobia, acrophobia, hypnogogic hallucination, delusion of reference, delusion of persecution and delusion of infidelity, depressed mood and affect, suicidal thoughts, fair judgment with Grade 4 insight. The patient was diagnosed with “Specific phobia with obsessive-compulsive disorder with Moderate depressive episode with paranoid schizophrenia” by a psychiatrist and was prescribed Pharmacological and psychological treatment. **Management:** The pharmacological treatment through SSRI continued and specific symptom-based psychological therapy and intervention including relaxation therapy has been planned and given to the patient. **Implications:** This case study reinforces the importance of a thorough psychological evaluation to rule out other disorders. Further, it also presents a case with the progression of illness and treatment plan.

Keywords: Comorbid disorders, Obsessive Compulsive disorder, Psychiatric disorder, Multiple phobias, Progression of illness

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*Corresponding Author

Akanksha Chaurasiya

Assistant Professor, Department of Psychology, Government Degree College, Dhindhui, Patti, Pratapgarh, Uttar Pradesh-230138, India. Phone: 9026203128

E-mail: akanksha80884@gmail.com;
akanksha.chaurasiya1@bhu.ac.in

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KEY MESSAGES

As per the authors' knowledge, there are no known studies in the literature describing a case of a patient progression of illness from phobia to OCD and who was later diagnosed with depression and schizophrenia. This case report contributes to the existing literature on psychiatric diagnosis of a longer history of comorbid disorders. It also educates psychological therapists about the signs and symptoms of a progression of illness, diagnostic clarification, and management plan.

INTRODUCTION

The primary distinguishing feature of a phobia is the recurrent, irrational fear of a specific object or situation [1-3]. Exposure to the feared object or situation results in an immediate and intense level of anxiety, sometimes to the extent of having a panic attack. While some do not consider phobias to be true OC Spectrum Disorders, they do have obsessive-compulsive features that are quite similar to OCD. Also, phobias and OCD both involve intense, irrational fears and repeated avoidance of anxiety-provoking objects and/or situations [1].

Not everyone with OCD will develop psychosis, but for some people, it's possible to experience symptoms of psychosis [2]. Bleuler, agreed with Westphal that the entire obsessive-compulsive syndrome was a variant or prodrome of schizophrenia. Superficially, both conditions appear to share several features. Both occur early in life, are chronic and unremitting, and involve intrusive thoughts and bizarre behavior [4].

Patients with Obsessive Compulsive Disorder (OCD) have been traditionally described as having a good insight into their symptoms; they perceive their obsessive-compulsive (OC) symptoms as excessive, unreasonable, and distressing. Whereas overvalued ideas lie somewhere in the middle, and delusions where the beliefs are considered rational, lie at the other pole [5]. The distinction between this severe form of obsessive-compulsive disorder and paranoid schizophrenia may be difficult. In particular, more introverted obsessionals who tend to isolate themselves to avoid exposure of their problem may appear so distant and secretive that the label "paranoid" seems fitting. A useful, although not invariant, distinction is that the obsessive-compulsive patient is more likely to fear hurting others, whereas the paranoid patient is preoccupied with harm to himself. More importantly, patients with obsessive-compulsive disorder have a history of recognizing the senselessness of their obsession even though they may fail to resist it. It is this recognition of

senselessness that defines the idea as an obsession and not a true delusion [6,9].

The prognoses of most psychoneurotic illnesses are unknown. The future life course of a young adult with an anxiety state, phobia, or conversion responses stays speculative. There are very few studies that clarify what his psychiatric status will likely be 10 or 20 years afterwards.

Weiss and colleagues [17-19] have studied 36 patients on a longitudinal course in whom obsessive-compulsive symptoms reached into delusional syndrome. These patients did not have premorbid compulsive traits and hallucinations; their obsessions were frequently ego-syntonic, aggressive, and apparently less a defense than gratification of an instinctual need. Many had an episodic course with symptom-free intervals in which the patients seemed shy and introverted yet had the option to seek after their occupations.

Solyom et al. [20] found 8 of 45 obsessive-compulsive disorder patients to be atypical due to either severely weakening or close to delusional symptoms. Besides being all more severely ill, this atypical subgroup was distinguished from more typical obsessive-compulsive patients by an earlier age at onset and poorer social adjustment. On psychological testing findings, the atypical group showed less anxiety but no differences from the typical group on the Maudsley Personality Inventory or the Leyton Obsessive Inventory. Despite the fact that Solyom and colleagues described a poorer prognosis for their atypical obsessive-compulsive patients, a survey of their individual case histories reveals that only four received pharmacotherapies, and in two of these cases, the atypical obsessional symptoms resolved entirely with tricyclic antidepressant treatment.

Jenike et al. [21] have also researched a group of schizo-obsessive patients. In their cohort study of 43 treated patients meeting DSM-III criteria for obsessive-compulsive disorder, 14 (32.6%) met the criteria for schizotypal personality disorder. Such features in this subgroup as social isolation, odd speech, paranoia, and depersonalization, were younger than the more typical obsessive-compulsive disorder patients. As a group, these schizotypal patients were consistently refractory to pharmacologic and behavioral treatments, to the degree that these investigators suggested barring such patients from controlled therapeutic trials.

Therefore, the general purpose of this case study is to make a quantitative & qualitative assessment of progression of illness from phobia to OCD and later on developing into psychosis.

There are very few reported case studies that addressed phobias, OCD, depression, and paranoid schizophrenia in a patient simultaneously.

Aim: To present a case of 42 years old male for demonstration of progression of illness, diagnostic clarification, and discussion on a management plan.

CASE DESCRIPTION

A 42yrs old married man, educated up to class 10th, painter by occupation, belongs to a nuclear Hindu family, hailing from a lower socio economic status from urban background was referred to a govt. mental hospital with chief complaints of fear from crowded places, height & blood, low mood, low self-esteem, repetitive thoughts, nightmares about a snake, excessive cleaning rituals, suspiciousness towards surrounding people, and hearing voices.

Previously, the patient was maintaining well before 29yr ago. His psychosocial functioning was normal at that time. In 1990, one day he went to the temple and there was a large crowd gathered there. He started feeling suffocated in the crowd and was sweating profusely and had started feeling fear of crowded places so he avoids to go there. Gradually he started fearful of closed places and traveling also. After some time, he used to become fearful even by the imagination of going outside of the house and family gathering as well to escape from the crowd. Along with these symptoms, the patient started feeling fear height since 1992. In 1998, during a hospital visit he fainted while seeing the blood when doctor was inserting the intravenous cannula into her wife's arm after this incident, he started to avoid the hospital and have fear of blood. The patient reported that although he has fearful symptoms, his overall functioning was not very much affected till 1999 before the death of his maternal grandmother. After that incident, the patient started feeling very low and lonely. He started having trust issues and suspicious thoughts towards his wife. Gradually, the patient also started having suicidal thoughts and started feeling repetitive thoughts of cleaning and checking. As time passed, he was seen to be interacting less with people and liked to spend more time alone. His interest in sexual activity, appetite, and sleeping pattern was also disturbed. The patient also started complaining that during this period he started hearing voices as he was about to fall asleep at night. These incidents happened 3-4 times in a week. This behavior persists to date.

Along with the above symptoms in year of 2004, he noticed that he had excessive thoughts of sexual content. These

thoughts were very disturbing to him. He was preoccupied with these thoughts which interfered with his occupational functioning.

In 2013, after the death of his sister during her child's delivery, he started feeling fear of the police. Due to this incident, all previous symptoms' intensity increased several folds.

Approximately around 2015-16, he reports feeling fearful of snakes without any adequate reason. Dreams related to snake came every day. At times it was noticed by his family that, if anyone touched him while he was sleeping, he would suddenly wake up and be fearful about snakes crawling up his body and he checked it multiple times. This issue persists till date.

During this entire period of his illness, his predominant mood remained sad and because of his symptoms, he was not fully able to concentrate on his work and family responsibilities. His sleep and appetite were also found to be decreased. However, the patient was able to maintain his personal hygiene in entire period of time further the family members report being having a lot of stress because of such symptoms.

There was no history of head injury, seizures, psychoactive substance use, thoughts being controlled by others, thoughts getting known to others, or thoughts being taken away. Further, there was no significant family history found of any neurological illness and psychiatric illness in the patient's paternal and maternal family.

The MSE revealed that the patient had checking & sexual obsession, dirt & contamination obsession and cleaning compulsions, Agoraphobia, claustrophobia, hemophobia, acrophobia, hypnagogic hallucination, delusion of reference, delusion of persecution and delusion of infidelity, depressed mood and affect, suicidal thoughts, fair judgment with Grade 4 insight.

For all these complaints patient contacted a private psychiatrist at a clinic in march 2019 when he was diagnosed with "Anxieties NOS" & prescribed medication, which he took for about 2 months but not felt relief in his symptoms. Following then he contacted Govt. mental hospital in the month of May 2019 and since then he treated with a diagnosis of "Specific phobia with Obsessive Compulsive Disorder with Moderate depressive episode with paranoid schizophrenia" getting treatment at govt. mental hospital.

Presence of childhood disorders

At the age of 5yr's of patient, his parents left him with his maternal grandparents. Because they were living alone so they adopted him. After that, there was an issue between his maternal grandparents and his mother. They never came back to meet the patient for the last 12yr. The patient said he was feeling very alone in his childhood period. His maternal grandmother was very strict towards him. She didn't allow him to go out of the house to play. The patient didn't share his feeling with anyone. He was inactive in extracurricular activities. He had very less interaction with his batch-mate and teachers. His fear of rejection and inability to initiate conversations made it difficult for him to make friends in school. The patient has reported a lack of confidence by nature, very shy and simple kind of person. He is not able to face adverse situation easily, felt restless and tensed. He used to avoid conflicts, had excessive worry about criticism by others, was involved in thinking what others may think about him, had feelings that are easily hurt, fearful of the dominant person. His persistent and pervasive mood used to be anxious & sad. He is Socially withdrawn, miser, and hypersensitive to rejections. He has a negative attitude toward his body image.

Psychological evaluation of patients has been done in 3 sittings. The patient was cooperative during all test administrations. The details are as follows:

Test administered

1. **Temperament Character Inventory (TCI):** The inventory was developed by Cloninger (1987). It is used to assess the personality disorder and it is used to identify the 7 basic dimensions of temperament & character. The test is widely used and has significant reliability and validity.
2. **Rorschach Psychodiagnostics Test:** It is a widely used projective personality test developed by Herman Rorschach in 1921. The test is used to assess the structure of personality.
3. **Thematic Apperception Test (TAT):** This test is used to assess the dynamics of the personality. The test was developed by Henry Murray in 1930. The test is widely used to assess personality.
4. **Yale-Brown Obsessive Compulsive Scale (Y-BOCS):** The scale was developed by Goodman et al. (1989) to rate the severity of obsessive and compulsive symptoms in adults. The checklist has two parts: obsession and compulsion. The obsession checklist measures contamination obsession, aggressive obsession, sexual obsession, exactness obsession, somatic obsession. The compulsions symptom checklist measures contamination compulsion, checking compulsion, and symmetry compulsion. The scale is found to be reliable and valid.
5. **Beck Depression Inventory (BDI-II):** Beck Depression Inventory is developed by Aaron T. Beck in 1961. The inventory is widely used to measure the severity of depression. The scale is found to be reliable and valid.
6. **Hamilton Anxiety Rating scale (HAM-A):** This Anxiety rating scale was developed by Max Hamilton in 1959. The scale is used to measure the severity of anxiety symptoms in an individual. The scale is a reliable and valid test.
7. **Brief psychiatric rating scale (BPRS):** John E. Overall, and Donald R. Gorham, 1962 the scale is used to measure the positive, negative, and affective symptoms of psychiatric illness. The scale is highly reliable and valid.

Table 1: Pre-therapy score of the patient on a psychological test.

S. No	Name of Test	Scores	Impression
I.	Temperament Character Inventory (TCI)	<p>Temperament: Novelty seeking = 12; PR=10 Harm Avoidance = 18; PR=75 Reward Dependence = 13; PR=25 Persistence = 4; PR=15</p> <p>Character: Self-directedness = 25; PR=20 Cooperativeness = 30; PR=35 Self-Transcendence =11; PR=9</p>	Novelty seeking = Very low Harm avoidance = High Reward Dependence = Low Persistence = Very low Self-directedness = Low Cooperativeness = Average Self-Transcendence= Very low
II.	Rorschach Psychodiagnosics Test	<p>Lambda(L) = 0.94</p> <p>Number of responses (R) = 18 (above average)</p> <p>Positive finding: Patient fulfilled 'Coping deficit index'(CDI)</p>	Person lies on Obsessional Compulsive Disorder. It suggests that personality organization of the person is less mature than might be expected. This creates a vulnerability for problems in coping with the requirements of everyday living.
III.	Thematic Apperception test (TAT)	<p>Most of the stories project around theme of death and fear. Death, separation, suffering was shown, where a man suffers from an incurable disease and he was hopeless about his future. Outcome of all the stories was negative, with a main character dying or separated from loved ones. Need of the hero was nurturance & love. Significant conflict of hero is between his fantasy and reality. These are two incongruent goals but he did nothing to fulfill them. Hero does not accurately perceive and relate to his external environment.</p>	He has fear of environment, people or negative judgment by others only passively acted. He feels anxiety of disapproval and punishment
IV.	Yale Brown Obsessive Compulsive Scale (Y-BOCS)	<p>Total score on obsession =17 Total score on compulsion =13</p> <p>Total Y-BOCS score = 30</p>	Score on obsession indicates - "Moderate category of OCD" Score on compulsion indicates - "Mild category of OCD" Total score on Y-BOCS indicates - Moderate to severe category of OCD
V.	Beck Depression Inventory (BDI-II)	Score= 19	Moderate depressive symptoms
VI.	Hamilton Anxiety Rating scale (HAM-A)	Score= 20	Mild anxiety symptoms
VII.	Brief psychiatric rating scale (BPRS)	Score= 30	Mildly ill

Table 1 represents the test scores of assessments of patients done for the diagnosis and treatment plan. On the basis of scores and impression of patients, following diagnosis and prognosis has been made:

Provisional Diagnosis according to ICD-10

Specific phobia with Obsessive Compulsive Disorder with Moderate depressive episodes with paranoid schizophrenia.

Diagnosis according to DSM-5

Obsessive-compulsive spectrum disorder, Depression, Phobic Anxiety Disorder.

Prognostic factors:

Good: Insight about illness, educated, good compliance with medication

Poor: Adolescence onset, Poor support system of family, insidious onset, Personality disorder, long duration of illness

Management

The symptoms of the patients were managed through pharmacological as well as psychological therapy.

Pharmacological treatment

Patient is already receiving SSRI, Histamine and Anxiolytic drugs as pharmacological management from psychiatrist at GMA and will be asked to continue psychiatric consultation for the same.

Non-pharmacological treatment (psychological therapies)

First and second sessions of psycho education have been taken focusing on nature of illness. Third session, use of relaxation technique JPMR has been introduced. It has been adequately demonstrated to the patient and motivated to practice once or twice a day. Along with-it simple breathing exercises were demonstrated and he was suggested to use them as when anxiety increases. Fourth & fifth session, systematic desensitization for claustrophobia has been introduced & homework assignment was given to practice. Sixth session, psycho-educate the patient about OCD symptoms, & anxiety graph had been introduced. Seventh to nine sessions, behavioral intervention in the form of distraction techniques has been demonstrated.

Treatment Response

The patient has shown approx 40-50% decrease in all of his symptom's severity on the scales.

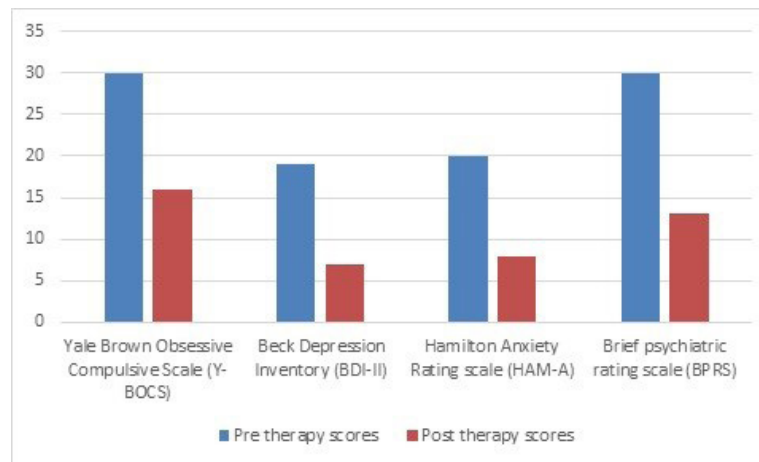


Figure 1: Bar diagram of psychological test score of pre and post therapy

The anxiety, depression, fear of environment, people or negative judgment by others, feeling of disapproval and punishment, and negative feelings have been significantly

reduced. The coping and personality organizations have been improved. The scores on psychological test have been significantly reduced (Figure 1).

Table 2: Comparison of Pre and post Therapeutic scores of patients.

Scale	Pre therapy scores	Post therapy scores	χ^2
Yale Brown Obsessive Compulsive Scale (Y-BOCS)	30	16	4.261*
Beck Depression Inventory (BDI-II)	19	7	5.538*
Hamilton Anxiety Rating scale (HAM-A)	20	8	5.143*
Brief psychiatric rating scale (BPRS)	30	12	7.714**

* Significant at .05 level

** Significant at .01 level

Table 2 indicates the changes in the scores of patients after treatment. The result table depicts that the pre-therapy Y-BOCS score was 30 which indicates moderate to severe obsession compulsion of the patient. After treatment, the score decreased to 18 which indicates a moderate symptom of obsession compulsion ($\chi^2_{df=1} = 4.261, P < .05$). Thus, the obsession compulsion symptoms have been significantly reduced in the patient. Similarly, the depression has decreased significantly ($\chi^2_{df=1} = 5.538, P < .5$) to the minimal level. Further, the anxiety score has significantly changed from moderate to mild category ($\chi^2_{df=1} = 5.143, P < .05$) after treatment. The psychiatric rating score of the patient has drastically decreased after treatment ($\chi^2_{df=1} = 7.714, P < .01$) and reached to absent psychopathology level.

DISCUSSION

This case demonstrates the significance of eliciting psychopathology in details description and for specific diagnosis and management plan in the presence of a clear history. Furthermore, recent studies indicate that 7% of those with OCD also have one or more phobias. In fact, a phobia may sometimes evolve into OCD, or vice-versa. Perhaps the most significant similarity linking phobias and OCD is the cyclical process by which the symptoms increase [1].

The complain of specific phobia is the recurrent, irrational fear of a specific object or situation [8]. The complain of with suspiciousness as the major symptom raised the possibility of psychosis. Additionally, the repetitive nature of own thought, which was stereotyped, automatic, uncontrollable, and causing distress pointed toward an obsession [3]. Patient was involved in excessive cleaning and checking rituals as compulsive nature, which provided some temporary relief to the anxiety caused by the obsessive thoughts. However, the good prognosis here was intact of insight of the patient into this thought phenomenon [7]. Depressive ruminations were another diagnostic possibility. The patient had a depressive

episode due to ongoing long-term unrecovered symptoms. Furthermore, depressive ruminations were usually associated with negative emotions regarding some past event, past childhood traumatic memories, and experiences, while in this case, the event appeared like an intrusive meaningless thought when it originated. [2] Pious [14] recommended that obsessional preoccupations and ritualistic ways of behavior helped to focus the schizophrenic patients, allowing some restoration of the sense of reality. Which shows a good prognosis for the illness. Insight into OCD had therapeutic implications such as good response to medications and prognostic implications, wherein, schizophrenic spectrum symptoms could lead to a worse prognosis. Rosen [15], in a survey of 848 schizophrenic patients, found that 3.5% had marked obsessional symptoms. For each case, the obsessional symptoms either preceded or coincided with the onset of schizophrenia. Be that as it may, only seven of these 30 cases addressed progress from an obsession to a delusion; in the rest of, obsessions were generally unaffected by the onset of schizophrenia. Like Stengel [16] preceding him, Rosen emphasized the depressive and paranoid quality of these obsessional schizophrenic patients, taking note further that these patients had a relatively good prognosis.

The continuity model between specific phobias, obsessions, depression, overvalued ideas, and delusions seems to be more satisfactory [5]. Although it calls for a careful analysis of the phenomenon in clinical settings and treatment choices. Experiencing psychosis with OCD is more common at times when OCD symptoms or anxiety levels are particularly high. Pharmacological, as well as psychological therapy, have a great impact on these symptoms. Further, family intervention, systematic desensitization for other left-specific phobias, and continued long-term treatment with behavioral intervention for OC symptoms can be implemented.

The study is very important in the sense that there have been few case histories reported in India that show a longer

duration of illness which develops gradually in different psychopathology into neurotic to psychotic illnesses. It is different from other studies because most of the studies show OCD with delusion symptoms only but this is a case where hallucinatory symptoms also got present with a good insight level which is dystonic to the patient. Although schizophrenic and psychotic depressive patients and patients with specific neurologic conditions might show obsessive-compulsive symptoms. The present study is that psychosis frequently rises out of and may try and exist within the range of primary obsessive-compulsive disorder. This is not simply a semantic idea, for it conveys a significant treatment implication. The findings of the study can be used for rehabilitation purposes, and its varying applications such as therapeutic management, medical systems, & medication combinations through which their quality of life and social skill could be improved.

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CONFLICT OF INTEREST

None declared.

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