CHAPTER II

REVIEW OF LITERATURE

In recent years researcher and clinicians have begun to realize that the processes underlying anxiety and fear might have some specific core features which have not been touched or untested that are the core dimensions of the dysfunction. There are lot many researches has been done on the persons those are having features of obsessive compulsive disorder and Generalized anxiety disorder but the Contemporary cognitive-behavioural studies on Obsessive–Compulsive disorder (OCD) is dominated by approaches that are focusing on OCD as an anxiety disorder with fundamental non-adaptive beliefs, such as expanded responsibility and overestimation of threat. Furthermore, some empirical results question the relevance of these beliefs for entre subtypes of OCD symptom (Calamari et al., 2006; Taylor et al., 2006) and their specificity for Obsessive–Compulsive disorder (Julien et al., 2006, Tolin et al., 2006 and Viar et al., 2011). Apparently, at least a substantial dimension of patients with Obsessive–Compulsive disorder (26%) their score were not high on any of the OCD-associated dysfunctional beliefs (Calamari et al., 2006), and only about half of the individuals with Obsessive–Compulsive disorder fear specific outcomes of not ritualizing (Tolin, Kozak, Abramowitz & Foa, 2001). In view of this it is very clear that there must be something else that keeps the person busy in some activity and there are some features because of which person could not be able to manage the anxiety provoking conditions.

The term “incompleteness” (INC) has been recently proposed as an additional affective-motivational factor driving compulsive behaviour (Ecker and Gonner, 2008, Pietreffesà & Coles, 2008, Pietrefesa and Coles 2009, Summerfield (2004). Janet (1903) was the first to emphasize Incompleteness feelings as a crucial phenomenological feature of OCD. Patients usually face difficulty to find exact term to describe this feeling, but lots of them get the term “comfortingly familiar” (Summerfield 2002). Janet (1903) emphasized that, OCD sufferers are anguished by inner feelings of imperfections and flaws. The patients usually feel that the task they do don’t not produce the desired satisfaction or the task they have done are incompletely achieved. Coles, Heimberg, Frost & Rheaume (2003) and Coles, Frost,
Heimberg, & Steketee (2005) have termed this incapability to achieve “closure” concerning actions/perceptions as “not just right experiences” (NJREs). Incompleteness in terms of NJREs having to do with an action (e.g., locking the door) or a perception (like, books on a shelf) results in a compensatory push to generate “just right” feelings, i.e., sufferers feel compelled to repeat their rituals (such as, locking the door, arranging books on a shelf) until the action or perception feels “just right”. The description of NJREs have been done as a form of “sensation-based” (Coles et al., 2003) or “sensory” perfectionism (Frost, Novara & Rheaume, 2002). Incompleteness has also been assessed recently in Body dysmorphic disorder done by Berta and colleague 2016, in the research they studied the role of ‘not just right’ experiences (NJREs) and incompleteness (INC) in body dysmorphic disorder (BDD). In result they found that the high symptom group reported greater Incompleteness (INC) and reactivity to a visual NJRE task than their low symptom counterparts, when controlling for co-occurring symptoms of depression, anxiety, and OC symptoms. They also found that there is no group differences were observed for tasks assessing auditory and tactile NJREs. These studies demonstrate a unique relationship between INC/NJREs and BDD.

Summerfield et al, 2004) see also Summerfield 2007 and Summerfield 2008 proposed a dimensional model with Incompleteness (INC) and Harm Avoidance (HA) as two continuous affective-motivational specific attributes of Obsessive Compulsive Disorder cutting across overt symptoms. They suggest that Obsessive Compulsive Disorder is either characterized “by anxious apprehension and exaggerated avoidance of potential harm” (alike other anxiety disorders) or by attempts to lessen feeling of Incompleteness, and that Harm Avoidance and Incompleteness “might in combination underlie most manifestations” of Obsessive Compulsive Disorder (Summerfeldt, 2004). Moreover, the model asserts that whereas Harm Avoidance shows “marked similarity to other anxiety disorders”, Incompleteness “is unique to obsessive–compulsive phenomena”.

In line with the Summerfeldt model, there is evidence for the relevance of Incompleteness in Obsessive Compulsive Disorder and for the usefulness of distinguishing between Incompleteness and HA. Studies involving confirmatory factor analyses in students (Pietrefesa and Coles 2008 and Summerfeldt et al 2001)
and Obsessive Compulsive Disorder study done by (Ecker, Gommer & Wilm, 2011) has been made for the support and legitimacy of Harm Avoidance and Incompleteness as different constructs and provided samples. Both Incompleteness and Harm Avoidance are highly prevalent motivational phenomena in Obsessive Compulsive Disorder (Ecker & Gommer 2008). Furthermore, Both Incompleteness and Harm Avoidance are linked very differentially to specific experiences while executing OCD-relevant tasks: Incompleteness, but Harm Avoidance was not associated with tension / discomfort feeling and a need to execute the work very perfectly or till the tasks were just right, whereas Harm Avoidance, but not Incompleteness, was linked to anxiety/nervousness and a desire to prevent harm (Pietrefesa & Coles, 2009). In addition, Harm Avoidance and Incompleteness were differentially associated to specific Obsessive Compulsive symptoms: In an undergraduate sample, (Pietrefesa & Coles, 2008) determined that sequencing or ordering has a better correlation with Incompleteness than with Harm Avoidance, whereas obsessing was more strongly correlated with Harm Avoidance than with Incompleteness. Other symptom like Cleaning, checking, washing, neutralizing were associated with both Incompleteness and Harm Avoidance to a high and similar extent. In accordance with these results, Coles et al. (2005) found strong correlations between ordering and symmetry symptoms and claimed to counter both NJREs (experimentally induced and naturally occurring). Ecker and Gonner (2008) examined the associations of symptom dimensions of Obsessive Compulsive Disorder with Harm Avoidance and Incompleteness in a huge sample of persons with OCD. Symmetry and ordering symptoms were independently linked to Incompleteness, obsessions were independently associated with harm avoidance, checking symptoms were motivationally heterogeneous, i.e. independently associated with both dimensions, now those other symptom dimensions (washing/contamination, neutralizing, and impulses) were not independently linked to either Harm Avoidance or Incompleteness. All these studies given evidences for the validity and distinctness of both constructs. Along with Harm Avoidance, Incompleteness may be an significant affective-motivational feature in Obsessive Compulsive Disorder, particularly in ordering and checking compulsions.

In the regression analyses of Ecker and Gonner (2008), symptom severity of OCD emerged as a significant predictor of Incompleteness, but not of Harm Avoidance.
Moreover, Obsessive Compulsive Disorder symptom dimensions have explained more discrepancy of the Incompleteness scores of OCD patients than of their Harm Avoidance scores. This was interpreted – in the lack of data from clinical control groups with some caution – as an indirect indicator of Incompleteness being more specific to OCD than Harm Avoidance.

Ghisi, Chiri, Marchetti, Sanavio, and Sica (2010) found that severity of NJREs discriminated OCD patients (n=30) from patients with (other) GAD (n=12) or depression (n=11), even when OCD-associated dysfunctional viewpoint were controlled, thus providing direct support for the OCD specificity of this construct. Interestingly, these beliefs did not discriminate among groups when NJRE severity was controlled. Moreover Sica, Caudek, Chiri, Ghisi & Marchetti (2012) reported that NJREs explained OC symptom variations over time in non-clinical individuals when general distress and looming style were accounted for.

While Ghisi et al. (2010) exclusively focused on the OCD specificity of Incompleteness, we would like to additionally look at the Harm Avoidance component of the Summerfeldt model. Thus, the aim of this study is to reproduce and extend the conclusion of Ghisi et al. (2010) in a larger sample by testing the hypothesis that (1) Incompleteness is unique to OCD and therefore the severity of NJREs is significantly higher in an OCD sample than in clinical controls (with GAD or depressive disorders) and non-clinical controls; (2) Harm Avoidance is more pronounced in OCD and in anxiety disorder controls than in depression disorder controls and non-clinical controls. In sum, hypotheses (1) and (2) predict specific between-group differences concerning Harm Avoidance and Incompleteness which would support the clinical validity of the Summerfeldt model (specificity of Incompleteness for OCD and of Harm Avoidance as a motivational dimension shared by OCD and other GAD).

However, a shortcoming of such comparisons between groups is the dilemma that due to the high co morbidity between OCD, other GAD and depressive disorders (Abramowitz et al. , 2007 and Roth Ledley et al. , 2007), between-group differences are potentially blurred by including patients with comorbid diagnoses in the samples, while, on the other hand, comparing “pure groups” containing only patients without comorbid diagnoses is clinically unrealistic. Complementary to our between-groups
comparisons, we therefore translated our hypotheses into a regression analytic approach not requiring the definition of mutually exclusive groups. Specifically, we predicted that the diagnosis of OCD independently contributes to Incompleteness severity, whereas a diagnosis of an anxiety or depressive disorder does not, and that OCD as well as anxiety disorder diagnoses independently contribute to Harm Avoidance severity, whereas the diagnosis of a depressive disorder does not.

The idea that overt symptoms are a meaningful basis for understanding heterogeneity in OCD has been the focus of considerable research attention over the past decade or so. Numerous studies have used data-reduction statistical methods like factor analysis to observe the structural features of OCD symptoms, and have generally found variations from three and five factors, contamination and cleaning, obsessions and checking (potentially further divisible into harm-related obsessions and checking, and other obsessions), comprising symmetry and ordering, and hoarding. Alongside this heightened research activity, however, has been growing awareness of the many conceptual and methodological challenges and limitations of this approach to classifying OCD.

Indeed, a fundamental limitation of symptom-based classification is that its exclusive focus on the topographic aspects of OCD ignores potentially more meaningful underlying features. This is because it is based upon “what the individual does, rather than why the individual does it” (Summerfeldt et al., 2004). Different symptoms, for example, may have noticeably similar motivational underpinnings (e.g., checking, like washing, may serve to ease anxious apprehension and alleviate fears about possible harm). In both cases, the harm avoidant, preventative, or neutralizing form of the two profiles is alike, though the content differs. On the reverse, behaviours that very clearly appear similar can be characterized by qualitatively diverse subjective experiences. Someone may clean to remove germs and avoid harm or, alternatively, to conserve the pristine “just right” state of belongings and so resume a sense of satisfaction or inner completeness, with a slight sense of threat, although symptom-based classification strategies would collapse both into the “cleaning” category.

Direct and indirect empirical support has accumulated from multiple sources not only for the value of differentiating overt obsessive-compulsive symptoms from their underlying motivations, but also for the possibility that such underlying motivations
may take harm avoidance and incompleteness forms. Examples include clinical accounts and case studies (e.g., Rasmussen and Eisen, 1988, Rasmussen and Eisen, 1990, Rasmussen and Eisen, 1992, Summerfeldt, 2004, Summerfeldt, 2006, Summerfeldt, 2008 and Tallis, 1996), and studies with nonclinical samples using both correlational (Pietrefesa and Coles, 2008 and Ghisi et al., 2010) and lab-based behavioural analog designs (e.g., Cougle et al., 2013 and Pietrefesa and Coles, 2009). In one of the few quantitative studies with clinical participants, Ecker and Gönner (2008) analyzed data from a large sample \((n=202)\) and multiple symptom measures to test hypotheses regarding whether harm avoidance and incompleteness underlie and cross over overt symptoms. In line with their general predictions, some symptoms (symmetry, harm-related and repugnant obsessions) were associated with only one dimension, whereas others (i.e., checking) were motivationally diverse.

These two motivational themes were first incorporated into a classificatory model of OCD by Rasmussen and Eisen, 1988, Rasmussen and Eisen, 1990 and Rasmussen and Eisen, 1992, who on the basis of theoretically-informed clinical observation posited that OCD may be subtyped according to three “core features”: abnormal risk assessment, pathologic doubt, and incompleteness, which cut across overt symptom manifestations and are associated with distinct features, comorbidities, vulnerabilities, and causal factors. Despite its heuristic appeal, this model has weaknesses. Foremost is that it is implicitly categorical; although the core features are ostensibly dimensional, paramount emphasis is placed upon the distinct subtypes that derive from them. This raises conceptual and methodological drawbacks true of categorical models in generation. At what point, for example, does an individual stop belonging to one subtype and enter into the domain of another? As yet, there is no known pathophysiology for the subtypes, and the distinction is made on the basis of behavioural, motivational and emotional features. These are continuous variables with gradations of severity, however, and could plausibly appear in “blends” in the same individual. The core features would be better depicted as discrete continuous dimensions. Individual profiles might then be predicted from their interaction, or the predominance of one, relative to the other. Relatedly, there is little basis for the distinctness of pathological doubt. In an effort to address these points and make the model more amenable to quantitative research, our group proposed a revision to Rasmussen and Eisen's model, comprising harm avoidance and incompleteness as its
continuous core dimensions. We see the two as orthogonal; that is, an individual's “placement” on one dimension has no direct causal bearing on placement on the other, and all combinations of levels are possible in the general population. In OCD, harm avoidance and incompleteness can be conceptualized as axes defining a dimensional space wherein particular symptom configurations are most likely to develop. In a case study in Summerfeldt (2004), for example, the combination of high incompleteness with normatively “typical” harm avoidance was associated with obsessions involving symmetry and the need to know or remember details, mental rituals, and re-reading, repeating, and ordering compulsions.

The research by Pietrefesa and Coles (2008), though informative, does not touch on some crucial foundational issues. Most importantly, the core dimensions model and its predecessor by Rasmussen and Eisen were developed to account for the motivations behind obsessive-compulsive symptoms, so clearly the coherence and divergence of the two factors as they relate specifically to symptoms, that is, as a state, need to be established, and in the clinical population. The empirical grounds for extrapolating these dimensions into assumedly cross-situationally stable traits, assessable via self-report questionnaire, as reported in several often-cited studies using the OC-CDQ including Pietrefesa and Coles, 2008 and Pietrefesa and Coles, 2009, and Ecker and Gönner (2008), also need to be established.

Studies support the contribution of incompleteness in OCD. To example, Coles, Heimberg, Frost and Rhéaume (2003) found that so called “not just right” experiences (NJREs) are usual innate occurrences, and can be both physical and mental in nature. Addition to that, their findings suggested that more often than not, subjects accounted that taking some action to correct this feeling of things being “not just right.” That study also revealed that NJREs were importantly associated with OC symptoms in non-clinical participants with strongest association being observed with checking, doubting and ordering. Lastly, the study revealed that not just right experiences had stronger correlations with OC symptoms than with a measure of excessive worrying, trait anxiety and social anxiety, depression. Coles, Frost, Heimberg and Steketee (2005) equated high- and low-intensity not just right experiences on several measures. First, in an experimental setting they induced NJREs. The study also discovered that NJREs never provoke the required to prevent harm, but induce distress and the need
to change something so it will feel just right. This brings the evidence that harm avoidance is not the only component that causes compulsions, but that incompleteness also plays a part. Additionally, participants were asked to self-monitor their NJREs for one week. This revealed that it is peoples’ reactions to their NJREs which lead to compulsions, but not the occurrence of such thoughts. Pietrefesa and Coles (2008) established the validity of harm avoidance and incompleteness as two separate constructs in a study using the Obsessive-Compulsive Trait Core Dimensions Questionnaire (OC-TCDQ). They also found that both factors were correlated with multiple symptom domains in OCD, including washing, checking, ordering, obsessing, and neutralizing. Their results did not show a stronger relationship between harm avoidance and washing, mental neutralizing and checking, than those symptom dimensions had with incompleteness. This suggests that compulsive washing may not be solely encouraged by a desire to check contamination. However, they did find that harm avoidance has more strongly correlation with obsessing, and that incompleteness had a stronger correlation with ordering. Thus, their results suggest that while both of these dimensions may drive compulsions, they may be differentially related to the various symptom domains in OCD.

The studies mentioned that both harm avoidance and incompleteness can motivate OC symptoms. Summerfeldt and collegues (2014) have proposed a model suggesting that these two dimensions serve as the prevailing motivational factors underlying OC symptoms. As previously mentioned, research suggests that the emotion of anxiety also plays a role in driving OC symptoms, especially symptoms concerning fear of contamination and washing behaviour (Olatunji et al., 2007). However, it is still not clear why anxiety drives these symptoms. Cisler and collegues (2010) showed that obsessive beliefs, especially overestimation of threat and harm, interact with anxiety to heighten fear of contamination. This may explain when anxiety leads to contamination fear. Olatunji, Beran, David, Unoka, and Armstrong (2009) investigated whether harm avoidance plays a mediating role in the relationship between anxiety and OC symptoms. Their results showed a significant relationship between anxiety and harm avoidance, between anxiety and OC symptoms, as well as between harm avoidance and OC symptoms. However, when they controlled for the effect of harm avoidance the relationship between anxiety and OC symptoms diminished and became non-significant (Olatunji et al., 2009). This suggests that harm
avoidance serves as a mediating factor in the relationship between anxiety and OC symptoms, explaining why this relationship exists. These results are in line with Rachman’s (2004) thoughts on compulsive cleaning as being driven by an attempt to avoid harm, independent of whether it is fear or anxiety that drives the behaviour.

Harm Avoidance speculates the trend to react more strongly to aversive stimuli. Persons with high Harm Avoidance scores are extra fatigable, they are generally shy and nervous with strangers, and be likely to worry and become stressed in unfamiliar situations. However, some evidence suggests that compulsions related to contamination are not only driven by harm avoidance. Tallis (1996) reported cases of OCD patients with cleaning compulsions where the compulsions were not driven by a need to avoid illness but by a need to have things remain in perfect conditions or achieve a perfect sensation of being clean. In one study, factor analysis revealed that there are two types of contamination worries, one related to fear of harm and the other driven by a need to reduce discomfort (Feinstein, Fallon, Petkova & Liebowitz, 2003). Also, as Coles and Pietrefsa (2008) results showed, it is not only harm avoidance, but also the dimension of incompleteness that is associated with washing compulsions. Cougle and colleagues (2011) used both self-report and behavioural methods to examine if NJREs were associated with hand washing. Their results revealed that both intensity and frequency of NJREs were positively correlated with duration of hand washing (Cougle, Fitch, Goetz & Hawkins, 2011). This suggests that while duration of washing may partly be determined by avoidance of harm (Wahl, Cotter and Salkovskis , 2008), it may not be entirely cognitively based. That is, termination of washing may also be determined by subjective sensory experiences (Cougle et al, 2011). Considering this, there have been speculations about whether incompleteness might also play a mediating role in the connection between anxiety and fear of contamination and/or washing behaviour. Ólafsson, Ólason, Emmelkamp and Kristjánsson (2009), carried out two separate studies to examine the mediating role of harm avoidance and incompleteness in the relationship between anxiety, as measured with Anxiety Propensity and Sensitivity scale (APSS), and contamination fear, as measured with the Padua inventory. In study 1, the Reponsibility Attitude Scale was used to measure harm avoidance, and the Not-Just-Right-Experiences questionnaire to measure incompleteness. In order to better validate the results, the study was repeated in another sample using Obsessive-Compulsive Core Dimensions Questionnaire (OC-
CDQ) as a measure of harm avoidance and incompleteness. Both studies revealed that the dimension of incompleteness and NJREs plays a mediating role in this relationship, but the results did not support a mediating role of harm avoidance. This emphasizes the role of sensations, but not sensitivity to harm, in explaining why anxiety leads to symptoms of contamination. In particular, the experience of anxiety triggers a feeling of internal imbalance, that leads to contamination related symptoms, such as washing, in order to restore a feeling of things being just right (Ólafsson et al, work in progress). The study attempts to explore the role of anxiety in OC symptoms. Consistent with previous research (Olatunji et al., 2007; Tsao & McKay, 2004) it is hypothesized that those who report more anxiety will show less approach behaviour towards anxiety stimulus. Moreover, it is expected that anxiety serves as a predictor for fear of contamination over and above what can be accounted for by anxiety (Mancini et al., 2001; Muris et al., 2000);

Above studies suggested that the focus of these researches were on finding the specific core features in the anxiety disorders mainly with Obsessive Compulsive Disorder. Now it was clearly mentioned that the not just right experience or feeling of incompleteness has been particularly found with the persons with Obsessive Compulsive Disorder, harm adoidance has also been seen but most of the chances occurs with other anxiety disorders.

**Relationship with Quality of Life**

The concept of quality of life can be considered as wellbeing or happiness. There are several definitions that describe quality of life, but the general consensus among investigators is that it refers to subjective wellbeing; a conception which is based on people’s standards to determine what a good life is (País-Ribeiro, 2004). Quality of Life is defined comprehensively; it refers to the part of life that makes it satisfying and beneficial and extends ahead of anxiety symptoms to incorporate persons’ subjective prosperity and life fulfilment (Angermeyer and Kilian, 1997). Accordingly, the evaluation of Quality of Life in the anxiety disorders incorporates patients' subjective perspectives of their life conditions including impression of mental health, social and family relationships, and physical health, functioning at work, and functioning at home (DuPont et al., 1996). In spite of the fact that investigations of Quality Of Life in anxiety disorders remain less frequent than investigations of
Quality Of Life in other disorders (Hansson, 2002), there is evidence of financial and marital problems in patients with panic disorder (Weissman, 1991), role limitations in patients with obsessive–compulsive disorder (OCD; Hollander, Kowan, Stein, & Broatch, 1996; Koran, Thienemann, & Davenport, 1996), and high grades of divorce and disability in patients who are having generalized anxiety disorder (GAD; Blazer, Hughes, Swartz, George & Boyer, 1991). In patients with social phobia, impairment in education and relationships has been found (Schneier et al., 1994; Stein & Kean, 2000), In patients with posttraumatic stress disorder, high orders of diminished subjective well-being and public financial assistance was found (PTSD; Warshaw, Fieman, Pratt, & Hunt, 1993; Zatzick et al., 1997) The findings of these studies suggest that anxiety disorders impact negatively on number of functional areas that have significant contribution to Quality Of Life.

The effect of anxiety disorders on Quality Of Life also seems to be rich in that it is independent of symptom severity, somatic health, demographic variables, and diagnostic co morbidity (Cramer, Kringlen, & Torgersen, 2005; Markowitz, Wiessman, Lish, Ouellette, & Klerman, 1989; Rapaport, Fayyad, Clary, & Endicott, 2005; Strine, Kobau, Chapman, & Balluz, 2005). Some researchers have compared differences in Quality Of Life among the anxiety disorders. Even though it has been proposed that overall Quality Of Life is largely compromised in patients suffering from panic disorder and PTSD (Hansson, 2002), there is some data indicating that different anxiety disorders effect some domains of Quality Of Life differentially. Older studies have focussed on specific destruction in vitality, physical health, and mental health amongst individuals with Post Traumatic Stress Disorder (Schonfeld et al., 1997), non-prescription drug use and physical health for individuals with panic disorder (Lochner et al., 2003; Schonfeld et al., 1997), activities of daily living and family life in persons with OCD (Lochner et al., 2003), and among individuals with social phobia social and leisure activities, activities outside occupation and problem in their relationships were seen (Lochner et al., 2003; Quilty, Ameringen, Mancini, Oakman, & Farvolden, 2003).

Clinical and Epidemiological studies indicating the harmful impact of anxiety disorders on Quality Of Life carry on to accumulate. As a result, there is a clear need for short and snappy reviews of this huge body of literature. Numerous qualitative
reviews of published studies examining the impact of anxiety disorders on Quality Of Life have been offered. Such as, Mendlowicz and Stein (2000) reviewed studies and obtained via MEDLINE and PsycLIT citations from 1984 to 1999) that have investigated Quality Of Life in patients with panic disorder, social phobia, PTSD, GAD, and OCD and concluded that the anxiety disorders significantly compromise Quality Of Life. Other qualitative reviews of Quality Of Life in anxiety disorders have come to similar conclusions (e.g., Maddux, Delraham, & Rapaport, 2003; Mogotsi, Kaminer, & Stein, 2000; Schneier & Pantol, 2006). Still, a quantitative description of this literature could permit for clear inferences to be made about the impact of anxiety disorders on Quality Of Life. A quantitative examination of this literature is a valuable starting point for making more significant comparisons of Quality Of Life between anxiety disorders and with other disorders with psychiatric conditions. Thus, our present study provides a meta-analysis of the literature on the effect of anxiety disorders on Quality Of Life. In particular, Anxiety disorder patients are compared with nonclinical controls on overall Quality Of Life. The different anxiety disorder diagnoses are also compared on specific Quality Of Life domains. Lastly, we scrutinized differences in each Quality Of Life domain collapsing across the anxiety disorders. It was predicted that anxiety disorder patients would report significantly more deficits in mental health than other Quality Of Life domains.

**Quality of life and OCD**

Investigators and Clinicians are increasingly paying attention toward the broaden indicants of burden of illness and its consequence, Quality of life (QOL) is one of the outcomes in it. The major gap in the field is the limited researches done with the appraisal of Quality of life on the basis of the measures. Some recent study places the current prevalence rate of Obsessive Compulsive Disorders in lower range; Stein et al. (2010) only few studies have attempted to measure the affect of Obsessive Compulsive Disorders on quality of life despite its well-known morbidity, too.

Researches done by Koran and colleagues (1996) on quality of life in sixty persons affected by OCD who were not prescribed medication who have midium to extreme OCD utilizing the wellbeing questionnaire (Short-form) and compared their scores with distributed standards to the all what's to the patients with Possibly melancholy or polygenic disorder. Persons affected by OCD had higher medial scores for every last
spot areas of physiological wellbeing for quality of life (physiological functions, limitation of role because of bodily pain and medical problems) in comparison to the patients who were having polygenic disorder and depressive features and close to the all populace standard. In a single study, continues to repeat depicted Obsessive Compulsive Disorder like an illness with a noticed quality of life with negative effect. This was the result came in contrast, in all the areas of mental health (because of affective difficulties the restriction of role in social functioning, and mental health), the patients’ with Obsessive Compulsive Disorder median scores were well below those of the general population. The depressed patient’s median scores were similar to those of the diabetic patients’. The inclemency of Obsessive Compulsive Disorder was observed to be negatively correlated in the scores on social functioning (the level of severity is high of the disorder, the scores would be lower). Elisabeth et al, (2013) studied the different domains of the Quality of Life (QOL) in persons who were having obsessive-compulsive disorder (OCD) a multimodal study of before and after, disorder particular in and out-patient treatment. They found that significantly diminished psychological, physical, global, and social Quality of Life in comparison to the normal population was reported by the subjects. The level of QOL was mainly improved at follow-up, exception of QOL in social perspective, simply remained below the values of norms. Environmental QOL were not afflicted in this sample.

A study was done by Stengler-Wenzke and colleague (2007) to assess the derivative effect of obsessions and compulsions on the quality of life (QOL) of patients with OCD. Seventy-five patients in which 43 were females, 32 were males between the age range of 21 and 62 years old with diagnosis of OCD by ICD 10. To assess the severity of OCD symptoms the scale, Yale Brown Obsessive-Compulsive Scale (a standardized, clinician-administered scale) has been administered QOL has been evaluated through the brief version of WHOQOL, a self-administered questionnaire which is originated by World Health Organization (WHO). It has been seen that in the WHOQOL-BREF areas of ‘psychological well-being’, ‘physical well-being’, and ‘environment’, compulsions brought down the patients’ QOL where symptoms of obsessions did not have any impact on QOL ratings. Symptoms of depressive were a strong prognosticato of pathetic QOL in persons with OCD. Obsessive-compulsive disorder (OCD) induces its impingement on the living of the persons as well as their congregators. objective observances intimate that OCD patients family members are
involved in the patients’ compulsive behaviour and rituals, frequently impairing their own everyday life. When Comparing with the general population, the level Quality of Life of relatives of persons with OCD when equated on the brief version of WHO assessment tool for QOL that is (WHOQOL-BREF) was found to be considerably low in the domains of psychological well-being, physical well-being, and social relationship. Stengler-Wenzke, et al., (2006) also observed that amongst the key co-generics of thirty two OCD patients, from which more than half reported a severe to moderate encumbrance, in which difficulty in planning trips, poor social relationships and neglect of hobbies were included.

Subramaniam et al 2013 studied the encroachment of obsessive Compulsive disorder on level of quality of life of the persons with OCD and they obtained that the persons with OCD had decreased QOL around all areas related to the subject with normative comparison, in the same study they tried to find out the impact of intervention of OCD will help in enhancement of QOL of the patients and they observed that some enhancement in the level of QOL in patients with OCD after management on cognitive behavioural therapy or pharmacotherapy with few studies proposing that this kind of enhancement in level of QOL is highly correlated with improvement in other features. Asnani and colleague (2017) in a planned study for randomized clinical trial has found substantial improvements in functioning in Quality of life which linked with reduction in the symptoms severity in OCD.

**Quality of Life and GAD**

Likewise Obsessive Compulsive Disorder, Generalized Anxiety Disorder also has a substantive encroachment on quality of life (QOL), Gladis, Gosch; Mendlowicz & Stein, (2000). The evaluation of QOL in Generalized Anxiety Disorder comprises patients' immanent opinions of their lifespan condition including perceptions of psychological health, physical health, family and social- occupational relationships, and functioning at home (DuPont et al., 1996). While investigating the status of QOL in persons with Generalized Anxiety Disorders, eminent ranges of disability and cases of divorce has been found in the persons with illness (Blazer, Hughes, George, Swartz, & Boyer, 1991). All These findings indicate that GAD has a negative impact on many operational domains that may leads to QOL. Encroachment of Generalized Anxiety Disorders on Quality of life as well comes along to be rich in that it is
independent of symptom severity, somatic health, statistic factors, and symptomatic co-morbidity (Cramer, Torgersen, & Kringlen, 2005; Markowitz, Wiessssman, Ouellette, Lish, & Klerman, 1989; Rapaport, Clary, Fayyad, & Endicott, 2005; Strine, Chapman, Kobau, & Balluz, 2005). Some more apparent is gathering that affective disorders and anxiety are linked with materialistic dysfunctions in daily functioning and quality of life, the impairments of quality-of-life are associated with these GAD symptoms are same as or greater than those observed with some other inveterate physical disorders (Koran & Thienemann 1996), Spitzer et, al 1995, Sherbourne et, al 1996). Generalized anxiety disorder patients have been seen to be more often divorced or unmarried. A higher proportion of persons with generalized anxiety disorder significantly than without disability gains throughout their lifetimes. However, when working, individuals with GAD showed indirect evidence of impairment: a significantly higher proportion has also been obtained in those who had annual incomes of less than Rs. 100000 Blazer et, al (1991).

Massion and colleagues (1993) assessed the impact of Generalized Anxiety Disorder and Panic Disorder on the status of quality of life of a patients group using inquiries gained from the National co-morbidity Survey. Through result it was observed that both groups showed impairment in role functioning and social life as well as low overall life satisfaction. Generalized anxiety disorder is found to be associated with a decrease in overall emotional health. However, the finding that the immense majority of the individuals with generalized anxiety disorder had at least one other anxiety disorder led the authors to confirm that “generalized anxiety disorder almost never occurs in isolation” and made it difficult to assess the role played by non co-morbid generalized anxiety disorder. In nut shell, these data suggest that, although relatively rare, generalized anxiety disorder can be found in a substantial minority of individuals and is associated with important impairment in its own right.

Ruiz et al (2011) consider that Generalized Anxiety disorder has a significant negative impact on the daily life of patients, and on their functionality, that linked it to quality of life. As such, quality of life is an overall assessment that the subject makes of their life, and it depends both on the characteristics of the subject like the demographics, personality, values and all as it does on extraneous modulators, such as illness and any treatment required (Lara-Muñoz and colleague 1995) The most useful assessments of
quality of life should include, or at least differentiate between, subjective and objective estimations. (Potter, Cantarero & Wood 2012). Ware and Sherbourne (1992) described eight functional domains of quality of life associated with health: physical functioning, physical role, somatic pain, general health, vitality, emotional role, mental health, and social functioning. Disability is a dynamic concept that changed dramatically in the second half of the 20th century. Cheng et al 2012 stated that substantial disability has been attributed to mental and neuropsychiatric disorders, which can cause the same, or even more incapacity than general medical conditions. As we can see in the work by Lara et al. 1995 around the quality of life associated with health in anxiety disorders, there is a association with disability in primary life roles, a reduction in mental health and vitality, difficulties in relationships, and that is more the case with disability in patients with Generalized Anxiety Disorder. Quality of life and disability do not only influence the course of the illness, but also decisions on treatment and the response to the same. Studies which assess the relationship between quality of life and anxiety disorders are made as a group, not as independent diagnoses. The importance of this research lies in two aspects. Firstly, there are no studies which measure both disability and quality of life in patients with OCD and GAD together. Secondly, it analyzes the majority of the factors related to quality of life and disability of these patients.

The aim of this research was to determine that what clinical factor that affects quality of life in patients with OCD and GAD.

Acceptance & Commitment Therapy with OCD and GAD

The approach of Acceptance and Commitment Therapy to anxiety disorders is predicated on the belief that anxiety disorders are marked by emotional and experiential avoidance, determined as a disposition to engage in behaviors to alter the frequency, duration, or form of unwanted events like physiological events, thoughts, feelings, and memories and the situations that function them when such avoidance leads to difficulty in functioning (Hayes et al., 1999). Anxiety disorders are the most usual disturbances of psychological condition that lead individual to look for mental health services (Narrow, Rae, Robins, & Regier, 2002). Yet, as effective treatments for these disorders exist, they are usually not efficient for all individuals (Stewart & Chambless, 2009). This issue is exaggerated in the treatments those are empirically
supported (Becker, Anderson and Zayfert, 2004). The bounded espousal by researchers through empirical observation based studies is also likely to determine through the need to learn different protocols for the management of different anxiety disorders—even though these protocols have essential features that don’t need to be learned again. This has directed to increase the interest in the growth of unified protocols for each anxiety disorder (Barlow, Allen, & Choate, 2004; Eifert& Forsyth, 2005; McEvoy, Norton & Nathan 2009).

The Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) was purposed as such an glide path (Eifert & Forsyth), but the descriptions of its use as a integrated protocol exist (Eifert et al., 2009), and its transportability to a private practice is not clear.

The Acceptance and Commitment Therapy framework for anxiety disorders suggests that efforts at regularizing anxiety are at the centre of anxiety disorders rather than the bearing of particular levels of anxiety. This peculiar approach to anxiety derives out of behavioral research on language and cognition, mainly relational frame theory (RFT). Studies on this theory depicted that internal undergoes come in operational and relational setting that’s why these contexts can be directed separately (Steele & Hayes, 1991). As well as fundamental behavioral study on extinction, which indicates that extinction require new acquisition rather than discarding, done by Bouton, (2002), it has been shown in RFT research that particular cognitions cannot be unlearned (Wilson& Hayes, 1996). Still, the context of use in which inner feeling occur can be changed, so that they have a behavior regulatory impact to a lesser extent. (Levitt, Orsillo, Brown & Barlow, 2004). Consequently, as like other third-generation behavior therapies, Acceptance and Commitment Therapy attempt to alter the functional outcomes of internal exp receives with very minimal interest for frequency, form, or likelihood of any specific category of inner experience such as worry, anxiety or panic sensations. ACT aims to decrease avoidance of these inner experiences as the prevalent response to anxiety. Their responses in anxiety are extended, that is leading in psychological flexibility which is defined as the capability to distinctly experience anxiety get through moving in directions that is chosen in person. This is carried out through aiming the six psychological processes believed to be responsible for the occurrence and maintenance of anxiety disorders from an the
position of ACT: being present, acceptance, diffusion, self as context, values, and committed action (Hayes, Luoma, Masuda, Bond & Lillis, 2006).

Supportive Outcome Studies

Data in the support of the mechanisms of change in Acceptance and Commitment Therapy are generally more inviolable in comparison to overall outcome data of ACT for whatsoever disorder (Hayes et al., 2006). Through the literature review it was obtained that more than 40 studies are there which are supporting the six processes targeted in ACT, with much of this support being for acceptance (Levitt et al., 2004; Hofmann, Heering, Sawyer & Asnaani, 2009), diffusion (Marcks & Woods, 2005, 2007; Masuda et al., 2010), being present or mindfulness (Arch & Craske, 2006), and values (Páez-Blarrina et al., 2008).

Evidences of the effectiveness of ACT for all anxiety disorders, with the most support existing for Generalized Anxiety Disorder (GAD) and Obsessive-Compulsive disorder (OCD). Roemer & Orsillo, 2007 done one open trial and one study of randomized controlled trial (Roemer, Orsillo, & Salters-Pedneault, 2008) measured the efficacy of a treatment based on Acceptance and Commitment Therapy for GAD. In this an open test done by Roemer & Orsillo, 16 treatment seekers demonstrated substantial diminutions in the significant GAD symptom severity, and enhances in quality of life, with anticipated cognitive operation changes.

In the study of randomized controlled trial (Roemer et al., 2008), subjects who were diagnosed with GAD (N=31) were allotted to an psychotherapeutic treatment based on ACT, other group was in control condition; after waitlist, they got treatment. The result shown that the treatment was more efficacious than waitlist and in the post-treatment, seventy eight percent of subjects who were treated got no longer encountered the criteria for Generalized Anxiety Disorder. Acceptance of inner feelings and involvement in activities which are based on value have been found to be coo relationally related to respondent position above decreases in worry (Hayes, Roemer & Orsilo, 2010).
**ACT and Obsessive Compulsive Disorder**

The therapeutic intervention of Acceptance and Commitment Therapy has also been seen in the patients who were having Obsessive Compulsive Disorder. Number of studies has been done like Twohig, Hayes, and Masuda (2006) that assessed the effectiveness of Acceptance and Commitment Therapy in intervention of eight-sessions for four patients with OCD. They supposed that diffusion and acceptance would be particularly useful with this kind of population because individuals with Obsessive Compulsive Disorder are excessively concentrated on their thoughts (obsessive thoughts) and keep them engage in a variety of avoidance behaviors and escaping tendency (American Psychiatric Association, 2000). The researchers obtained significant reduction in the frequency of compulsive behavior at the termination of psychotherapeutic treatment for all the subjects grounded on a measure of self-report for the frequency of compulsions, and after -month follow-up, the results were maintained. Each and every subjects showing significant decrements in other symptoms like their levels of anxiety and depression.

Another case study done by Eifert et al. (2009) in which a 52 year-old woman with a chief diagnosis of Obsessive Compulsive Disorder with the secondary impression of panic disorder. She was managed successfully with the protocol of ACT. That female encountered a total of 1-hr. therapeutic session for 12 week, and at the end of treatment, her OCD severity deteriorated from moderately severe at pre-treatment to non-clinical levels at post treatment. She likewise supported altogether bring down condition of overall suffering, and notably, no pain identified with her panic. At 6-month follow-up, her OCD issues stayed at subclinical levels, and she revealed rolling out positive life improvements with respect to professional goals. One randomized clinical trial has been done to find the comparison with progressive relaxation training and Acceptance & Commitment Therapy on OCD patients, of an 8-session ACT protocol to progressive relaxation training (PMT) in the treatment of individuals with OCD (N= 79) without in-session exposure (Twohig et al., 2010). The investigator found that in spite of the fact that treatment refusal and drop-out were low in both conditions, those treated with ACT showed more noteworthy changes at posttreatment and follow-up on OCD seriousness than those treated with PMT.
ACT and Generalized anxiety Disorder

Generalized Anxiety Disorder is determined to be the most widely recognized anxiety disorder and possibly most hard to manage due to disseminate appearance of the stimuli which provoke anxiety (Roemer & Orsillo, 2002). A few reviews executing ideas of Acceptance and commitment therapy in the psychological management of Generalized Anxiety Disorder have shown its potential viability with this particular population. For instance, Huerta, Gómez, Molina, & Luciano (1998) reported a case study of a 26-year-old woman with GAD, who was successfully treated with therapy that integrated all key components from ACT. In another review, specialists applied an incorporated communications protocol of conventional cognitive-behavioural methods and value-based concepts and acceptance underlying to improve the individuals with to ACT who were suffering from Generalized Anxiety Disorder (Orsillo, Barlow & Roemer, 2001). It was seen that after the treatment period of ten weeks, half from all four clients manifested substantial diminution in symptoms of anxiety and depressive.

In a study some patients of older primary care treated with twelve weekly sessions of ACT and other with CBT (cognitive-behavior therapy; Wetherell et al., 2011). Though every members of condition with ACT finished every one of the weekly sessions (12), out of the nine only five participants in the Cognitive Behavior Therapy consideration completed treatment. All the same, completer data for both groups brought out improvement in symptoms of anxiety and depression that was significant. The investigators mentioned that though the consequences of the approach of ACT in the study they have conducted on more small-scale than those established in more youthful adult samples who were diagnosed with GAD (Roemer et al., 2008; Roemer & Orsillo, 2007), ACT might be helpful for the more seasoned grown-up populace and benefits extra exact assessment.

Through, the survey about researches, it can state that Acceptance and Commitment Therapy has a moderately affirmed model of anxiety disorders and its treatment. The fundamental model of Acceptance and Commitment Therapy was created out of escalated work with the issues intrinsic to anxiety disorders. There is preparatory information on its viability for uneasiness issue, and the constrained information is steady of its procedure of progress. However, there is paucity in testing of Acceptance
and Commitment Therapy as a unified protocol for anxiety disorders. Despite the fact that the examination base is little, preliminary data support the belief that the ACT model of anxiety may be appropriate for conceptualizing and subsequently treating these disorders.

To summarize, the available evidence seems to be suggest that there are studies done on few of the variables with other than Generalized anxiety disorder and obsessive compulsive disorder. Acceptance and commitment therapy has also been seen in different pathologies including medical conditions but paucity of researches found in enhancement of quality of life. In view of theoretical (chapter-I) and empirical background (Chapter-II), investigator may move on to Chapter III dealing with aim, objectives and hypotheses of the study.