CHAPTER - I

INTRODUCTION TO STUDY
CHAPTAR - I
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1.0. INTRODUCTION
1.1. THE BAKEGRAUND OF PRESENT STUDY
1.2. RESEACH PROBLEM
1.3. OBJECTIVES FO STUDY
1.4. HYPOTHESES OF STUDY
1.5. DEFINATON OF EACH DISORDER IN THE ENCLUDING IN
THE RESEACH WORK
1.6. OPERANTINAL DEFINITION OF TERMS
1.7. THE VARIABLE OF THE STUDY
1.8. IMPORTANCE OF STUDY
1.9. LIMITATION OF STUDY
1.10. ORGINATION OF STUDY
1.0. INTRODUCTION

Fear and stress reactions are essential for human survival. They enable people to pressure important goals, effect of any disease in a healthy individual. The stress response (fight of flight) is provoked by a genuine threat of challenge and is used as a spur for appropriate action.

Rapid changes are being carried out in every walk of life the development of science and technology and industrialization, urbanization in mordent age. On occults this life style of human beings is being change life style has increased human needs. Due to the blind running after the means of material happiness the proportion of complication, conflict, anxiety, obsessive compulsive behavior, phobia behavior, pressure, frustration have increased. Such situation produces stress. There are individual differences in coping with such stressful situation. Some people face anxiety, obsession – compulsion behavior and phobia. Situations quietly, while some other become the victim of behavior disorder.

The fact of stress are essentially limitless, however broad categories are include physical exertion emotional upset, persistent psychological pressure, existential crisis and residual effects of emotional trauma. It has consistently been shown that individuals experiencing stress have impaired physical and mental function and needed more use of healthcare services. The world health organization (W.H.O.) global burden of disease, including stress related disorders, will be the year 2020. The current therapies for dealing with stress are extensive but perhaps not ideally targeted in most of the cases. Any psychically disease effect of mentally behavior. many time I observed people psychically.

Work an extremely pervasive activity which reflects and influences human behavior. We are seen the many people that have a physical illness that their effect of mentally behavior. So here investigate the eye disease
patient and non eye disease patient that effect of Obsessive Compulsive disorder, Anxiety and Phobia in human nature.

This section brings out the major viewpoint in psychology this section is more than definition of human behavior and activities. This section also brings out topics in detail such as research problem, objective of study, definition of each disorder included of the study, key title of the problem, the variables of the research study, importance of the study, limitation of study and organization of study.

1.1. THE BACKGROUND OF PRESENT STUDY

1.1.1. Obsessive Compulsive Disorder

Obsessive compulsive come into usage the new term was popularized by 15 century intellectuals, Jeangeson and john diner. in the late 1600s several English clergymen wrote down how to deal with obsessive compulsive those self help writings by Richard Baxter and other probably were very helpful physicians of the (1700 and 1800) described many types of obsessive compulsive washing compulsive choking and other reported than in earlier centuries. Hennery Manud sly published an 1895 psychiatric text book recome ned prescring such opium and morphine to be taken three time day. And suggested that adding low dose of arsenic along with these narcotics could be helpful.

By the beginning of the twentieth century the view of obsessive compulsive neurosis had shifted toward a psychological explanation with ford’s publication in 1909 of the psychoanalyst of obsession neurosis (the ray man)obession and compulsive actions were seen as the result of unconscious and of thoughts and actions being isolated from their emotional components (fread 1909).as a result of this shift in the treatment of OCD turned away from the symptoms although this shift identified that actions
can be motive by factors of which the individual in unaware there was little imprudent in the treatment out comes for individuals who had suffered for obsessive compulsive disorder.

William Hammond (1828 1900) and other used bromides as sedatives for patients suffering from obsessive compulsive two figures dominated the early 20th century history of obsessive compulsive Freud theories about such matters gained influence and continued to be fairly well accepted up to the 1970s nineteenth regarded manifestations of depression (ranchman & hodson 1980).

1.1.2. Anxiety Disorder :

Anxiety is one king of emotion why do emotions play accentual part in our lives? Many researchers now view emotions as response patterns shaped by natural selection of offer selective advantages in certain situations (Plutchik and Kellerman 1998, Marks 1987; Elliott al 1989.) The bodily, behavioral and cognitive responses that constitute emotions are a preprogrammed pattern of responses that increase ability to cope with threats or seize opportunities.

Hysteria become a term used to describe anxiety and other related disorder begging in the 16th century hysteria was thought to be the reason for a women’s involvement in which craft by English physician Edward Jordon in 1603 da Costa’s views were published in 1871 and would have been diagnosed today as anxiety identification in 1903 john b. Watson introduced the term behaviorism to suggest that people could be conditions that cause anxiety term anxiety disorder had yet been widely used, the association hotels however research that linked abnormal blood flow in the brain to panic attack helped lead to new medications and treatment of
anxiety disorder association of America changed its name in 1990 to reflect the growing knowledge about anxiety disorder.

1.1.3. Phobia Disorder:

Phobia is marked and persistent fear of circumscribed object or situations (phobic stimuli), such as animals, blood heights closed spaces or flying. The fear is excessive or unreasonable exposure to the phobic stimuli provokes an immediate anxiety response (American psychiatric association 2000). People with social phobia suffer from amerced and persistent fear of one or more social or performance situations in which he or she is exposed to unfamiliar people or to possible scrutiny by others social phobia is common disorder with lifetime prevalence rates for DSM-III-R or DS-IV criteria in the range from 7-13 (Becker, turke, Neumer, Soeder & margrave,2002, Kessler at al.2005)

The first written reference to phobia problems we have is in the words of the ancient Greek physician Hippocratic (470-419.c.e.). Hippocratic wrote about the many aliments and problems of his patients and we can still read many of his volumes of observations today. After time first relatively modern use the word phobia wasn’t until 1786, when (According to the oxford English dictionary) an unknown write in the Columbian magazine defend the word as meaning “A fear of an imaging evil or undue fear of a feal one”. in the late 1800 medical science were by creating clear scientific categories of psychological problems. In 1885 Sigmund Freud (1856-1839) vienesse neurologist who founded the science of psychoanalysis. But wasn’t until 1947that phobia become a separate diagnostic category in the international classification of disease. In modern time in the 1960, it was observed that phobias basically divide themselves in to their rather different kinds of categories, an agoraphobia, social phobia and specific phobias.
1.2.  RESEARCH PROBLEM

The present time more than every person have a disturb a daily activities. Psychological study had discovered to 50% up people effect of psychoneurosis behavior in the 21 century, therefore more people effect of negative behavior. The necessary search of obsessive compulsive disorder, anxiety and phobia. Investigator want to know that are there are any differences between the eye patent and normal patient with reference to their obsessive compulsive disorder, anxiety and phobia.

Hence there for the below title has been undertaken as the research problem.

“A COMPARATIVE STUDY OF OBSESSIVE COMPULSIVE DISORDER, ANXIETY AND PHOBIA AMONG NORMAL PATIENTS AND THE EYE PATIENTS OF GUJARAT”

1.3.  OBJECTIVES OF STUDY

1. To find out significant mean difference between Normal Patients and Eye Patients with their Obsessive Compulsive Disorder, Anxiety Disorder and Phobia Disorder score.

2. To find out significant mean difference between male patients and female patients to their Obsessive Compulsive Disorder, Anxiety their and Phobia their score.

3. To find out significant mean difference between order of birth-1 patient and order of birth-3 patient to their Obsessive Compulsive Disorder, Anxiety Disorder and Phobia Disorder score.

4. To explore correlation behavior the patient of Obsessive Compulsive Disorder Anxiety Disorder and Phobia Disorder.

5. To suggest some steps for to reduce the eye patients.

6. To suggest some for the Normal Patients.
1.4. NULL HYPOTHESES OF THE STUDY

1. There is no significant mean difference between the eye patients and the normal patients and their obsessive compulsive disorder score.

2. There is no significant mean difference between the male patients and female patients and their obsessive compulsive disorder score.

3. There is no significant mean difference between order of birth-1 patient and order of birth-3 patients and their obsessive compulsive disorder score.

4. There is no joint significant mean difference effect between the type of patient and sex variable and their and there obsessive compulsive disorder score.

5. There is no joint significant mean difference effect between the type of patient and order of birth variable and their obsessive compulsive disorder score.

6. There is no joint significant mean difference between the sex and order of birth variable and their obsessive compulsive disorder score.

7. There are no joint significant mean difference effects between the type of patient, sex and order of birth and their obsessive compulsive disorder score.

8. There is no significant mean difference between the eye patients and the normal patients and their anxiety disorder score.

9. There is no significant mean difference between the male patients and female patients and their anxiety disorder score.

10. There is no significant mean difference between order of birth-1 patients and order of birth-3 patients and their anxiety disorder score.

11. There is no joint significant mean difference between the type of patient and sex variable and their anxiety disorder score.
12. There is no joint significant mean difference between the type of patient and order of birth variable and their anxiety disorder score.
13. There is no joint significant mean difference between the sex and order of birth variable and their anxiety disorder score.
14. There are no joint significant mean difference effects between the type of patient, sex and order of birth and their anxiety disorder score.
15. There is no significant mean difference between the eye patients and the normal patients and their phobia disorder score.
16. There is no significant mean difference between the male patients and female patients and their phobia disorder score.
17. There is no significant mean difference between order of birth-1 patients and order of birth-3 patients and their phobia disorder score.
18. There is no joint significant mean difference between the type of patients and sex variable and their phobia disorder score.
19. There is no joint significant mean difference between the type of patient and order of birth variable and their phobia disorder score.
20. There is no joint significant mean difference between the sex and order of birth variable and their phobia disorder score.
21. There are joint significant mean difference effects between the type of patient, sex and order of birth and their phobia disorder score.
22. There is no correlation between the patients of obsessive compulsive disorder and their anxiety disorder score.
23. There is no correlation between the patients of obsessive compulsive disorder score and their phobia disorder score.
24. There is no correlation between the patients of anxiety disorder and their phobia disorder score.
1.5. DEFINITION OF EACH DISORDER INCLUDING IN THE RESEARCH WORK

1.5.1. What is obsessive compulsive?

Obsessive compulsive disorder (OCD) is a heterogeneous condition that involves unwanted distressing thoughts and rites (Abramowitz et al., 2003). The American Psychiatric Association (Cited in Obsessive-Compulsive, 1995) explained the disorder as a set of obsession ideas or compulsive action that are recurrent and take up more than an hour a day.

The most common obsessions involve cleanliness of dirt and germs (obsessive-compulsive disorder part-I, 1998). American reason for the obsessions is the doubt that something has been done correctly (Battling persistent, 2005). People who suffer from obsessions usually fear that something awful is about to happen to them or someone close to them (bottling persistent, 2005). Individuals realize that the ideas and compulsions make no sense and do not need to be continued; however, they are unable to control and dismiss them (Spritzer & Heidelberg, 1997). Obsessions are usually relived for a period of time by compulsive acts, also known as rituals. They have to be performed according to rigid rules (Battling persistent, 2005).

Obsessive Compulsive Disorder is a disorder that seems to be under-diagnosed and under-treated in all age groups (Hayman et al., 2003) the research suggests that OCD affects up 2-3 % of the population (Journey, 2006; Zepf, 2004). The median age of onset of OCD is about 18 Years, although many cases have been found in children younger than the median age (Clinical Practice Guidelines 2006). The ratio of males to females is two males afflicted for every and female (Purcell, 1999). Previously, OCD was thought to be very rare, but recent research has identified OCD in both
children and adolescents as one of the most common of all psychiatric illnesses affecting youth (stewart et, al., 2004).

The onset of OCD generally beginning in adolescence and young adulthood. In the diagnostic and statistical manual of mental disorder fourth edition (Classed in Merlo & Stroch, 2006) has been classed as an anxiety disorder. The two symptoms clutters of the disorder are obsession thoughts and compulsive action. Both adults and children share common symptoms.

A major problem with understanding and treating this disorder is that the cause is not completely known. There have been studies that have indicated links to brain malfunction in patients with OCD (Obsessive-Compulsive Disorder-part –II, 1998). There have also been cases of OCD (giving up the seert, 1998). Although yet cause is not mind, research suggests the cause is neurobiological in nature and genetics and stress reacted situations may also play a role in OCD symptoms (Adams, 2004).

The diagnosis of OCD must follow yet criteria according to the DSM-IV. The person must also have symptoms that cause distress and consume a great deal of his? her time (Spizer & Heidelberg, 1997).

The assessment for person with OCD may involve multiple phases. These may include an interview that determines the description of the problem, the impact of time the problem, and a definition of how the person wishes his? Her life to be (Gournay,2006).

Imagine that your mind got stuck.

On a certain thought of image.

Then this thought or image got Replayed in your mind Over and Over again  No matter What you did You don’t what these thoughts it Feels likes an avalanche Along with the thoughts come intense feelings of anxiety…..
Anxiety is your brain’s warning system when you feel anxious, it feels like you are in danger. Anxiety is an emotion that tells you to respond, react, protect yourself, do SOMETHINGS.

On the one hand, you might recognize that the fear doesn’t make sense, doesn’t seem reasonable yet it still feels very real, intense and true.

Why would your brain lie?
Why would you be experiencing feelings if they weren’t true?

Unfortunately, if you have OCD, they do lie if you have OCD. The warning system in your brain is not working correctly. You are in danger when you are not.

When scientists compare pictures of the brains of groups of people with obsessive compulsive disorder, they can see that on average some areas of the brain are different compared to individuals who don’t have obsessive compulsive disorder.

1.5.1.1. What is Obsession?

1. Thoughts, images or impulses that occur over and over again and feel out of the person’s control.
2. The person does not want to have these ideas.
3. He or she finds them disturbing and unwanted and usually knows that they don’t make sense.
4. They come with uncomfortable feeling such as fear, disgust, doubt, or a feeling that is “just right”.
5. They take a lot of time and get in the way of important activities the person values (socializing, working, going to school, eat).
What obsessions are not….

It is normal to have occasional thoughts about getting sick or about the safety of loved ones.

1.5.1.2. What is Compulsions?

1. Repetitive behaviors or thoughts that a person engages in to neutralize, counteract, or make their obsessions go away.

2. People with OCD realize this is only a temporary solution but without a better way to cope they really rely on the compulsion as an aspect.

3. Can also include avoiding situations that trigger their obsessions.

4. Time consuming and get in the way of important activities the person values (socializing, working, going to school, etc.)

Not all repetitive behaviors or “rituals are compulsion bedtime routines, religious practices and learning new skills involve repeating an activity over and over again, but are a welcome part of daily life.

Behaviors depend on the context:

Arranging and ordering DVDs for eight hours a day a compulsion if the person works in a video store. (Merlo & Storch, 2006)

1.5.1.3. How common is Obsessive Compulsive Disorder:

Our best estimates are that about 1 in 1000 adults or between 1 to 3 million adults in the United States currently have OCD.

Three are also at least 1 no 200 or 5,000 kids and teens that have OCD. This is about the same number of kids who have diabetes. That means four or five kids with OCD are likely to be enrolled in any average size elementary school in a medium to large high school. In a medium to 20 students struggling with the challenges caused by OCD.
OCD effected men women and children of all races and back grounds equally.

1.5.1.4. **At what time age does Obsessive Compulsive Disorder begin?**

Obsessive compulsive disorder can start at any time form preschool to adulthood. Although OCD does occur at earlier ages, there are generally two age ranges is between ages. Range when OCD first range is between ages 10 and teens and early adulthood.

1.5.1.6. **Is Obsessive Compulsive Disorder Inherited?**

Research shows that OCD does run in families and that development of the disorder. Genes appear to be only partly responsible for causing disorder though. No one really knows what others factor might be involved, perhaps an illness or even ordinary life stresses that may induce the activity of genes associated with the symptoms of obsessive compulsive disorder.

1.5.2. **What is Anxiety Disorder?**

Anxiety case difficulties across social occupational and every day functioning (Castle, kylkarni Abel 2006) and have been liked worth physical disease, relationship difficulties and reduced concentration (Nutt, 2004), thus significantly contributing to determents in suffers performance. These negative effects are important when considering counseling services and treatments because anxiety disorder are the most common mental illness(Word Health Origination,2000) and may therefore be expected to occur in a large proportion of people who present for counseling.

As well as having its own negative sequel, anxiety may be a risk factor for later development (Marra, 2004), which also has damaging
consequences for many aspects of functioning. Anxiety have several causes and one of the strongest is stress.

Anxiety is characterized as a component of fear and such fear has cognitive, neurobiological and behavioral manifestations. If often is present concurrently with their. Anxiety an unpleasant mood characterized by thoughts of worry is an adaptive response to perceived threats that can disorder. If it become sever and chronic. National institute of mental health.

1.5.2.1. Anxiety Disorder Classified DSM-IV

One person has been exposed to traumatic event in which both of the following were present.

1. The person experienced witnessed, or was confronted with an event that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others.

The person’s response involved intense fear, helplessness or horror either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms.

A subjective sense of numbing of numbing detachment, or absence of emotion.

1) A reduction in awareness of his her surroundings
2) Responsiveness serialization
3) Depersonalization
4) Dissociative amnesia (i.e. inability to recall an important aspect of the resume)

3. The traumatic event is persistently re-experienced in at least one of the following ways recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience of the traumatic event.
4. Marked avoidance of stimuli that arouse recollections of the trauma (e.g. Thoughts, feelings, conversations, activities, places, people)

5. Marked symptoms of anxiety or increased arousal (e.g. difficulty sleeping response motor gentleness)

6. The disturbance cause clinically significant distress or important in social, occupational, or other important areas of functioning or impairs the individual’s ability to pursue some necessary task such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

7. The disturbance lasts for a minimum of 2 days and maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

1.5.3. What is Phobia Disorder?

A phobia is an overwhelming and unreasonable fear of an object or situation that poses little real danger but provokes anxiety and avoidance. Unlike provokes anxiety most people feel when they give a speech or take a test, a phobia is long lasting, causes intense, and can affect your ability to function in normally at work or in social settings. Several types of phobias exist. Some people fear large, open spaces. Other is unable to tolerate certain social situations. And still other have a specific phobia, such as a fear of snakes, elevators of flying.

A phobia is an irrational fear, a kind of anxiety disorder in which the suffer has a relentless dread in which the sufferer has a relentless dread of a situation, living creature, place or thing,

Individuals with a phobia go to grat lengths to avoid a perceived dander which is much greater in their minds than in real life. If confronted with the sourer of their phobia, the person will suffer enormous distress,
which can interfere with their normal function; it can sometime lead total panic. For some people, even thing about their phobia is immensely distressing.

1.5.3.1. **Phobia Disorder Classified DSM-IV**

The terms distress and impalement as defined by the diagnostic and statistical manual of mental disorder, fourth edition (DSM -IV) should also take into account the context of the sufferer’s averment if attempting a diagnosis the DSM-IV TR states that if a phobia stimulus. Ether it be an object or a social situation is absent in an environment a diagnosis cannot be made. An example of this situation would be an individual does not encounter mice in the environment no actual disorder or impairment is ever exasperated proximity and the degree to which increases in ophidiphobia ) and the degree to which escape of the phobic stimulus is limited has the effect or varying the intensity of fear in instances such as riding an elevator (e.g. anxiety increases at the midway point between floors and doors open)

The term phobia is encompassing and usually discussed interims of specific phobia and social phobia are noun such as agora phobia Agra phobia with are specific and social phobia are phobia within social situations such as public speaking and crowded eras. Some phobia such as xenon phobia overlaps with many other phobias.

1.6. **OPRATIONAL DEFINATION OF KEY TERMS:**

1.6.1. **Sex :**

The state of being male and female

1.6.2. **Order of birth :**

Rank of siblings by age
1.6.3. **Dependent variable:**
Variable which are observable and which have Relation To The Independent variable

1.6.4. **Independent variable:**
Variables which are measured and which determine the Value of dependent

1.6.5. **Disorder:**
Disease or illness

1.6.6. **DSM- IV :**
Diagnostic and statistical of mental diseases (IV)

1.6.7. **Eye Disease :**
All type of disease Related to eyes

1.6.8. **Blood Pressure :**
Heart failure is common in patients with high Blood presser.

1.6.9. **Heart Attack:**
When the flow of blood to the heart is blocked, most Often by a buildup of fat cholesterol and other…

1.6.10. **Diabetic:**
Diabetes symptoms vary depending on how much your Blood Sugar is elevated.

1.6.11. **Patient:**
A Clint for take a medical service (as of a physician)

1.6.12. **OCD:**
Obsessive Compulsive Disorder
1.7. THE VARIABLE OF RESEARCH STUDY

Independent variable are those whose values are controlled of selected by the person experimenting (experiment) to determine its relationship to an observed phenomenon (the variable). An attempt is made to find evidence that the values of the independent variable (that which is being measured). The independent variable can be changed as required, and its values do not represent a problem requiring explanation in analysis, but are taken simply as given. The depended variable and the other hand usually cannot directly control.

1.7.1. Independent Variable:

This variable which are measured and which determine the value of Dependent variable, so independent variable as bellow

(A) Type of Patient:
   - Eye Disease patient = $A_1$
   - Non Eye Disease Patient = $A_2$

(B) Sex:
   - Male = $B_1$
   - Female = $B_2$

(C) Order Birth:
   - Order of Birth-1 = $C_1$
   - Order of Birth-3 = $C_2$

1.7.2. Dependent variables:

Variable which are observable and which have relation to the Independent variable. A total score obsessive compulsive disorder, Anxiety disorder and phobia disorder are relying questionnaires.

1. Obsessive compulsive disorder score
2. Anxiety disorder score
3. Phobia disorder score
1.8. **IMPORTANT OF STUDY:**

Now after having know the organizations in which the study was conducted, it is essential to understand as to how the study was conducted on over view of the same is brought under this study has been intended to bring out the clinical importance of the differences between obsessive-compulsive disorder, anxiety and phobia.

1.9. **LIMITATION OF THE STUDY**

We all they know that our research depend on human behaviors so many human (traits) are effect to in our research (e.g. nature, prejudice, like dislike, attitude etc.) So we can say that some limitation of clinical psychology is as under.

1) Here total sample consisting 880 so we getting this result are using only area for Ahmadabad, Kutch, junagadh, Rajkot district in Gujarat state so that finding of study can not to be generalized of large population.

2) The present research to method of collecting data using only the inventory method, are using for data collecting like as analytical method etc.

3) In the study only selected dependent variable was choose like as obsessive compulsive disorder, anxiety and phobia, but we included same other dependent variable (e.g. personality disorder, type of anxiety etc.)

4) In the study the sample respondent’s age range was 18 to 70 years. non those who are lower and upper age involved.

5) The present study only Eye patient and Normal (heart patient, diabetic patient and blood presser patient) patient.
6) The respondent’s beliefs personal options perceptions may be effect on their scores. Hence it may be possible trial-it does not reflect the real patient of the respondents.

1.10. ORIGINATION OF STUDY

This section brings out the various organization in the study was undertaken and under which guidance the study was authorized.

Saurastra university, department of psychology, Rajkot authenticated the guidance of prof. and head of department, Dr. D.J. Bhatt, the research was organized.

The clinical practice was with the help of Dr, tilvani, md. Psychiatric) dr. kahma maheta, Dr. kavita shah (ophthalmic sarsen) Bhuj and other


The library of Saurashtra University, govt. library, Bhuj college library, university of Gujarat, library have largely benefited in collection of the historical evidences of psychology.

G .K .general hospital Bhuj, general hospital junagagh government hospital Rajkot, government hospital surendrananger and its have largely contributed in the collection of the data for the research work.

Now after having study was conducted it is essential to understand as to how the study was conducted an overview of the same is brought under.

This study has been intend ant to bring out clinical and behavior importance of person know of obsessive compulsive, anxiety, and phobia disorder in order to understand the nature of the disorder included in the research topic it was felt essential that a brief break ground in psychological is required to be under stood. Moreover , to have a good
command in understanding the disorder their epidemiology, etiology, diagnosis, diagnostic criteria under DSM-IV, clinical features, differential diagnosis, in the present medical condition are felt essential to be brought down and the same have been illustrated in the introductory chapter, further this study which was warranted and a pre investigation before undergoing doctoral work for the same was conducted the results and suggestions of the pilot study were accepted and utilized in the research process. the present study has its roots form the development of psychology to the yesteryears of psychology to the modern day and the literature for the same has been reviewed from various sources viz libraries, reviewed from various sources viz libraries, websites, medical journals etc. it was felt essential to experimentally evaluate the public affected with the disorders undertaken for the research. hence, as suggested by the pilot study questionnaires in accordance with the DSM-IV criteria questionnaires were constructed and utilized for the randomly selected patients of bhuj hospital junagadh govt. hospital Rajkot hospital and govt. Ahmadabad hospital also case histories were recorded for the respondents who reported to the researcher. Statistical inferences obtained and the outcome of the investigation its importance, de limitations, limitations of the study, suggestions for further study was recorded upon subsequently. The entire study is divided into six chapters and brief description of each chapter is brought down here under.

1.10.1. Chapter-1: Introduction

The first chapter is of the introductory nature dealing with the need of this type of research work and its relevance in the present day context training to the background of psychology statement of the research problem and the objectives clarified, null hypothesis, definition for obsessive compulsive disorder, anxiety and phobia, the variables of the
research study, importance of the study delimitation, limitation quoted organization of the chapters mentioned.

1.10.2. Chapter 2: Review of Literature

In this chapter literatures on the obsessive compulsive disorder, anxiety and phobia have been discussed well-mannered in detail. The evidences of we seen review of literature for obsessive compulsive disorder, anxiety and phobia the last we seen with obsessive compulsive disorder, anxiety and phobia.

1.10.3. Chapter 3: Development Scale and Standardization of Research Tools

This chapter deals with the develop of obsessive compulsive disorder, anxiety and phobia scale. The scale contraction and obtained of validity, reliability and norms are discussed in detail.

1.10.2. Chapter 4: Research Design of the, procedures and methods of analysis

The third chapter deals with the research design. It also states how the same was selected from the population, which sampling method was used and its detailed narration has been discussed. Collection of data, research tools, measurement of independent variables discussed in detail.

1.10.4. Chapter 5: Analysis of the Results, Interpretation and Discussions

This chapter deals with the analysis of the disorders interim of statistics and the interpretation from the inferences obtained through the
statistics. Further, case histories, suggestions for improvement and recommendation are discussed in detail.

1.10.5. Chapter 6: Summary and Conclusion

This chapter deals with the summary of the research conclusions based on statically technique, conclusions regarding all disorder recommendations, suggestions for further research are discussed.