REVIEW OF LITERATURE
CHAPTER 2

REVIEW OF LITERATURE

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REVIEW OF LITERATURE

The literature is related to neurotic disorder. An attempt has been made to review the literature available in the area of neuroticism. The literature has been divided into the three categories, viz., Anxiety, Phobia and Dissociative Disorder.

Psychology means 'study of the soul or mind'. Psychology is not only considering with behavior but also understanding the behavior of people in different situations.

2.1. PERSONALITY

Personality is the dynamic organization within the individual that determine his characteristic behavior and thought. Normal people exhibit satisfactory work capacity, they adjust well with themselves and their surroundings. The abnormal behavior deviates from society norms. It interferes with the well being of the individual or the group (Ullman and Krasner 1969).

Psychiatric disorders have traditionally been classified into two main groups, organic and functional. In the organic disorders physical aetiology can be established, the symptoms resulting from overt brain disorders as in dementia, acute delirium. In the functional disorders, there are no physical factors, it constitute the large majority of psychiatric
illness. Functional disorders separated into psychotic or neurotic, depending on the presence of certain psychotic symptoms. These are abnormal beliefs (delusions), abnormal perceptions (Hallucinations and Delusions) and certain disturbances in the pattern of thinking. Neurotic symptoms in contrast are mainly exaggeration of emotions such as anxiety and depression, which are universally experienced (Davidson’s 1996).

The two main classification systems currently used in clinical practice are the American Psychiatric Association’s Diagnostic and Statistical Manual (4th edition) usually represented as DSM-IV and the World Health Organizations. International classification of disease (10th edition) known as ICD-10, the ICD-10 is the more widely accepted.

2.2. ANXIETY DISORDERS

Anxiety neurosis, a diagnostic category first given prominence by Hecker (1893) and Freud (1894). Freud also describes how chrome anxiousness could easily develop into phobias and obsessions if transportation of affect allowed anxiety to be linked to specific (external) situations or (internal) thoughts.

Anxiety is an unpleasant emotional state with characteristic cognitive, behavioral and physiological components. For example, anxiety may involve feelings of worry and apprehension and may be accompanied by
increased pulse and respiration, sweating and by avoiding situations in which anxiety occurs.

Anxiety disorders are not caused by organic brain disease or another psychiatric disorders. Anxiety disorders are divided as follows in ICD-10.

1. Generalized anxiety disorders in which anxiety is unvarying and persistent.

2. Phobic anxiety disorders in which anxiety is intermittent and arises in particular circumstances.

3. Panic disorder in which anxiety is intermittent and unrelated to particular circumstances.

It was observed that phobias accompanied by marked panic attacks responded poorly to behaviour therapy and better to treatment with imipramine (Klein 1964).

2.2.1. GENERALIZED ANXIETY DISORDERS

The symptoms of generalized anxiety disorder are persistent and are not restricted to any particular set of circumstances. There are three characteristic features.

- **Worry and apprehension**, which are difficult to control and more prolonged than the ordinary worries and concern of healthy people.

The worries are widespread and not focused on a specific issue.
• **Motor Tension**, which may be experienced as restlessness, trembling inability to relax and headache (often frontal or occipital).

• **Autonomic hyperactivity**, which may be experienced as sweating, palpitations, dry mouth, abdominal discomfort and dizziness. Other psychological symptoms are irritability, poor concentration and sensitivity to noise, sleep is often intermittent and accompanied by unpleasant dreams, and for diagnosis the duration of symptoms should be several weeks to several months.

### 2.2.2. STUDIES RELATED TO ANXIETY DISORDER

The hierarchical system of classification, argued by Foulds (1976) and accepted by implication in most other system puts anxiety on the lowest tier.

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Disintegrated
Psychosis
(e.g. Schizophrenia)

Integrated Psychosis
(Manic-depressive, Paranoid)

Depression (Non-Psychotic)

Phobias, Obsessions, Hysteria, Hypochondriasis, Somatoform disorders

Anxiety
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The role of anxiety in a depression patient is to declare him morally guilty, which implies the inevitability of deserving punishment. The anxiety of these patients has in fact two aspects; moral and biological. Moral anxiety in cases of depression is also sometimes quite pathological as the individual becomes intensely preoccupied with possibility of punishment by supernatural forces. The biological aspects of these patients are in fact secondary to disturbances in regulation of his vital functions: loss of sleep, poor appetite, alterations in sexual functions etc. (Prick 1967).

In the life of a Schizophrenic patient’s anxiety plays a significant role. In the initial state of the disease, anxiety warns the patient that his existence is in danger; with the worsening of disease, anxiety is experienced by him as the dissolution of his own word. The schizophrenic’s anxiety may serve the patient as a protection against his environment, which he feels to be threatening. This anxiety affects his concept of the world, which becomes even more fearful and terrifying. Anxiety in such a patient renders him to be hypersensitive and his interpretation of the significance of the perceived world deviates from the norm. This abnormal interpretation results in a view of the world coloured by anxiety and by paranoid ideas.
Anxiety disorders in elderly populations have received relatively less attention. Increasing isolation of the elderly is a major problem. Similarly, retirement can be particularly difficult milestone to an elderly person. Real life burdens such as financial problems, fear of personal safety, caring for an ill spouse, problems of housing and difficulties in obtaining medical care are stress on that can precipitate anxiety or worsen preexisting disorders (Finalay-Jones and Brown 1981).

Insight oriented psychotherapy benefits the patients by helping them to understand the hypothesized unconscious meaning of anxiety, symbolism of avoided situations.

Role of cognitive behaviour therapy in OCD is well known but many controlled studies have also demonstrated it to be effective in other anxiety disorders (Butler et al., 1991; Crowe 1976). Most patients will experience a marked lessening of anxiety when given the opportunity to discuss their difficulties with a concerned and sympathetic physician.

Meditation and Yoga have shown promising results in anxiety disorders. Meditation is defined as a technique in which a conscious attempt is made to focus attention in a non-analytical way and gradually develop the ability to control the ruminating thoughts. The practice of meditation confects anxiety by reducing distractibility. Reduced distractibility and resultant improved concentration enhance personal and occupational
efficiency, which in turn induces a positive self-image and reduces the
level of anxiety (Trivedi 1995).

The combination of EMG feed back assisted relaxation and stress
inoculation training (SIT) is beneficial in the management of anxiety
neurosis (Abraham et al., 1993).

Several studies in the literature, which have used relaxation and cognitive
therapies in the management of clinical anxiety.

A patient with anxiety requires a complete neuropsychiatric evaluation
and an individually tailored treatment plan. The clinician is probably
most likely to treat the patient on the basis of symptoms present their
severity and the clinicians experience with various treatment modalities.
The most effective treatment is probably one that combines
psychotherapeutic pharmacotherapeutic and supportive approaches.

2.3. PHOBIA

A phobia is a persistent fear of some object or situation that presents no
actual danger to the person, and also may be defined as a fear of
particular object or situation. Normal fear for water harmless animals
closed places dark rooms are established due to childhood conditions.
Phobic anxiety disorders have the same core symptoms as generalized
anxiety disorders, but these symptoms occur only in particular
circumstances. In some phobic disorders these circumstances are few and
the patient is free from anxiety for most of the time in other phobic disorders, many circumstances provoke anxiety with the result that anxiety is more frequent. Two other features characterize phobic disorders, the person avoids circumstances that provoke anxiety, and he experiences anticipatory anxiety when there is the prospect of encountering these circumstances. The circumstances provoking anxiety include situations (for eg. crowded places), objects (for eg. spiders), and natural phenomena (for eg. thunder).

Phobic neurotics usually show a wide range of other symptoms in addition to their phobias, such as tension headaches, back pains, stomach upsets, dizzy spells and fear of “cracking-up”. At times of more acute panic, such individuals often complain feelings of unreality, strangeness and of not being themselves. In some instances, phobic neurotics also have serious difficulty in making decisions a condition that Kaufman (1973) has somewhat facetiously called decidophobia.

Phobic disorders are classified in slightly different ways in DSM-IV and ICD-10. In both systems phobic disorders are divided into simple phobia, social phobia, and agoraphobia.

2.3.1. SIMPLE PHOBIA

Simple phobia may be characterized by adding the name of stimulus, for eg. Spider phobia. Phobia of flying anxiety during aeroplane travel is
common. A clinical experience suggests that simple phobias that originate in childhood continue for many years, while those starting in adult life after stressful events have a better prognosis. In a study of over 2000 female twins the results from those with simple phobia fitted an etiological model in which a modest genetic vulnerability combined with phobic specific stressful events (Kendler et al., 1992a).

2.3.2. SOCIAL PHOBIA

Social phobic people tend to avoid such situations and not engaged them fully, for eg. they avoid making conversation, or they sit in a place where they are least conspicuous. Social phobia has to be distinguished from avoidant personality disorders characterized by life long shyness and lack of self-confidence. The causes of social phobia are not well understood. Socially phobic people are often preoccupied with the idea of being observed critically, though aware that the idea of groundless (Amies et al., 1983).

2.3.3. AGORA PHOBIA

Agoraphobic patients are anxious when they are away from home, and also crowd places and situations they cannot leave easily. Many situations provoke agoraphobic include buses and trains, shops and supermarkets and places that cannot be left suddenly without attracting attention. When the agoraphobia is severe involving many situations the distinction may
be difficult to make on the basis of current psychic state. Agoraphobic patients may have depressive symptoms; usually careful history taking and mental state examination will show which set of symptoms develops first. It has been suggested that once started, agoraphobia could be maintained by family problems.

Roth (1959) described the phobic anxiety depersonalization syndrome and suggested that it might result from a disorder of the temporal lobes. While most patients associated the onset of agoraphobic symptoms with a panic attack, some describe an onset without such an attack. In one study, two thirds of 260 new cases of agoraphobia reported an onset without a panic attack (Eaton and Keyl 1990). This finding is relevant to the theory that agoraphobia develops as a consequence of panic disorder.

As the condition progress, agoraphobic patients become increasingly dependent on the spouse or other relatives for help with activities, such as shopping, that provoke anxiety. The consequent demands on the spouse often lead to arguments, but serious marital problems are no more common among agoraphobics than among other people of similar social background (Buglass et al., 1977). Jones (1924a) exposed children to presumably frightening situations such as a dark room, being left alone, being suddenly presented with a snake, and so on.
2.3.4. STUDIES RELATED TO PHOBIA

Flooding is the continued exposure of the patient to the phobic situation until anxiety and avoidance responses are extinguished. This exposure is greatly facilitated when carried out in real life situations rather than in fantasy prolonged flooding in practice significantly reduces phobias (Marks, 1972). However, it may be that patients improve rapidly during in vivo treatment only after previous exposure in fantasy (Matthews and Gelder, 1974).

Stevenson and Hain (1967) insist that one does not consider merely a specific phobia; for example, fear of barbershop. There may be a dread of scrutiny by others, rebelliousness against social customs, impatience with delays, aversion to confinement, fear of mutilation, anxiety-arousing experiences with chairs resembling barber chairs; sexual arousal; issues of seniority; and other explanations for the phobia a multiplicity of stimuli that touch off the central response.

Relapses occur when the patient is pushed too fast, the phobic situation is reinforced, or a general overall increase in anxiety occurs. In a study of speed of generalization in systematic desensitization, Rachman (1966) showed that reductions in fear from imaginal to real-life situations occur almost immediately. Relapses, however occurred in slightly less than 50% of the occasions tested during the succeeding hours and days.
In general, very similar methods have been used to measure the existence and strength of phobia in psychiatric patients, but in a less systematic way. Three studies of special interest may be mentioned. Dixon, de Monchaux, and Sandler (1957) administered an inventory of 26 phobic items to 250 unselected psychiatric patients. The items are shown below:

Phobic items used by Dixon, de Monchaux, and Sandler.

I have an intense dislike of snakes

I am rather afraid of water

The thought of a surgical operation would terrify me

I am very uneasy when alone in a large open space

I am afraid of the dark

I worry about getting accidentally hurt

I sometimes have the fear of finding myself in a small-enclosed space

I am very nervous of knife

I am nervous when I am left alone

I feel uneasy when I am in a crowded space

I sometimes fear that I might drown

I hate dirty or dirty things

It generally makes me uneasy to cross a bridge or a main street

There is some situation or thing of which I am particularly frightened

I sometimes worry in case I might be involved in a street accident
I worry about the prospect of having to bear pain

I am frightened of mice or spiders

I dislike and distrust dogs

I dislike having my hair cut

For some reason I am very frightened of insects

Hospitals make me very nervous

I am very afraid of going to the dentist

I feel nervous when I have to go on a train journey

There are certain things I cannot bear to touch

I am rather frightened of cats

I worry about picking up germs or dirt from door handles

Lazarus (1961) directly tested the strength of a phobia by requiring the patient to perform the feared activity to the best of his ability (an acrophobic patient, for example, would be required to climb a blaze-escape; a claustrophobic patient would be required to remain in a small cubicle whose size was gradually reduced moveable screens).

Hoenig and Reed (1966) measured physiological concomitants of exposure to the feared objects or situations. Wolpe and Lang (1964), in constructing (FSS) Fear Survey Schedule-III, divided fears into a number of categories: animal; social interpersonal; tissue- damage, illness, and death; noises; other classical phobias; and a miscellaneous category.
Several factor analyses of the fear survey schedule or similar scales have been carried out recently, while the results are not directly comparable, these analyses all agree that the schedules cover a limited number of areas. Rubin et al (1968), for example, identified two factors (fear of water and fear of death, illness, or injury), which were common to males and females; and two factors (fear of interpersonal contacts and fear of discreate objects), which were less stable across sex differences, as might be expected.

Using the items and subjects mentioned earlier, Dixon, de Monchaux, and Sandler (1957) carried out a centroid factor analysis, which revealed seven factors, of which the first two were interpreted. The first was a general factor, loading positively on all of the items and accounting for 18.42% of the variance. The second factor, contrasted two types of phobias, those relating to fears of separation and those relating to fears of injury, hurt, or pain. The conclusion of this analysis was that monosymptomatic phobias (that is the existence of a single, relatively uncircumscribed phobia) would be the exception rather than the rule and that most patients would manifest a wide range of phobias.

Watson and Rayner (1920), in their famous study of “Little Albert”, did not actually get round to attempting to remove the fear they had produced in the child, but they suggest four ways in which the conditioned fear
response might be eliminated. The first of these involved the repeated presentation of the feared object, in the expectation that this procedure might lead to habituation. The remaining three techniques they suggested all involved the technique of reciprocal inhibition, namely stimulation of erogenous zones while showing the feared object, feeding while showing the feared object and building up constructive activities around the feared object by, for example, manipulation of it with the hands (obviously all of these methods but particularly the last would also have required desensitization procedures).

Freidman (1950) reported on the effects of short-term therapy with 50 cases of travel phobia (excluding sea and air travel phobias) and found 23 completely recovered, 15 improved and 12 unimproved. On the other hand, Errera and Coleman (1963) found that 18/19 phobic followed up by personal interview 22-24 years after treatment were essentially changed. A similar pessimistic result was reported by Kringlen (1965), with a follow-up at a mean interval of 30 years from the time of onset. Kringlen's group is also virtually an untreated control group as the mean treatment duration was only 2 months.

Little and James (1964) have recently reported the successful ether abreaction of a battle phobia 18 years after its onset, using the techniques described by Shorvan and Sargant (1947). The conclusion from this work,
unsatisfactory thought most of it is seems to be that polysymptomatic phobias are extremely resistant to psychotherapy.

Two studies by Lazarus (1959) and Lazarus and Abramovitz (1962), report-striking success with children and adolescents. Lazarus (1959) used four variants of reciprocal inhibition (feeding responses, relaxation, drug-induced relaxation and a special form of aversion-relief therapy) with 18 children aged 3½–12 years. With a follow-up period varying from 6 months to 2½ years, he claimed that all of the children recovered or were much improved.

Solyom and Miller (1967) who used a modified form of aversion-relief therapy involving the pairing of relief produced by shock termination with presentation of anxiety evoking verbal stimuli. The results with eight phobic patients were not particularly clear cut or encouraging, in spite of the rather optimistic conclusions of Solyom and Miller.

Marks and Gelder (1965), 20 agoraphobics and 11 other phobic states who had been treated by behavior therapy were carefully matched with similar cases treated by psychotherapy and rated blind on change in phobic symptoms and general improvement at five points in time: on admission; at the end of treatment; and one, three and 12 months after the end of treatment. The results indicated no difference in outcome for
agoraphobic patients (either symptomatic or general). Behavior therapy produced better results at the end of treatment for the other phobias.

No extended discussion of the results of behavior therapy with fears and phobias is required. Most of the studies provide no convincing evidence whatsoever of the efficacy of behavior therapy since, almost without exception, they reflect the influence of either (a) the uncontrolled case study, or (b) the medical-model paradigm for the assessment of the effects of a particular standard technique.

On other significant study should be mentioned here Lang et al., 1965 in a study already referred to found that a "Pseudotherapy" group of phobic did not differ in post treatment status from an untreated control showed significantly more change (improvement in real-life ability to handle snakes) than either of the other groups. The study is important because of the degree achieved of quantification of the intensity of the fear, thus making group comparisons of this kind more valid.
2.4. DISSOCIATIVE DISORDER (HYSTERICAL NEUROSIS)

The term hysteria is derived from the Greek word meaning "uterus". Hippocrates and other ancient Greeks that this disorder was restricted to women and that it was caused by sexual difficulties, particularly by the wandering of a frustrated uterus to various parts of the body because of sexual desires and a yearning for children, thought it. Thus the uterus might lodge in the throat and cause choking sensations, or in the spleen resulting in temper tantrums.

In ICD-10 the 10th revision of International Statistical classification of disease and related health problem previously used term hysteria has been replaced in the ICD-10 classification.

Chodoff and Lyons (1958) points out, the term “hysteria” has been used in a number of different ways to refer to: the “hysterical personality”; conversion hysteria; anxiety hysteria and a particular psychopathological pattern (including a particular psychosexual history). It has also as they point out been used as a term of opprobrium by psychiatrists for patients they find irritating and annoying (i.e., who arouse hostility in the psychiatrist).

2.4.1. HYSTERICAL NEUROSIS: (CONVERSION TYPE)

The conversion type of hysterical neurosis involves a neurotic pattern in which symptoms of some physical illness appear without any underlying
organic pathology. The hysterical patients demonstrating clear-cut conversion symptoms (such as hysterical blindness or deafness, anesthesia, paralyses and so on) will also manifest the hysterical personality syndrome.

Conversion type hysteria has been defined as a three type of functional disorders.

(i) **Sensory Symptoms**: Any of the senses may be involved in sensory Conversion reactions. The most common forms of these reactions are:

- Anesthesia - loss of sensitivity
- Hypesthesia - partial loss of sensitivity
- Hyperesthesia - excessive sensitivity
- Analgesia - loss of sensitivity to pain
- Paresthesia - exceptional sensations, such as tingling

(ii) **Motor Symptoms**: Hysterical paralyses are usually confined to a single limb, such as an arm or a leg and the loss of function is usually selective. The most common hysterical disturbances of speech are aphonia, in which the individual is able to talk only in a whisper and mutism, in which he can not speak at all.

(iii) **Visceral Symptoms**: Hysterical visceral symptoms also cover a wide range of disorders including headache, “lump in the throat”
and choking sensations, coughing spells, difficulty in breathing, cold and clammy extremities, belching, nausea and so on, for example, the individual may slow all the usual symptoms—coughing, loss of weight, recurrent fever and night sweats—without actual organic disease.

In relation to other neurotic types, the conversion hysteria tends to be highly suggestible and dramatic—a "histrionic personality": excitable but shallow in emotional responsiveness, particularly capable of ignoring, denying and repressing what he does not want to perceive, prone to exaggeration and demanding and manipulate in interpersonal relationships (Alarcon, 1973; Chadoff, 1974; O’Neill & Kempler, 1969; Slavney & McHugh, 1974; Steele, 1969; Verbeck, 1973). Female conversion hysterics have also been described as sexually seductive but often frigid in actual sexual relations.

2.4.2. HYSTERICAL NEUROSIS: (DISSOCIATIVE TYPE)

In the forth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the essential feature of the dissociative disorders is defined as a state of disrupted "consciousness, memory, identity or perception of the environment: DSM-IV offers specific diagnostic criteria for four dissociative disorders:

(1) Dissociative Amnesia (once called psychogenic amnesia)
(2) Dissociative Fugue (once called psychogenic fugue)

(3) Dissociative identity disorder (once called multiple personality disorder)

(4) Depersonalized disorder

2.4.3. STUDIES RELATED TO DISSOCIATIVE DISORDER

Chodoff and Lyons (1958) examined the personality structure of 17 patients with a clear-cut diagnosis of conversion hysteria and found that only three showed evidence of hysterical personality as they defined this term. Lewis and Berman (1965) found 57 cases of clear-cut conversion hysteria in 16000 discharges; 50% of these were also diagnosed as hysterical personality. They also found some evidence for a syndrome of classical symptoms in otherwise diversely presenting conversion hysterics, consisting of amnesia, fits, unexplained pain, vomiting, urinary retention, blindness importance, paralysis and aphonia.

A similar classical pattern in conversion hysteria was found by Ljungberg (1960) in a large-scale study, for example that conversion patients would also show a high incidence of depression, Schizophrenia and neurotic anxiety. Ziegler and Imboden (1962) careful follow-up studies of patients diagnosed as conversion hysteria show a remarkable incidence of subsequent organic basis for the symptoms as well as a tendency for the diagnosis to change (Slater, 1961, 1965).
(Eysenck, 1947) he reported a correlation of \(-0.41\) between “hysterical attitude” and the factor, while “hysterical conversion” correlated 0.63. This would appear to suggest a fairly strong relationship and in a subsequent study reported in the same volume, he found very similar correlations with suggestibility for patients diagnosed either as “hysterical personality” or as “conversion hysteria”. In another study (Eysenck, 1955) the selection of a criterion group of “hysteric” was made on the basis that the psychiatric diagnosis should be “conversion hysteria” or hysteria (the latter term presumably referring to “hysterical personality” without conversion symptoms).

The characteristics of hysterical patients have been well described by Chodoff and Lyons (1958) as follows:

(i) Egoism, vanity, egocentricity, self-centeredness, indulgence.

(ii) Exhibitionism, dramatization, lying exaggeration, play-acting, histrionic behavior, mendacity, pseudologia phantastica, dramatic self-display, center of attention, simulation.

(iii) Unbridled display of affects, abile affectivity, emotional capriciousness, deficient in emotional control, profusion of affects, emotions volatile and labile, excitability, inconsistency of reactions.
(iv) Emotional shallowness, affects fraudulent and shallow, go through the motions of feeling.

(v) Lasciviousness, sexualization of all non sexual relations, obvious sexual behavior coquetry, provocative.

(vi) Sexual frigidity, intense fear of sexuality, failure of sex impulse to develop toward natural goal, sexually immature, sexual apprehensiveness.

(vii) Demanding, dependent relationships.

Ziegler and his colleagues (Ziegler, Imboden and Meyer, 1960; Ziegler and Imboden and Rodgers, 1963) and Forrest (1967) have delineated a similar personality syndrome but Forrest (1967) has also argued for a “hysterical psychopathic” syndrome which is characterized differentially from the hysterical personality by lower social class tendency to develop addiction habits, frequent hospitalization and operations of an unnecessary kind and complete failure to respond to ant form of therapy or to cooperate in therapy. Forrest argues that the syndrome of “hysteria” developed by Guze and his colleagues (Gatfield and Guze, 1962; Guze and Perley, 1963) is essentially identical with his syndrome of the “hysterical psychopath”.

The one case of functional blindness that has been investigated by behavior techniques has given rise to considerable controversy. Brady
and Lind (1961) carried out a detailed experimental study of a male who had demonstrated apparent total hysterical blindness for more than two years, the condition being unaffected by various forms of psychiatric treatment. In the experiment, the patient was required to estimate a time interval of 18 seconds by pressing a key within three seconds of the end of the period. If the response was made correctly, a buzzer sounded to indicate success; if incorrect, the apparatus was reset to commence a new trial. Each session lasted one half hour. The first six sessions constituted a base rate situation. At the end of the sixth session, the patient's correct response rate had stabilized at about 50%. During the next 10 sessions, a light bulb (not visible to the patient) was illuminated at the 18-second point, remaining on for three seconds and serving as a visual cue for time interval by increasing the overall room illumination by a just perceptible amount for a person with normal vision. During these sessions, the patient's correct response rate declined significantly. Since he tended to press the key prematurely and thus prevent the appearance of the light. In the following seven sessions, the light was turned on at full intensity in a position where it could be seen by the patient. After a further initial fall, the correct response rate rose of 67%. The patient denied being able to see the light and attributed his success to feeling the heat from the lamp. During sessions 25 through 45, the intensity of the light was gradually
diminished. After an initial improvement to 82% correct responses, the response rate suddenly dropped to 48% and the patient declared he could see the light. After this, the response rate rapidly improved. In the group of session (45 through 63), the visual cues for pressing the key were made more complex by the introduction of a pattern of change to signal the end of an interval. In the final session the correct response rate was virtually 100% and the patient could clinically see.

In psychogenic deafness, mention should be made of an important study by Reed (1961). From a population of 3000 children, he identified 24 with psychogenic deafness. The children were categorized into groups: those showing deafness for pure tones but not speech; and the reverse. He then examined personality characteristics of the two groups and found that the children psychiatrically diagnosed as predominantly "hysteric" showed deafness for pure tones but not speech in 13/14 cases; whereas children psychiatrically diagnosed as predominantly "anxiety state" showed deafness for speech in 9/12 cases. These results are particularly interesting because they appear to refute the view sometimes expressed that all forms of the perceptual defense phenomenon (Kleinman, 1957; Kodman and Blanton, 1960). Reed attempts to relate his two types of functional deafness to Eysenck's neurotics and extraversion dimensions.
Bangs and Freidinger (1949) related a 13 years old adolescent with functional aphonia of seven years duration by reductive speech therapy, which was essentially a form of SD (R). The steps in treatment involved:

(i) Breathing and Laryngeal exercises to restore tonicity of the speech muscles that had been affected by disuse.

(ii) Making of the easiest of the speech sounds (that is, those involving the least amount of muscular effort) namely, $<[m], [n], [z], [v]>$

(iii) Combining consonants with vowels.

(iv) Reading passages of prose.

--This case is interesting as an example of functional disorder producing physiological changes that compounded the disability. Progress in treatment was slow but steady, transference from the laboratory to real-life (ward outside world) situations was obtained and vocalization was maintained over a two-year follow-up. The treatment occupied $10^{1/2}$ weeks. Similar techniques were used with an adult female with dysphonia of five years duration (Bangs and Freidinger, 1950). The patient made a good recovery, which was maintained over a four-years follow-up. Given the severity of the disorder in both these cases, it is highly likely that the treatment techniques were directly responsible for the improvement.

A study BY Walton and Black (1959) relating to hysterical aphonia is important for several reasons, not least of which is the curious method of
treatment applied. They argued that if the patient were given massed practice in trying to speak, the situation would lead to the accumulation of reactive inhibition in relation to the "not being-able-to-speak" habit and hence this would extinguish through the generation of not being able not to speak. Periods of practice were prolonged if speech did not improve during a given session and shortened if it did. Leaving aside this curious theoretical reasoning, the study by Walton and Black is interesting because of the introduction into the practice situation of increasingly social stimulation in the form of other persons; and the sue of reading situations (such as play reading) which approximated real life more and more closely. By the end of the treatment, the patient's voice had returned completely and the improvement was maintained over seven follow-up tests over nearly two years, in spite of severe traumatic experiences, which the patient underwent.

Sleepwalking has attracted little attention thus far from behavior therapists, but two case studies have been carried out. Walton (1961) treated a somnambulist who attracted his wife during sleep each night, the attack being aborted by the wife awakening him. Walton's theory was that this patient hated his domineering mother but was unable to express the hatred directly because of anxiety. During sleep, reduction in sympathetically mediated anxiety allowed expression of the aggression
indirectly against his wife. Walton therefore argued that training in
assertive behavior against the mother would lead to disappearance of the
somnambulism. After only one session of assertive training, the
somnambulism was reported by Walton to have disappeared and to be
still absent on follow-up two years later.
A rather different approach was used by Edmonds (1967) who treated a
male somnambulist who had walked and talked in his sleep for seven
years, two or three times per week, and had suffered severe injuries from
falls. Aversion therapy was tried, utilizing shock to the arm whenever the
patient initiated walking or talking in his sleep. The shock continued until
the patient awoke or resumed sleeping (which he did do). However, the
treatment was abandoned after 53 aversion trials had been given over a
fortnight (44 for talking, the remainder for walking) without any apparent
effect. When a midday sleep the patient invariably took was abolished
and sedation with sodium amyntal was given, the somnambulism
disappeared and was still absent on follow-up six months later, while
talking occurred only one night per week on average.
Brady (1966) in a recent comment, has argued for a continuum of
hysteria/malingering and believes that the patient in question was
originally a "genuine" case of hysterical blindness, which may
subsequently have developed into malingering. The problem is a difficult
one, since it is well known that hysterical disorders may involve in time a considerable degree of "secondary gain". In effect, this means simply that the patient learns to control his environment initially by means of the hysterical symptoms in a fairly general way but that as a result of experiences consequent on the primary disability, he comes to utilize the disability to control many other aspects of the environments. Brady argues that conversion reactions are characterized by sudden onset, belle indifference and non-exaggeration of the disability; whereas malingering is characterized by gradual onset, feigned concern and exaggeration of the disability. Barber (1967) has pointed out in a recent comprehensive review, most studies of hypnotically induced behavior change have suffered from a failure to utilize a proper control group. In the majority of studies, the hypnotic group has not only been subjected to hypnosis, but also to heightened suggestibility whereas, when a control group has been used, it has not only subjected to suggestions alone. Thus in any adequate study, four groups are required; hypnosis plus suggestion; hypnosis without suggestion; control waking group plus suggestion; control waking group without suggestion. Recent studies on hypnotic deafness (Barber and Calvey, 1964; Kline, Guze and Haggesty, 1954), hypnotic blindness (Barber and Deeley, 1961), and hypnotic analgesia and anesthesia (Barber and Hahn, 1962) showed that the phenomena
attributed to the induction of hypnosis could be demonstrated equally
well in the waking state with suggestion, providing the experimental and
control groups were properly chosen. The importance of these recent
studies lies in the methodological suggestions arising out of them
concerning the experimental investigation of the abnormal forms of
behavior.

2.5. OBSESSIVE COMPULSIVE DISORDER

The term "obsession" is usually used by psychiatrists refer to persistent,
repetitive and unwelcome trains of thought, the term "compulsion" to
refer to impulsions to perform repetitive acts or rituals which may involve
complex sequences of acts- or to the acts themselves.

Eysenck (1947) described a dysthyemic syndrome, comprising anxiety
neurotic, depressives and obsessional compulsives (e.g. intelligence,
neurotic symptoms in childhood, age of onset, and first admission).
The incidence of obsessional and compulsive traits in unselected neurotic
or psychotic groups is unknown. The incidence of the classical syndrome
is however, certainly very small. Michaels and Porter (1949) reported an
incidence of only 0.2% in 1383 cases but their sample was an army
sample and it has been pointed out that obsession may adjust to the
orderly demands of army life rather better than they do to civilian life.
In obsessive/compulsive disorders, neurological factors may be correlated with EEG abnormality and hence possibly have a clear-cut neurological correlate. In a careful comparison of large numbers of obsessional neurotics and non-obsessional neurotic controls, Grimshaw (1964) found a noticeably higher incidence of significant neurological disorders prior to breakdown in the obsessional patients. The presence of abnormal EEG patterns was clearly correlated with the presence of other behavioral disorders (e.g., psychopathic behavior) much more likely to be casually related to the neurological abnormality than the obsessional symptoms.

Judd (1965) has very thoroughly reviewed the literature on the unsettled question as to whether a classical obsessive/compulsive syndrome can occur in children. As he points out, ritualistic behavior appears as part of the normal development process in children. However, in a survey of 405 children under 12 years, 34 were found to have abnormal obsessive/compulsive symptoms, but only 5 of these appeared to be genuine classical cases. All of the children displayed the following characteristics: sudden onset; superior IQ; concomitant presence of compulsions and obsessions; severe disruption of adjustment to environment by symptoms; verbalized guilt feelings; rigid absolute moral code; active fantasy life; absence of psychosis. Four of the children showed normal prebreakdown personality; family history of obsessive/compulsive symptoms;
uneventful bowel training identifiable precipitating event; transient phobic phenomena and excessive ambivalence towards parents, including strong overt aggression.

Freudian account of the genesis of obsessive / compulsive neurosis. The two principal conclusions to be drawn from this survey seem to be the following:

1) The classical obsessive- compulsive syndrome is very rare, both in children and adults.

2) A distinction must be drawn between the normal obsessive / compulsive traits which may be found in some persons and the obsessive/compulsive traits which approximate the classical syndrome and which may be predictive of future breakdown.

2.5.1. STUDIES RELATED TO OBSESSIONS AND COMPULSIONS

The most important studies of the behavioral treatment of obsessive behaviors are those of Walton (1960) and Walton and Mather (1963; 1964). Walton considered that obsessions, during early stages of the disorder, represented examples of drive- reducing conditioned avoidance response, whereas in the later stages, they would achieved a considerable degree of "functional autonomy", by which he meant that they would now be evoked by a wide range of stimuli, in addition to the anxiety that originally produced them. From these considerations, he formulated two
predictions. The first was that a direct attempt to remove the obsessional behavior in the early stages of the disorder would fail and that it was necessary to desensitize the stimuli. If this were patient to his anxiety-provoking successfully accomplished, the obsessional behavior would disappear, since there would be no anxiety to evoke it.

An important study by Meyer (1966) should be mentioned. It is generally considered that preventing the obsessional patient from performing his rituals will induce severe anxiety, just as forcing a phobic patient to stay in a feared situation will provoke panic, since in both instances the response or inhibition of response occurs in order to ward off a subjectively perceived threatened disaster. If the patient could be prevented from as it were leaving the threatening situation, and nothing disastrous does happen, the behavior should extinguish. Systematic desensitization is, of course precisely designed to overcome this problem by not placing the patient directly in a situation he cannot handle and which may lead to a panic reaction and consequent strengthening of the fear. Its intent is to enable the patient gradually to handle the feared situation. Meyer, however, prevented his two patients from performing their obsessional rituals while at the same time making them perform actions inconsistent with the ritualistic activities. Thus, the patient with compulsive washing and cleaning was made to handle doorknobs, dustbins etc. Without being given the
opportunity of washing her hands or cleaning the objects. In other words, the patients were required to reality test for the belief that touching certain "unclean" objects would be followed by disastrous consequences such as contamination and illness or disease. Considerable success attended the use of this method with satisfactory long-term follow-up (14 months and two years).

Haslam (1965) treated a 25-year-old girl with a phobia about broken glass, which had led to obsessional rituals. The patient had previously received ECT, insulin, drugs, and leucotomy (indicating the severity of the disorder) to no effect. Haslam successfully treated the phobia for glass by Watson's original desensitization technique, that is, the introduction by stages of broken glass objects in a feeding situation under strong hunger drive. The obsessions and compulsions disappeared simultaneously, and the patient was symptom free a year later.

The relationship between obsessional thoughts and obsession behaviors is a complex one, however, Wolpe (1958), for example argued that a distinction must be made between anxiety-arousing obsessions and anxiety-reducing obsessions. Thus persistent thoughts about killing someone may lead to ritualistic behavior to prevent the patient from carrying out the act.
The above studies suggested that the psychotherapies play certain role in the treatment of Anxiety, Phobia and Dissociative Disorder.