EFFECTIVENESS OF COGNITIVE BEHAVIOUR THERAPY ON PATIENTS WITH OBSESSIVE COMPULSIVE DISORDER

A Dissertation
Submitted to the Department of Clinical Psychology, University of Dhaka, in partial fulfillment of the requirements for the degree of Master of Philosophy in Clinical Psychology

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Dedicated to my father and my husband

Approval Sheet

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ABSTRACT

Obsessive Compulsive Disorder (OCD) is the fourth most common mental disorders in Bangladesh and it is an extremely debilitating and frustrating disorder that interferes with virtually every aspect of everyday life. Cognitive behaviour therapy (CBT) is one of the most promising non-medication based psychotherapeutic interventions for treating OCD patient. But in Bangladesh, very few studies have been conducted on the efficacy of CBT in the treatment of OCD. Hence the present study aimed to investigate the effectiveness of CBT on patients with OCD. The specific objectives of the study were: i) To see the effectiveness of CBT on pharmacologically treatment resistant OCD patients ii) To compare the functional level changes of the clients of non responders to medication before, mid and after receiving CBT treatment iii) To compare the functional level changes of the clients of non responders to medication (who did not receive CBT) between before, mid and after measure iv) To compare the functional level changes between the clients of non responders to medication who received CBT and the non responders who did not receive CBT. Present study adopted systematic case study design with before, mid, after and follow-up measurement. A CBT structure was developed for the assessment and treatment session for the patients who have treated under CBT. Besides this, adult initial assessment form, Anxiety Scale (Deeba & Begum, 2004), Depression Scale (Uddin & Rahman, 2005), Dhaka University Obsessive Compulsive Scale (Mozumder & Begum, 2005), Self-rating measurement scale (11 point verbal rating scale) were administered to measure the changes in the severity of the OCD. Purposive sampling technique was used to select the sample of the present study. In the present study 14 adult clients were selected following inclusion criteria. All the clients were divided randomly into two groups. 7 (4 males and 3 females) clients were in group-A (Experimental group), they were non responders to medication and received CBT and other 7 (4 males and 3 females) clients were in group-B (Control group), they were also non responders to medication but they continue medication and received no CBT. The age of the clients ranged from 20 to 43 years. They were from lower middle class to upper middle class family. Their educational levels were from class X to Bachelor

Degree. 5 clients of all the clients were married and remaining 9 clients were unmarried. The samples were taken from the Psychiatry outpatient and/ or inpatient department of Bangabandhu Sheik Mujib Medical University (BSMMU) in Dhaka and Dhaka Medical College Hospital (DMCH). Pre-assessment measures were done for both groups with three semi-structured interview sessions and mid-assessment sessions were also done for both groups with one interview session. After completing the baseline measurement, intervention were applied on group-A for about 7-10 sessions (7-10 weeks). Finally for 6 clients from group-A, three follow-up measurements were also taken for one month and 15 days interval after the termination of the sessions but 1 client did not want to continue his follow up participation in the study. Also three follow-up measurements were taken for one month and 15 days interval after the termination of the sessions for 6 clients from group-B but 1 client did not want to continue his follow up participation and 1 client did not want to continue her post and follow-up participation in the study. Results were analyzed through content analysis and in-depth case study for both the groups. From the case study and content analysis it was found that CBT was effective in reducing the severity of the symptoms. In the subjective rating the CBT group clients reported 75 to 90% reductions in their symptoms and the care givers reported 70 to 80% reductions of symptoms of the clients. The clients of group-B reported 0 to 25% reduction in their symptoms and the care givers reported 0 to 20% reductions of symptoms of the clients. Reports of the Psychiatrist also revealed higher improvement in experimental clients than control clients. Changes also differed according to their functional level. The subjective rating of problem severity was also consistent with the psychometric scale scores. The present study has some limitations. First, sample size was not big enough, only adults were selected and child clients were not included. Therefore, the findings of this study can not be generalized for all sorts of OCD clients. Second, the investigator and the therapist was the same person and it increased the probability of subjective bias. Nevertheless, the present study developed a guideline for the CBT therapist for the treatment of OCD. From the results of the study it was found that CBT could bring a positive change among the OCD patients and therefore, it can be concluded that CBT is effective in treating patients with OCD and medicine resistance patients could reduce their symptoms if CBT is given with medicine.

ABBREVIATIONS

AS: Anxiety scale

BDD: Body dysmorphic disorder

BSMMU: Banghabandhu Sheikh Mujib Medical University

CBT: Cognitive behaviour therapy

DMCH: Dhaka Medical College Hospital

DS: Depression scale

DTR: Dysfunctional Thought Record Sheet

DUOCS: Dhaka University Obsessive Compulsive Scale

ERP: Exposure with response prevention

GAD: Generalized anxiety disorder

Group-A: Experimental Group

Group-B: Control Group

OCD: Obsessive Compulsive Disorder

OCPD: Obsessive compulsive personality disorder

SSRI: Serotonin Re-uptake Inhibitors

SST: Social Skill Training

TCA: Tri-cyclic Anti Depressant

TS: Tourette's syndrome

TTM: Trichotillomania

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Chapter-1

INTRODUCTION

INTRODUCTION

Everyone feels anxiety, fear, uncertainty or worry at sometimesin his or her life. These normal emotions and reactions help people to protect themselves, stay safe and solve problems. Usually these feelings do not last long and do not come often. But for people with Obsessive Compulsive Disorder (OCD), these feelings are taken to extremes. It is as if the brain's filter for sorting out what is dangerous from what is not dangerous is not working properly. Instead of keeping normal worry in perspective, there is a constant stream of uncertainty, doubt or fear in the person's mind.

OCD is the fourth most common mental disorders and is diagnosed nearly as often as the physiological ailments asthma and diabetes mellitus. The phrase "obsessive–compulsive" has become part of the English lexicon, and is often used in an informal or caricatured manner to describe someone who is meticulous, perfectionistic, absorbed in a cause, or otherwise fixated on something or someone.

1.1: What is Obsessive Compulsive Disorder (OCD)?

OCD is a type of anxiety disorder. Anxiety disorder is the experience of prolonged, excessive worry about circumstances in one's life. OCD, in which a person feels compelled to engage in certain physical or mental acts ("rituals" or compulsions) in order to relieve his anxiety connected with intrusive thoughts (obsessions). OCD is characterized by everyday intrusion into conscious thinking of intense, repetitive, personality abhorrent, absurd and alien thoughts (Obsession), leading to endless repetition of specific acts or to the rehearsal of bizarre and irrational mental and behavioural rituals (Compulsion). As such clinical manifestations of OCD may be very diverse. OCD often described as the "disease of doubt," the sufferer usually knows the obsessive thoughts and compulsions are irrational but, on another level, fears they may be true. When a sufferer begins to acknowledge these intrusive thoughts, the sufferer then develops anxiety based on the dread that something bad will happen. The sufferer feels compelled to voluntarily perform irrational, time-consuming physical behaviors to diminish the anxiety.

Diagnostically OCD is defined by the occurrence of unwanted and intrusive obsessive thoughts or distressing images; these are usually accompanied by compulsive behaviours designed to neutralize the obsessive thoughts or images or to prevent some dreaded event or situation.

OCD is one of the conditions traditionally considered as a neurotic disorder, like phobias and anxiety states. Other terms used for this disorder include Obsessive (or Obsessional)-Compulsive Neurosis and Obsessive (or Obsessional)-Compulsive illness- or simply Obsessive (or Obsessional) disorder or Compulsive Disorders.

According to the American Psychiatric Association (1994), OCD is a problem in which the sufferer is plagued by either obsessions or compulsions, or usually both. Unwanted recurrent intrusive thoughts, impulses, or images that cause marked distress and are not simply excessive worries about real life problems. The sufferers make attempts to ignore, suppress, neutralize the obsession and recognize them as products of their own mind.

In current psychiatric thinking, OCD is classified as an anxiety disorder. Other anxiety disorders include, among others, phobias, panic disorder, and generalized anxiety; they all share anxiety as a basic feature, and there is overlap of symptoms among them.

1.1.1: What is Obsession?

According to DSM-IV (APA, 1994), Obsessions are defined as persistent thoughts, impulses, or images that occur repeatedly and are experienced as intrusive, inappropriate and distressing.

Obsession can be defined as an unwanted intrusive, recurrent and persistent thought, images or impulses which are not voluntarily produced, but are experienced as events that invade a person's consciousness (de Silva and Rachman, 1992).

Obsessions are unwanted ideas, images or impulses that repeatedly enter a person's mind (Heyman et al., 2007).

An obsession is a recurrent and intrusive thought, feeling, idea or sensation (Sadock and Sadock, 2000).

Obsession is an uncontrollable and intrusive thought, something that is completely involuntary and involves passive experience. Akhtar et al. (1975) identified the types of obsessions that OCD sufferers typically experienced. The vast majority of intrusive

thoughts involved doubts, thoughts, fears and impulses (of course these sets are not mutually exclusive), with intrusive images being less prevalent: Doubts (74%); Thinking (34%); Fears (26%); Impulses (17%); Images (7%); other (2%). Obsessions can take many forms, as well as varying types (thoughts, impulses, images) the content can vary enormously from simply doubts, to impulses, to bizarre intrusions.

Obsessions generally seem to fall into certain common groups that can all be broadly defined in terms of being socially unacceptable (morally, spiritually or physically). For example contamination, illness, disease, dirt and death are common linked themes. Sex or morally unacceptable sexual practices, are also a common themes. These all, coincidentally, link with disgust which is now considered as one of 6 universal emotions and disgust sensitivity has been linked to other anxiety disorders such as spider phobia (Davey, 1994).

The diagnostic criteria from DSM-IV-TR (2000) of obsessions are as follows-

1. Recurrent and persistent thoughts, impulses, or images that are experienced at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress.
2. The thoughts, impulses, or images are not simply excessive worries about real-life problems.
3. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.
4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her mind, and are not based in reality.
5. The tendency to haggle over small details that the viewer is unable to fix or change in any way. This begins a mental pre-occupation with that which is inevitable.

1.1.2: What is Compulsion?

A compulsion differs from an obsession in that it is a conscious, voluntary action.

According to DSM-IV (APA, 1994), Compulsions are defined as repetitive behaviors (e.g., washing, cleaning, repeating actions) or mental acts (e.g., thinking certain words, counting, checking) that an individual feels compelled to perform in response to an

obsession or according to certain rigid rules (e.g., having to complete tasks in a particular order). De Silva (1988) defines compulsions as: "A compulsive behaviour, either overt or covert, which has a rigid set pattern or sequence of steps with a clear-cut beginning and end". These rituals can be overt (behavioural) such as cleaning, checking, hoarding and orderliness. Alternatively they can be covert (cognitive) such as imaging sequences, or repeating 'cancellation thoughts'. Typically these behaviours have a rigid sequence of steps with a clearly defined beginning and end.

Compulsion can be defined as repetitive and seemingly purposeful behaviour that is performed according to certain rules or in a stereotyped fashion and is not an end in itself but is usually intended to prevent some event or situation (de Silva and Rachman, 1992). Compulsions are repetitive stereotyped behaviours or mental acts driven by rules that must be applied rigidly (Heyman et al., 2007).

A compulsion is a conscious, recurrent pattern of behaviour a person feels driven to perform (Sadock and Sadock, 2000).

The diagnostic criteria from DSM-IV-TR (2000) of compulsions are as follows-

1. Repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
2. The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

A person may have both obsessions and compulsions. It is certainly true that obsessions are mental events, but not all compulsions are motor behaviour. Many patients have covert, or mental compulsions that have all the main features of overt compulsions.

1.1.3: Symptoms of OCD

Most people with OCD have both obsessions and compulsions, but some people experience just one or the other. The symptoms of OCD may wax and wane over time. Symptoms of OCD tend to come and go over time and range from mild to severe. OCD symptoms are wide ranging. Most people with OCD generally fall into a set pattern or

cycle of thought and behaviour. Major symptoms of obsessions and compulsions are discussed below:

Obsessions:

1. Contamination

Excessive fear or disgust, and preoccupation with avoiding: bodily waste or secretions-urine, feces, saliva, blood; dirt or germs; sticky substances or residues; household cleansing agents or chemicals; environmental contaminations-radon, asbestos, radiation, toxic waste; touching animals; insects; becoming ill from contamination; making others ill by contaminating them; diseases-AIDS, hepatitis, sexually transmitted diseases etc.

2. Hoarding, Saving, and Collecting

Worry about throwing things away, even seemingly useless items; urge to collect useless things; urge to pick up items from the ground; uncomfortable with empty space-feel need to fill it etc.

3. Ordering

Preoccupation with symmetry, exactness, or order; excessive concern that handwriting be perfect or just so; concern with aligning papers, books, and other items a certain perfect way etc.

4. Religious Obsessions, Scrupulosity

Excessive fear, worry, and preoccupation with: having blasphemous thoughts or saying bad things; being punished for blasphemous thoughts; concern with religious beliefs; issues of right and wrong, morality; dwelling on religious images or thoughts etc.

5. Somatic

Excessive fear, worry, and preoccupation with: having an illness or negative reactions of others to one's appearance.

6. Aggressive

Preoccupation and excessive, illogical fear of: harming self; harming others; acting on unwanted impulses-e.g. run someone over, stab someone; harming others through own carelessness; violent or horrific images in individual mind causing individual to do harm to others etc.

7. Sexual

Unwanted, worrisome and intrusive sexual thoughts, images, or impulses; thoughts about molesting own or other children; thoughts about being or becoming a homosexual; thoughts or images of violent sexual behaviour toward others etc.

Miscellaneous Obsessions:

Urge to know or remember certain things-slogans, license plate numbers, names, words, events of the past; fear of saying something wrong, not saying something just right, or leaving out details; worry about losing things; worry about making mistakes; easily bothered by certain sounds and noises-clocks, ticking, loud noises, buzzing; excessive superstitious fears with rigid adherence to them; excessive concern with lucky and unlucky numbers with rigid adherence to them.

Compulsions:

1. Cleaning and Washing

Excessive, illogical, and uncontrollable hand washing, often performed in a ritualistic way; showering or bathing, often performed in a ritualistic way; ritualistic tooth brushing, grooming, shaving; cleaning of the house, certain rooms, yard, sidewalk, car; cleaning of objects, household items; use of special cleansers or cleaning techniques; avoidance of objects considered contaminated; avoidance of specific places-cities, towns, buildings- considered contaminated; concern with wearing gloves or other protection to avoid contamination.

2. Checking

Checking over and over (despite repeated confirmation): some aspect of physical condition, health-pulse, blood pressure, appearance; physical surroundings-locks, windows, appliances, stoves etc.

3. Hoarding, Saving, and Collecting

Saving, collecting seemingly useless items; pick up useless items from the ground etc.

4. Repeating, Counting, Ordering

Repeating and rereading things, sometimes for hours; excessive writing and rewriting things; repeating routine activities-going in and out of doorways, repeated crossing of thresholds, getting up and down from a chair, combing hair, tying shoes, dressing and undressing over and over; doing certain activities a particular number of times; counting items-books on a self, ceiling tiles, cars going by; counting during compulsive activities, such as checking and washing; arranging items in a certain order-books, pencils, cupboards etc.

Miscellaneous Compulsions:

Mental rituals-prayers, repeating 'good' thoughts to counteract 'bad' thoughts (Note: Unlike obsessions, these mental rituals are performed with the intention of reducing or neutralizing anxiety); excessive need to repetitively ask others for reassurance when ample assurance is evident to others, and has already been provided by those around individual; need to confess wrong behaviour, even the slightest insignificant infractions of behaviour toward others.

Related symptoms:

Pulling own hair-from scalp, eyebrows, eyelashes, pubic area; acts of self-damage or self-mutilation-picking skin; compulsive shopping.

Intense anxiety and even panic can come whenever the person attempts to stop the ritual. The tension and anxiety build to such an intense degree that individual surrenders once again to the thoughts or behaviours. Therefore, the symptoms of OCD are accompanied by varying degree of anxiety, depression, and depersonalization (Gelder, Mayou and Cowen, 2001).

1.1.4: Sub classes of OCD

OCD can be classified into several sub classes according to their major symptoms which are described below.

Checkers live with a more than normal sense of being responsible for dangers and events causing great damage or suffering as a result of their perceived negligence. They are compelled to check things like doors, windows, taps, gas, locks and electrical appliances etc in hope that they have prevented potential catastrophes from happening. Washers and cleaners have obsessions surrounding contamination either to themselves or others. They live in fear that unless they fulfill their compulsion either themselves or someone else will become contaminated. Orderers and repeaters feel that they must arrange certain items or repeat certain actions over and over in a particular, exact, or perfect way to somehow prevent harm to them or a loved one. They become extremely distressed if their things are moved, touched, or rearranged.

People with pure obsessional thought experience unwanted intrusive thoughts and images of causing danger or harm to others. Instead of behavioural rituals, many engage in repetitive thoughts, such as counting, praying, or repeating certain words, to counteract their anxious thoughts. They may also mentally review situations obsessively to ward off doubt and relieve anxiety. Hoarders have difficulty in discarding items that most people would consider rubbish. They develop a strong attachment to their hoarded items and overestimate their importance. They are plagued by fear that may need them at some time in the future. People with Scrupulosity are obsessed about religious or moral issues. Their sense of self discipline goes beyond the normal code of behaviour. Their compulsions may involve prayer and seeking reassurance from others regarding their moral purity.

1.2: Prevalence and incidence of OCD

The true prevalence of OCD has been a source of controversy in the literature. Early research concluded that OCD was relatively rare, with general population estimates as low as 0.05% (Karno & Golding, 1991). Two recent epidemiological studies reported a lower 1-year prevalence rate (0.7%) than the 1-year rate (1.6%) found in the Epidemiologic Catchments Area (ECA) study (Kringlen, Torgersen & Cramer, 2001; Andrews, Henderson, & hall, 2001). The only estimate of OCD's prevalence in the general population made prior to 1983 was proposed by Ruedin, who estimated the prevalence to be 5 in 1000 (Rassmussen &

Eisen, 1990). The main knowledge about OCD based almost entirely on patient samples, before the ECA study was carried out in the United States (Weissman et al., 1994). The primary results of the latter were published 1984 (Meyer et al., 1984; Robins et al., 1984) and further comprehensive analysis 1988 (Karno et al., 1988). A similar investigation was carried out in Edmonton in Canada with similar results (Koloda et al., 1994). Degonda et al., (1993) studied the prevalence of OCD in Zurich and came up to a one year prevalence of 0.3-0.8% in this city. The life-time prevalence of OCD in other parts of the world seems similar to the findings in the United States: Puertorico 2.5%, Munich 2.5%, Korea 1.9% and New Zealand 2.2%. The prevalence in Taiwan seems to be lower than other regions. Generally the six-month prevalence of OCD in the general population is estimated 0.7-2.1 and its lifetime prevalence 2-3% (Weissman et al., 1994; Jenike, 2004). Almost one out of every 40 people will suffer from obsessive-compulsive disorder at some time in their lives. Approximately 3.3 million American adults ages 18 to 54, or about 2.3% of people in this age group in a given year, have OCD and about 2.3% of the U.S. population ages 18 to 54- approximately 3.3 million Americans- has OCD in a given year (Source: excerpt from Facts about OCD: NIMH).

The Incidence of OCD might be more probable at time of hormonal changes like in pregnancy and childbirth; the symptoms may increase in intensity during the menstrual period (Rasmussen and Eisen, 1984). The possible role of pregnancy in the onset of OCD is investigated in some studies (Williams & Koran, 1997; Neziroglu et al., 1992). There are some reports of increase prevalence of OCD in widowhood (Nestadt et al., 1998). The OCD patients might be less fertile than the general population (Noshirvani et al., 1991).

1.2.1: Sex ratio

The prevalence has generally been reported higher in women than men (Saxena & Rauch, 2000; Pigott, 2003). The reverse was the case only in Germany (Sasson et al., 1997). The lifetime prevalence in women has been reported as 0.9%-3.4% (Weissman et al., 1994).

1.2.2: Ordinal position

It was assumed previously that OCD were significantly more prevalent in first-born children, but this has not been confirmed in recent studies (Nestadt et al., 1994).

1.2.3: Marital status

Men are likely not to be married and display a higher frequency of symptoms such as sexual, exactness and symmetry obsessions and odd rituals; by contrast, women are more likely to be married. Recent evidence suggests an association between obsessional illness, separation, and divorce (Yaryura-Tobias and Neziroglu, 1983).

1.2.4: Family, social class and education

It is widely believed by clinicians that OCD is more common among those in higher social classes and with a higher educational background. The lifetime prevalence of OCD is lower for those who have graduated high school than for those who have not (1.9% versus 3.4%).

1.2.5: Religion

There is some evidence to suggest that OCD may be associated with certain religions more than others. However, Steketee, Quay & White (1991) did not find any specific association between denomination and OCD. Moreover, obsessional patients were not found to be more religious or guilty than anxious controls.

1.3: Association of OCD with other psychiatric conditions

A wide range of psychiatric and medical disorders have been hypothesized to be related to OCD and thus, together, to form a family of disorders known as obsessive compulsive (or OCD) spectrum disorder. The grouping of these conditions is based on their phenomenological similarities with OCD (i.e., obsessive thinking and/or compulsive behaviors), as well as their having courses of illness, co morbidity and family history patterns, biological abnormalities, and treatment responses similar to OCD. The association of OCD with other disorders is discussed below.

1.3.1: OCD and Obsessive Compulsive Personality Disorder (OCPD)

A number of empirical studies found that obsessional personality characteristics were quite distinct from obsessive-compulsive symptoms and that the majority of patients with OCD do not have a pre-morbid obsessional personality (Rachman & Hodgson, 1980). Despite an Axis II co morbidity rate of 50-65%, the most common personality disorders in OCD are the

dependent and avoidant patterns, with OCPD being less prevalent than one might expect (Summerfeldt, Huta, & Swiuson, 1998). However, other studies continue to find elevated levels of OCPD in clinical samples of patients with OCD (e.g., Samuels et al., 2000).

1.3.2: OCD and generalized anxiety disorder (GAD)

GAD is similar to OCD in that it is often associated with prominent ruminations, anxiety, a lack of control over worry, and sometimes checking rituals (usually related to safety or illness). In contrast to individuals with OCD, people suffering from GAD typically experience worries about more ordinary life circumstances, including finances, work and minor matters. However, for certain types of worries (e.g., health-related fears), the boundaries can be more blurred. Also, when repetitive behaviours are present in GAD, they are frequently cognitive and usually do not involve the common OCD rituals of washing, checking, or counting. Despite overlap in the features of OCD and GAD, these disorders typically do not occur together and are usually easy to distinguish from one another.

1.3.3: OCD and mood disorder

OCD commonly co-occurs with a mood disorder. Bellodi, Scinto, Diaferia, Ronchi, and Smeraldi (1992) found that among the 35.9% of OCD patients who also met criteria for a mood disorder, only 15% reported that the depression predated the OCD, suggesting that the depression may have occurred in response to the OCD. Demal, Lenz, Mayrhofer, Zapotoczky, and Zitterl (1993) found that 79% of OCD patients had clinical levels of depression. According to a study by Ricciardi and McNally (1995), presence of co morbid depression seems to be related to more severe obsessions but is not related to the severity of compulsive behaviours. For decades clinical researchers have recognized a close relationship between OCD and depression (e.g., Lewis, 1936; Rosenberg, 1968; Stengel, 1945).

1.3.4: OCD and bipolar disorder

OCD has a complex relationship with bipolar disorder. In one study, 20% of people with bipolar disorder had OCD, twice the number seen in unipolar depression (which is also higher than people with no diagnosis). A group of researcher has looked at now OCD and bipolar relate. They found that whereas unipolar depression was "incidental"' i.e. not clearly

related to the OCD, by contrast bipolar disorder seemed to be more directly related to the OCD.

1.3.5: OCD and panic disorder

Panic disorder is also associated with OCD symptoms. Interestingly, behavioural treatment of agoraphobia appears to decrease OCD symptoms in PD patients with obsessions or compulsive behaviours (Fava, Zielezny, Luria and Canestrari, 1988).

1.3.6: OCD and phobias

Most OCD patients experience a lot of anxiety (De Silva & Rachman, 1992) and anxiety disorders are commonly manifested along with OCD. In OCD patients there is high lifetime prevalence of specific phobia (22%), social phobia (18%), and panic disorder (12%) as reported by Rasmussen and Eisen, (1991). Phobias and OCD both involve intense, irrational fears and repeated avoidance of anxiety-provoking objects and/or situations. Furthermore, recent studies indicate that 7% of those with OCD also have one or more phobias.

1.3.7: OCD and schizophrenia

Joseph Zohar, MD (Tel Hashomer, Israel- Obsessive Compulsive Spectrum Disorders Conference, 2006)), presented a paper outlining the empirical data supporting the possible inclusion of a schizo-obsessive subtype of schizophrenia. Available data suggests little correlation between the severity of OCD symptoms (which are typically moderate to severe) and core schizophrenic symptoms. Fifteen out of 18 studies revealed at least a five-fold elevation of OCD prevalence in schizophrenia compared to general population (e.g., ranging from a low of 3% to a high of 64% depending on patient setting and methodology). Higher rates of disorders in the OC spectrum (BDD, chronic tic, etc) also occur in these individuals as compared to schizophrenia patients without OCD.

1.3.8: OCD and eating disorder

Thiel, Broocks, Ohlmeier, Jacoby, and Schussler (1995) found that 37% of patients with anorexia nervosa or bulimia nervosa also met criteria for OCD. Similarly, Schwalberg, Barlow, Alger, and Howard (1992) found that 15% of bulimic individuals had a lifetime diagnosis of OCD. OCD diagnoses were assigned in 5% of individuals (or fewer) for each

other group (social phobia, PD, obese binge eaters). In a group of 62 OCD patients, 12.9% met criteria for an eating disorder.

1.3.9: OCD and hypochondria/health anxiety

Hypochondria / Health Anxiety are based on an individual's misinterpretation of symptoms, and exist despite medical reassurance that the individual does not have a disease or illness. Hypochondria have numerous obsessive-compulsive features that are quite similar to those of OCD. One essential difference between the two conditions is that those with OCD often fear getting a disease, while those with hypochondria fear already having a disease. Perhaps the most significant similarity linking OCD and Hypochondria is the cyclical process by which the symptoms of both increase.

1.3.10: OCD and autism

Eric Hollander, MD (New York, NY- Obsessive Compulsive Spectrum Disorders Conference, 2006)) presented evidence suggesting that autism may fit into the obsessive compulsive spectrum. Autism is a neurodevelopmental disorder with strong genetic factors (e.g., 90% concordance with identical twins). One of the core symptom areas of autism is repetitive behaviors and compulsivity and there are elevated rates of OCD-like behavior in individuals with autism (e.g., up to 25% with contamination obsessions and 32% with ordering compulsions).

1.3.11: OCD and Body dysmorphic disorder (BDD)

BDD has obsessive-compulsive features that are quite similar to those of OCD. One recent study found that 24% of those with BDD also had OCD. Perhaps the most significant similarity linking BDD and OCD is the cyclical process by which the symptoms of both increase. Katharine Phillips, MD (Obsessive Compulsive Spectrum Disorders Conference, 2006) examined the relationship between body dysmorphic disorder (BDD) and OCD. Available data suggest that BDD and OCD have many similarities but also apparent differences. However, individuals with BDD have poorer insight (i.e., approximately 2% of OCD patients are currently delusional vs. 27-39% of BDD patients). Furthermore, compulsions in BDD (e.g., checking mirrors) appear less likely to reduce anxiety or distress.

1.3.12: OCD and Trichotillomania (TTM)

TTM has obsessive-compulsive features. Dan J. Stein, MD, PhD (Cape Town, South Africa- Obsessive Compulsive Spectrum Disorders Conference, 2006)) presented on TTM and OCD. TTM may be better conceptualized as a stereotypic disorder. OCD and stereotypic disorders have some overlap (i.e., both have repetitive and ritualistic symptoms) but also have some differences (stereotypes are often driven by affect rather than by obsessions).

1.3.13: OCD and Tourette's syndrome (TS)

Euripedes Miguel, MD, PhD (Sao Paulo, Brazil- Obsessive Compulsive Spectrum Disorders Conference, 2006)) examined the relationship between OCD and TS. Among patients with TS, 60% have obsessions and/or compulsions and 30% have full-blown OCD. Among patients with OCD, 40% have had a history of a tic disorder. Patients with OCD and tics as opposed to patients with OCD without tics have several distinguishing features. For example, patients with both OCD and tics are more likely to have an earlier age of onset, hoarding behavior, repeating rituals, tic-like compulsions, symmetry/ordering, and aggressive obsessions than OCD counterparts without tics. Evidence supporting a close association between OCD and tics include similar clinical presentations; co morbidity patterns; course; genetic data and certain neuroimaging. Evidence that argues against an association with OCD includes neuropsychological data and pharmacological treatment involving different classes of drugs.

1.3.14: OCD and Parkinson's disease

Laura Marsh, MD (Baltimore, MD- Obsessive Compulsive Spectrum Disorders Conference, 2006)) reviewed the evidence for obsessive-compulsive spectrum behaviors in Parkinson's disease. An estimated 80- 90% of Parkinson's patients have a psychiatric disturbance over the lifetime of the disease, some of which are prodromal to the onset of motor symptoms. There is no consistent evidence for increased rates of OCD or OC symptoms in Parkinson's disease, which is in contrast to the higher rates of co-morbid anxiety disorders that occur in patients with Parkinson's.

1.3.15: OCD and addictive disorders

Epidemiological data support a greater than expected co-occurrence of OCD and substance dependence (odds ratios from 2 to 4), but a weaker relationship between pathological gambling and OCD (odds ratio 0.6). Regarding clinical course, addiction is characterized by high rates in adolescents and young adults and a decline in prevalence over the age spectrum. In contrast, OCD often has an earlier onset and lacks a peak with a rapid decline. With respect to gender differences, addictions typically have a male to female ratio of 2:1 which differs from a 1:1 ratio for OCD. The pharmacological and behavioral therapeutic approaches for OCD and addiction are largely different.

1.4: Causes of OCD

Although the exact cause of OCD is not fully understood, studies have shown that a combination of biological and psychological/environmental factors may be involved.

1.4.1: Biological cause

(a): Genetic

There is evidence to suggest that OCD may be the result of certain inherited genes that affect the development of the brain. No specific genes have been linked to OCD, but there is some limited evidence that the condition runs in families. Studies of OCD patients and their families have established a 10% prevalence of OCD in first degree relatives (an additional 8% have a sub clinical degree of OCD symptoms). The genetic connection seems to be higher if the onset of OCD is before age 14. In studies of twins, there is a 63% concordance rate for OCD in identical twins. A comprehensive review of studies of twins shows that in children, genetic influences account for 45 to 65% of the risk of developing OCD (van Grootheest DS et al 2005). In another study, researchers at the National Institutes of Health's National Institute on Alcohol Abuse and Alcoholism identified a gene variant that doubles a person's risk of developing OCD (Hu XZ et al 2006).

(b): The serotonergic system

The chemical serotonin seems to play a part in OCD. Serotonin deficiency has also been implicated in anxiety, depression, and other psychiatric disorders. (Yaryura- Tobias and

Neziroglu, 1997).Various neuroimaging studies also suggest that an electrical dysfunction in certain brain regions may contribute to OCD (Whiteside SP et al 2004). This observation is supported by comparisons of brain activity taken by single photon emission computed tomography and positron emission tomography from healthy controls and people with OCD. Investigators have also suggested that OCD, tic disorders, or both may be caused by an autoimmune response to streptococcal bacteria in some susceptible children (Arnold PD et al., 2001). It is believed that these receptors may be abnormal in people with OCD (Jenike, 1996).

(c): The basal ganglia

Brain imaging studies have shown that people with OCD have abnormalities in a part of the brain known as the basal ganglia (a group of nerves). One theory is that OCD develops as a result of a malfunction of the basal ganglia, which leads to a person with the condition believing that they are under threat. Their conscious mind knows that the threat is not real, but the subconscious, emotional power of the basal ganglia prevents the conscious mind from shaking off the anxiety and fear. As a result, the brain adopts compulsive behaviour as a kind of coping strategy.

(d): Autoimmune diseases

Research has found that certain autoimmune diseases, such as Sydenham's chorea, rheumatic fever, pediatric streptococcal infections, and lupus, also may cause some cases of OCD. In some studies, an association of OCD with von Economo's encephalitis, hypothalamic lesions, head trauma, brain tumors, and epilepsy has been demonstrated. However, most cases of OCD occur without such causative explanations (Jenike, 1998; Yaryura-Tobias and Neziroglu, 1997).

1.4.2: Psychological cause

Some psychological and environmental factors may develop OCD. These factors are as follows- stress , abuse, changes in living situation, illness, death of a loved one, work- or school-related changes or problems, relationship concerns, interpersonal relationships, parental influence, perfectionistic beliefs (McFall & Wollershein, 1979), inflated responsibility (Rachman, 1976; Salkovskis, 1985), deficits or abnormalities in decision

making (Reed, 1985; Persons & Foa, 1984; Sher, Mann & Frost, 1984), thought action-fusion (Rachman, 1993), meta-cognitive beliefs (Clark & Purdon, 1993; Wells & Matthews, 1994).

1.5: Effects of OCD

OCD is a common, serious anxiety disorder that can have a significant impact on function. The obsessions or compulsions are time-consuming and interfere significantly with the person's normal routine, occupational functioning, usual social activities, or relationships (Sadock and Sadock, 2003). OCD occurs in a spectrum from mild to severe, but if severe and left untreated, can destroy a person's capacity to function at work, at school, or even in the home.

The occupational and social effects of an OCD depend on the severity of the problem. In mild to moderate cases, patients are usually able to continue working and maintain a reasonable social life. However, in severe cases the social and occupational effects of the disorder can be incapacitating.

Married life can be affected by this disorder. The divorce and separation rate is high for people affected by this disorder, among the highest of any group with psychological or psychiatric problems. If the obsessional fear or concern centers on contamination from bodily products, it is not uncommon to find associated sexual problems.

OCD can be a pervasive and time-consuming disease, affecting the way someone works, plays, eats, thinks and interacts. People with OCD may spend many hours a day focusing on their obsessions and compulsions. It is no wonder that their interpersonal relationships often suffer.

The quality of life is diminished in OCD. The World Health Organization defines six areas for assessing the quality of life: physical health, psychic health, level of Independence, social relations, environmental health, individual and spiritual beliefs (Koran, 2000). The juncture of health to familial, social and occupational factors has been evaluated and reviewed in OCD patients (Koran et al., 1996; Steketee, 1997). Problems indicated by OCD patients were problems in social relationships, financial problems and decrease in learning ability. Many patients point out the lowering of self-esteem and suicidal ideations. Severe problems according to compulsive rituals seem also bothersome (Hollander, 1997). Deficits in social functioning and quality of life of individuals with this disorder may contribute more to their

"burden", suffering and disability (Bystritsky et al., 2001). The quality of life of these patients has been worse according to studies comparing them with other chronic disorder (Koran et al., 1996; Bobes et al., 2001).

1.6: Measurement of Obsessive Compulsive Disorder

A number of self-report and clinician-administered instruments are available to provide a more detailed measurement of the frequency, severity and diversity of obsessive-compulsive symptoms. These measures are most useful for quantifying the severity or intensity of OCD and are, therefore, particularly valuable in evaluating treatment effectiveness. Moreover, most of these measures assess a range of obsessional content, which can be useful in determining OCD subtypes and planning treatment.

There are several scales that measure the nature and intensity of OCD symptoms. These are as follows-

1. The Maudsley Obsessive compulsive Inventory (MOCI) is a 30-item true-false self-report questionnaire developed by Hodgson and Rachman (1977).
2. Yale-Brown Obsessive-Compulsive Scale (YBOCS) is a 10-item clinician-rated scale (Goodman et al., 1989).
3. Clark-Beck Obsessive- Compulsive Inventory (CBOCI) is a 25-item self-report questionnaire (Clark & Beck, 2002; Clark, Antony, et al., 2003).
4. Compulsive Activity Checklist (CAC) is a 62-item clinician-administered schedule (H.,Richard, 1975).
5. Obsessive-Compulsive Inventory (OCI) is a 42-item self-report questionnaire (Foa, Kozak, Salkovskis, Coles & Amir, 1998).
6. Dhaka University Obsessive compulsive Scale (DUOCS) is developed for screening and determining severity of the Obsessive Compulsive Disorder (Mozumder, K. & Begum, R. 2005).

1.7: Cognitive models of OCD

1.7.1: The Salkovskis model

A comprehensive cognitive analysis of OCD, and one based within Beck's cognitive theory, has been presented by Salkovskis (1985). Salkovskis's original formulation integrated important cognitive and behavioural concepts in the cognitive formulation of obsessional

problems. It combined features of earlier models such as the concept of inflated responsibility (e.g. Rachman, 1976), beliefs about thought and action (e.g. McFall & Wollersheim, 1979) with behavioural principles. Salkovskis (1985, 1999) proposed that specific intrusions become more frequent, intense, and distressing as a result of a person's inflated sense of personal responsibility. Salkovskis defined an inflated sense of responsibility as a person's tendency to believe that they may be pivotally responsible for causing or failing to prevent harm to themselves or others. According to this view, an inflated sense of responsibility causes one to develop certain patterns of response to specific (rather than all) intrusive thoughts, impulses, or images. These patterns of response are attempts to neutralize (put matters "right" and make amends for) the unwanted intrusions, thereby reducing the distress caused by them. Examples of "neutralizing" include thought-control strategies such as thought suppression, deliberately thinking good thoughts, or compulsive acts such as hand-washing and constant rechecking for possible sources of danger (Freeston & Ladouceur, 1997). Thus, like Rachman (1997, 1998), Salkovskis' conceptualization of OCD implies that individuals with OCD hold particular perceptions of self and the world (i.e., harm is preventable in the world and one is able to prevent harm). However, Salkovskis also argued that neutralizing behaviors in and of themselves lead to a debilitating cycle that reinforces the person's sense of responsibility and the subsequent negative appraisals of the thought. The temporary reduction of anxiety caused by neutralizing and its "success" in preventing the dreaded event is purported to reinforce the belief that one's actions are pivotal in preventing harm, thereby leading to an escalation in the frequency of the neutralizing. This in turn focuses even more attention on the intrusive thought, image or impulse, increasing its perceived frequency and the significance attached to its content or occurrence. Salkovskis et al. (1999) also proposed that the development of an inflated sense of personal responsibility may be associated with "a high degree of conscientiousness, marked by dedication to work and an acute sense of social obligation" (Salkovskis et al., 1999; p: 1060).

Salkovskis, Richards and Forrester (1995) define neutralizing as: voluntarily initiated and conducted activity which is intended to have the effect of reducing the perceived level of responsibility' (p. 285).

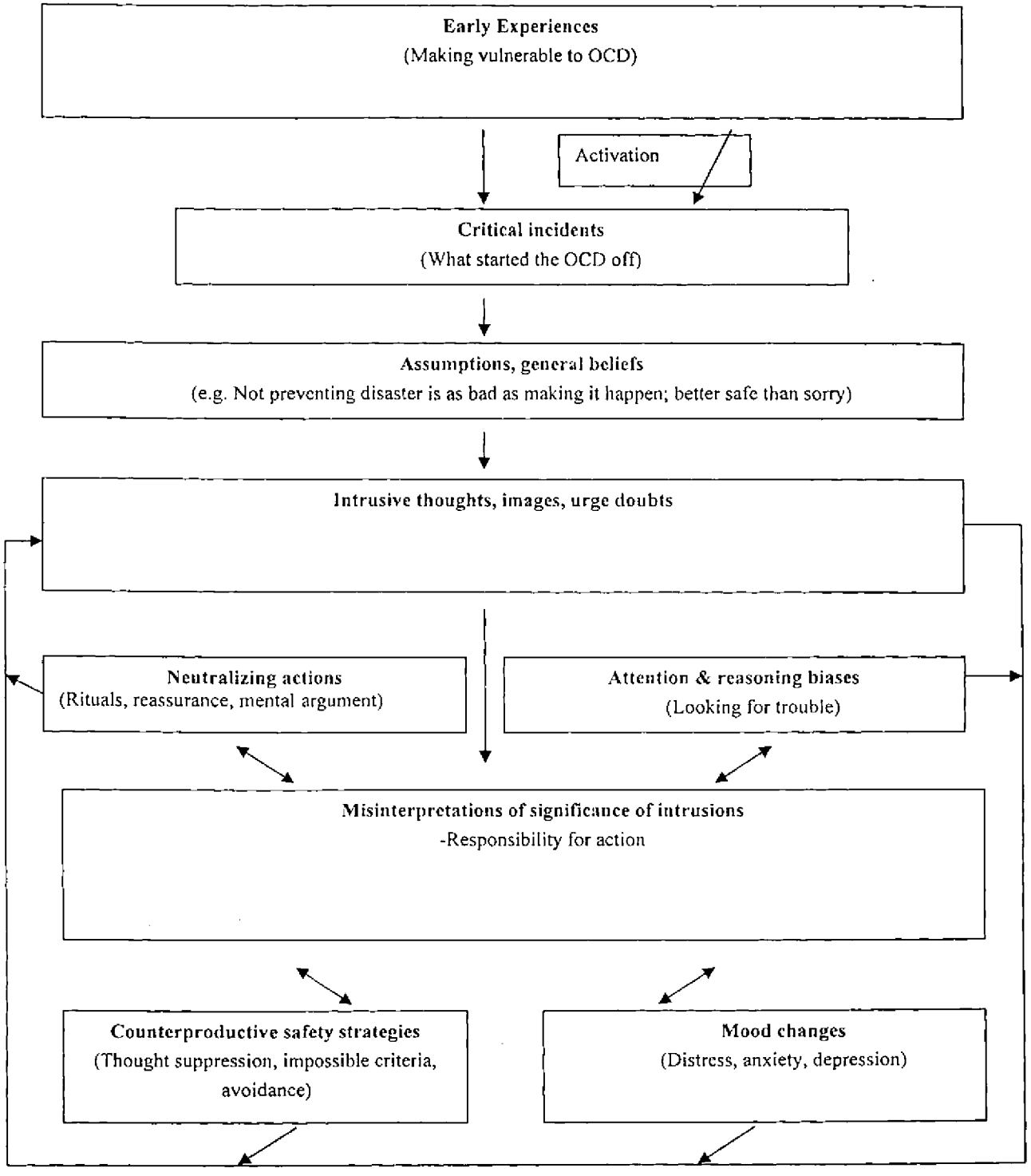

Figure-1: Integrated schematic model describing the cognitive hypothesis of the origins and maintenance of obsessional problems. Authors: Salkovskis, P.M., Forrester, E., Richards, C. (1988) British Journal of Psychiatry, 173 (Suppl. 35, 53-63.

1.7.2: The Wells and Matthews meta-cognitive model

Wells and Matthews (1994) present a prototypical model of OCD mapped on a detailed cognitive processing framework of vulnerability to emotional disorder. They suggest that intrusions activate beliefs concerning the significance of the intrusion. In a meta-cognitive framework, beliefs about intrusions are relevant in understanding OCD. Rachman (1993) has introduced a useful new concept of 'thought-action fusion' (TAF) which represents meta-cognitive beliefs equating thoughts with actions (e.g. having a thought about harming my children means I am going to harm them). It is proposed that beliefs supporting the fusion of thought and action and positive and negative beliefs about rumination and neutralizing strategies are relevant in conceptualizing OCD. Once an intrusion has been appraised as dangerous, the individual is compelled to select a strategy for overcoming this danger. The strategy selected is determined by beliefs held concerning different strategies. In some instances, the individual will continue to ruminate and reprocess the intrusion, in order to challenge the intrusion's validity.

1.7.3: A general working model

An outline general working model of relationships between beliefs, behaviours and emotion in OCD is depicted in the following figure.

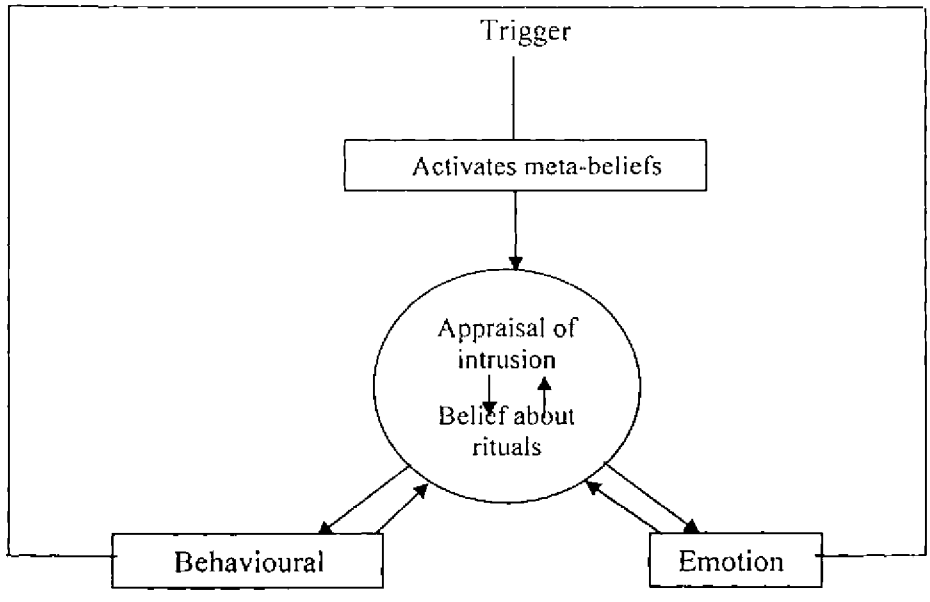

Figure-2: A cognitive model of OCD

In this model a trigger (most often an intrusive thought or doubt, although an intrusive feeling/ emotion can also act as a trigger) activates beliefs concerning the meaning of the trigger. The beliefs relevant at this level include: beliefs about the dangers and meaning of thought encompassing themes of thought-action fusion and thought-event fusion; and beliefs about the consequences of emotion/ discomfort. These beliefs influence the nature of appraisal of intrusions. A further influence on appraisals of intrusion results from beliefs that the individual holds concerning rituals and behavioural responses. Two types of beliefs are relevant here: positive and negative beliefs.

1.8: Cognitive behaviour therapy (CBT)

Cognitive therapy was developed by Aaron T. Beck at the University of Pennsylvania in the early 1960s as a structured, short-term, present-oriented, psychotherapy for depression, directed toward solving current problems and modifying dysfunctional thinking and behaviour (Beck, 1964). Cognitive therapy helps the client learn effective self-help skills that are used in homework assignments that help changing the way of thinking, feeling and behaviour. CBT is a category of psychological treatments that are used effectively to treat OCD. Most cognitive behavioural therapies have the following characteristics:

1. CBT is based on the cognitive model of emotional response: CBT is based on the scientific fact that our thoughts cause our feelings and behaviours, not external things, like people, situations and events. The benefit of this fact is that we can change the way we think to feel/ act better even if the situation does not change.

2. CBT is briefer and time-limited: CBT is considered among the "fastest" in terms of results obtained. The average number of sessions clients receive (across all types of problems) is only 16.

3. CBT therapists focus on teaching rational self-counseling skills: CBT therapists believe that the clients change when they learn to think differently; therefore, CBT therapists focus on teaching rational self-counseling skills.

4. CBT is a collaborative effort between the therapist and the client: Cognitive behavioural therapists seek to learn what their clients want out of life (their goals) and then help their clients achieve those goals. The therapist's role is to listen, teach and encourage, while the client's roles is to express concerns, learn and implement that learning.

5. CBT is based on stoic philosophy: CBT does not tell people how they should feel. CBT teaches the benefits of feeling, at worst, calm when confronted with undesirable situations.

6. CBT uses the Socratic Method: Cognitive behavioural therapists want to gain a very good understanding of their clients concerns. That's why they often ask questions. They also encourage their clients to ask questions of themselves.

7. CBT is structured and directive: Cognitive behavioural therapists have a specific agenda for each session. Specific techniques/ concepts are taught during each session. CBT focuses on helping the client achieve the goals they have set. CBT is directive in that respect.

8. CBT is based on an educational model: CBT is based on the scientifically supported assumption that most emotional and behavioural reactions are learned. Therefore, the goal of therapy is to help clients unlearn their unwanted reactions and to learn a new way of reaching.

9. CBT theory and techniques rely on the Inductive Method: A central aspect of Rational/thinking is that it is based on fact, not simply assumptions made. The inductive method encourages individual to look at their thoughts as being hypotheses that can be questioned and tested. If they find that their hypotheses are incorrect, then they can change their thinking to be in line with how the situation really is.

10. Homework is a central feature of CBT: CBT therapists assign reading assignments and encourage their clients to practice the techniques learned.

1.9: Studies on effectiveness of CBT for OCD Clients

OCD is often a chronic, relapsing illness. Fortunately, through research supported by the National Institute of Mental Health (NIMH) and by industry, effective treatments have been developed to help people with OCD. Until the mid 80's of the previous century, the OCD was assumed to be a rare condition with poor outcome (Nestadt et al., 1998).

There are many effective treatments for OCD, ranging from therapy to self-help and medication. However, the treatment for OCD with the most research supporting its effectiveness is CBT. CBT helps people to learn to use the power of their own behaviour to change their thoughts and feelings for the better. In a recent review, research examined 7 different psychological studies and 10 comparison studies (usual care) to consider the efficacy of CBT treatment for OCD. Patients receiving any form of CBT had significantly fewer obsessive compulsive symptoms post-treatment than subjects receiving treatment as

usual. Theoretically, CBT can be employed in any situation in which there is a pattern of unwanted behaviour accompanied by distress and impairment. Completion of a course of cognitive behaviour therapy (CBT) is an important part of recovery from OCD. Research by Dr. Lewis Baxter of UCLA demonstrated that behaviour therapy results in positive changes in brain activity similar to those changes brought about by successful drug treatment (Yaryura-Tobias and Neziroglu, 1997). Salkovskis and Warwick (1985) reported one of the first single-case studies in which an evidence-gathering technique was used to modify an overvalued idea ("I will give myself cancer by using contaminated cosmetics") in a woman with severe OCD who relapsed after a trial of ERP. Since this study, these have also supported the effectiveness of CBT based on the newer cognitive appraisal theories of OCD. Simos and Dimitrion (1994) used audio taped habituation and reassessment of responsibility to reduce a harming obsession. Freeston (2001) reported on the successful treatment of a 14-year-old boy who compulsively brushed his teeth, using a cognitive-behavioural treatment rationale, modification of beliefs about perfection, and gradual introduction of response prevention. Sookman and Pinard (1999) reported substantial reductions in obsessive-compulsive symptoms, depression, and maladaptive beliefs for 6 out of 7 treatment-resistant patients with OCD who received, on average 10 months of weekly CBT.

Cognitive behaviour therapy helps by providing the person with OCD the tools necessary to manage their obsessions and compulsions. Continued practice and use of the tools and skills learned in CBT help keep symptoms manageable. Successful behavioural treatment requires motivation and daily practice. Initially, it can appear quite challenging, even scary-but obtaining relief from OCD symptoms makes it worthwhile. When used together, medication and behaviour therapy complement each other. Medication alters the level of serotonin, while behaviour therapy helps to modify behaviour by teaching the person with OCD the skills to resist compulsions and obsessions. Medication can reduce individual anxiety level, thus making it easier to implement cognitive behaviour therapy principles.

One study provides new evidence that cognitive behavioural therapy may also prove effective for OCD. This variant of behaviour therapy emphasizes changing the OCD sufferer's beliefs and thinking patterns. Additional studies are required before the promise of cognitive behavioural therapy can be adequately evaluated. The ongoing search for causes, together with research on treatment, promises to yield even more hope for people with OCD and their families. There have been several studies published on the efficacy of combined

treatments for OCD. The first comparison (Marks, Stern, Mawson, Cobb, & McDonald, 1980; Rachman et al., 1979) included 48 patients with OCD, of which 40 were completers. Patients with covert compulsions only were excluded. In the first 4 weeks, the patients received treatment with a maximum of 225 mg of clomipramine or placebo or an outpatient basis. From weeks 4-10, the patients were admitted to hospital. During the first 3 weeks of hospitalization, they received 15 sessions of either exposure or relaxation. After week 7, relaxation was terminated. After week 10, the patients were discharged from hospital. The medication was continued until week 36 and then tapered off over a period of 4 weeks (Marks et al., 1980). The patients were followed up naturalistically for 6 years (O'Sullivan, Noshirvani, Marks, Monteiro, & Lelliott, 1991). The results were analyzed after 7 weeks of treatment. At that point, the specific treatments (clomopramine and exposure in vivo) yielded more improvement than the control treatments (placebo and relaxation). Although the combination of clomipramine with exposure in vivo yielded slightly superior results relative to the three other conditions on most ratings, there was no statistically significant interaction between exposure in vivo and clomipramine.

1.10: Treatment of OCD

Prior to studies in the 1980's, the usual view of OCD was that it was a relatively rare disorder with a poor prognosis. However it is now recognized to be much more common (2-3% prevalence rate), it is generally seen to be treatable, with some 60%-80% of patients showing at least some response to treatment.

1.10.1: Pharmacological management: OCD is more common than generally believed 20 years ago. It appears to be largely a neuropsychiatries condition, rather than a product of overly strict upbringing (as was once believed). Although OCD can have a paralyzing impact if not properly diagnosed and treated, there are fortunately behavioural and pharmacological approaches available that can help many of the sufferers from this potentially devastating illness.

(a): Drug treatment: Medications can help make the therapy go faster and easier, so often recommend the combination of BT/CBT and medication. Many psychiatrists believe that pharmacological treatment is of considerable value in obsessive compulsive disorder,

and there is evidence that some types of medication are effective. The most effective medications to treat OCD belong to the family of drugs known as antidepressants. The five most useful medications are fluvoxamine (luvox), flextime (Prozac), sertraline (Zoloft), paroxetine (Paxil), and clomipramine (Anafranil). Citalopram (Celexa), venlafaxin, (Effexor), nafazodone (Serzone), and other antidepressants also may be useful, but more study is needed.

(b): Psychosurgery: Psychosurgery, or the physical destruction of small amounts of brain tissue, is extremely rare. It is an invasive and drastic form of treatment, although the techniques used are now much more refined than they were, and therefore have fewer side effects than in the early days. It is used only in severe cases of OCD when several trials of CBT and thorough trials of all antiobsessional medication have been tried.

(c): Electro convulsive therapy: Occasionally, severe obsessive- compulsive patients have been treated with ECT (also called electric shock therapy). In this procedure, convulsions or fits are induced by passing a small electric current through the brain from electrodes applied to the head, while the patient is under the effects of a short-acting an aesthetic and a muscle relaxant.

1.10.2: Psychological treatment

(a): Behaviour therapy

Studies of behaviour therapy for OCD have found it to be a successful treatment for the majority of patients who complete it. For the treatment to be successful, it is important that the therapist be fully trained to provide this specific form of therapy. It is also helpful for the patient to be highly motivated and have positive, determined attitude. The positive effects of behaviour therapy endure once treatment has ended. A recent compilation of outcome studies indicated that, of more than 300 OCD patients who were treated by exposure and response prevention, an average of 76% still showed clinically significant relief from 3 months to 6 years after treatment (Foa & Kozak, 1996).

There are different types of therapy for both overt compulsions and covert obsessional phenomena, such as exposure and response prevention, modeling, imaginal exposure,

systematic desensitization, exercise, relaxation techniques, thought-stopping, thought-switching, thought-control, habituation training, extinction, distraction etc.

(b): Psychotherapy

Traditional psychotherapy, aimed at helping the patient develop insight into their problem, is generally not helpful specifically for OCD symptoms. Traditional psychotherapy may be of benefit as part of a treatment package for patients who have been ill and isolated for many years or for those whose illness started at an early age. The aim of the therapy, carried out in sessions in which the patient is encouraged to 'free associate' is to unravel these hidden factors and solve them.

(c): Hypnotherapy

There is no satisfactory evidence that hypnotherapy has much to contribute in treating OCD. Some patients and/or their families are fascinated by the very idea of hypnotherapy and ask for it when they come for help, but faith in its efficacy is misguided.

(d): Group therapy

Group therapy is another helpful OCD treatment. Through interaction with fellow OCD sufferers, group therapy provides support and encouragement and decreases feelings of isolation. Treating patients in a group setting is sometimes undertaken by therapists for various conditions. For example, patients with difficulties in social skills are often treated in social skills groups.

(e): Family therapy

OCD often causes problems in family life and social adjustment, family therapy often advised. Family therapy promotes understanding of the disorder and can help reduce family conflicts. It can also motivate family members and teach them how to help their loved one.

1.11: Reasons for using CBT for the present study:

Cognitive behaviour therapy was used for the present study for the following reasons:

- Cognitive-behaviour therapy (CBT) is the recommended psychological treatment and relapse prevention for OCD, with research studies backing its effectiveness.
- CBT is a short term and structured psychological therapy that looks at the relationship between what clients think what clients feel and how clients respond.
- CBT is a combination of cognitive therapy, which examines cognitive processes such as unwanted thoughts, attitudes, and beliefs and behavioural therapy, which focuses on behaviour in response to those thoughts.
- CBT is explicitly based on learning and cognitive principles. Twelve to 16 sessions are typical, though the function of each individual will determine the duration of treatment (Franklin, Foa, 2002). Treatment may be stopped if significant symptom reduction has lasted for at least 4 consecutive weeks. Thereafter, periodic booster sessions are helpful to maintain gains and prevent relapse (Foa , Liebowitz, Kozak, 2005).
- CBT helps clients to fight back against OCD and not carry out clients compulsions.
- As the clients learn to think and do things differently, he/she will be able to see that the anxiety he/she feel as a result of OCD will begin to go away.
- As the client start to feel less anxious and worried about OCD, he/she begin to feel more confident to resist doing what OCD wants he/she to do and to confront his/her fears and doubts.
- Using CBT strategies to overcome the clients OCD will take time, practice and lots of practice. The more he/she put into it, the more he/she will get out of it.
- The 3 central aspects of CBT therapy for OCD:
- Exposure—placing the client in situations that elicit anxiety related to their obsessions.
- Response prevention—deterring the ritualistic or compulsive behaviors that may serve to reduce or avoid anxiety
- Cognitive therapy—training the client to identify and refrain from anxiety-provoking cognitions.
- Finally, family involvement is often central to the success of CBT. Family members may accommodate the patient's symptoms by facilitating avoidance, assisting with

ritualistic behaviors, or inadvertently facilitating the development of the disorder by participating in rituals (e.g, providing reassurance, allowing compulsive avoidance of feared stimuli, and tolerating delays associated with ritual completion). Given this, CBT often includes the client's spouse, parents, and significant others.

1.12: Rationale of the present study

From the intensive literature review it was seen that OCD affects a person's normal routine, occupational functioning, usual social activities, physical health, psychic health, level of independence, social relations, environmental health, individual and spiritual beliefs. It also destroy a person's capacity to function at work, at school, or even in the home and it increases person's financial problems and decreases in learning ability.

There are many effective treatments for OCD, ranging from therapy to self-help and medication. However, the treatment for OCD with the most research supporting its effectiveness is CBT and completion of a course of CBT is an important part of recovery from OCD. A number of research have shown that substantial reductions in obsessive-compulsive symptoms, depression, and maladaptive beliefs for 6 out of 7 treatment-resistant patients with OCD who received, on average 10 months of weekly CBT. Continued practice and use of the tools and skills learned in CBT help keep symptoms manageable. Successful behavioural treatment requires motivation and daily practice. Initially, it can appear quite challenging, even scary-but obtaining relief from OCD symptoms makes it worthwhile. When used together, medication and behaviour therapy complement each other. Medication alters the level of serotonin, while behaviour therapy helps modify behaviour by teaching the person with OCD the skills to resist compulsions and obsessions. Medication can reduce individual anxiety level, thus making it easier to implement CBT principles. Several studies have been published on the efficacy of combined treatments for OCD (Marks, Stern, Mawson, Cobb, & McDonald, 1980; Rachman et al., 1979). But in Bangladesh, very few studies had been conducted on the efficacy of CBT in the treatment of OCD. From the world wide literature review, it was seen that OCD is often a chronic global problem, relapsing illness and it occurs with considerable frequency in both developed and developing countries (Al - Issa and Oudji, 1998). As CBT is structured and time-consuming therapy, it will in turn contribute to the client's overall functional level.

For all the above mentioned reasons the present study was conducted to see the effectiveness of CBT on patients with OCD.

It is hoped that, this study will contribute a treatment package in our country for different health care professionals and clinical psychologists to manage successfully an OCD client.

1.13: General objective

To see the effectiveness of cognitive behaviour therapy on patients with OCD

1.13.1: Specific objectives

i) To see the effectiveness of CBT on pharmacologically treatment resistant OCD patients

ii) To compare the functional level changes of the clients of non responders to medication before, mid and after receiving CBT treatment

iii) To compare the functional level changes of the clients of non responders to medication (who did not receive CBT) among before, mid and after measure

iv) To compare the functional level changes between the clients of nonresponders to medication who received CBT and the non responders who did not receive CBT

Chapter-2

METHODOLOGY

METHODOLOGY

2.1: Participants:

2.1.1: Sampling:

The sample of this study comprised of 17 subjects (9 males and 8 females) having Obsessive Compulsive Disorder and attending either the Dhaka Medical College Hospital (DMCH) or Bangabandhu Sheikh Mujib Medical University (BSMMU) in Dhaka. All these clients were referred to Trainee Clinical Psychologist for cognitive behaviour therapy. One subject dropped after attending two sessions and two subjects dropped after attending one session. So, the final total number of sample was 14. All the clients were randomly divided into two groups. Of the 14 samples 7 (4 males and 3 females) were in the experimental group (Group-A) and the rest 7 (4 males and 3 females) were in the control group (Group-B). All the clients of Group-A were from lower middle class to upper middle class family. Among the clients one had graduation, one passed S.S.C, and one client was Hons. student and the other four had gone to school up to class-X. The age range of the experimental subjects of this study was 21 to 43 years and their average age was 27.14 years. All the clients of Group-B were from lower middle class to upper middle class family. Among the clients one had graduation, one passed H.S.C, one passed S.S.C, two clients were Hons. student and the other two had gone to school up to class-X. The age range of the control subjects of this study was 20-40 years and their average age was 25.71 years. By maintaining the following criterion all of the participants were selected.

2.1.2: Inclusion criteria:

1. Clients who suffered from OCD at least for two years and received medication as treatment
2. Clients who met DSM-IV criteria and clinical range of DUOCS score for OCD
3. Clients who did not have any experience of receiving CBT
4. Diagnosed adult cases of OCD of either sex

2.1.3: Exclusion criteria:

Diagnosis of schizophrenia, neurological deficits or mental retardation.

A detail description of the client's age, sex, education, occupation, socio-economic status, marital status, duration of problem, current medicine status and major OCD symptoms of Group-A and Group-B is given in Appendix no-7.8.

2.2: Design of the study:

The present study adopted systematic case study design with before, mid, after and follow-up measurement. The researcher of this study chose this design for some reasons;

1. It is not possible to measure the problem specifically through a questionnaire.
2. Structured quantitative methodology may not be adequate to reveal all the related information.
3. In case study assessment and measurement of the outcome of treatment takes long time. Therefore, in the present study the sample size was small (Total-14, experimental group-7 and control group-7).
4. Another reason for case study design was the unavailability of participants after three months for follow up sessions. Pre-post design was applied to find out the changes in OCD symptoms.

In short the design of the present study was given in the following table:

(Identified 14 sample following inclusion criteria with informed consent)

Table-1.1: The present research design

Group-A (7 Clients) **(Non respondents to medication who received CBT)**	**Group-B (7 Clients)** **(Non respondents to medication who did not receive CBT)**
Pre-assessment (First 3 sessions)	Pre-assessment (First 3 sessions)
Mid-assessment (During 8 sessions)	Mid-assessment (After 5 weeks)
Implementation of CBT (7-10 sessions)	No CBT given (8 sessions)
Post-assessment After terminating intervention (1 session)	Post-assessment After 3 weeks (1 session)
Follow up (Three follow up sessions- first two for two weeks interval and last one follow up for one month interval)	Follow up (Three follow up sessions- first two for two weeks interval and last one follow up for one month interval)

In the present study 14 clients were selected following inclusion criteria. After that half (7 clients) of them were selected randomly for Group-A. The rest of 7 clients were included in Group-B. Group- A received structured cognitive-behaviour therapy whereas; Group-B did not received CBT but after three follow up sessions these 7 clients will be refered for receiving CBT. Pre-assessment measures were done for both groups with three semi-structured interview sessions and mid-assessment sessions were also done for both groups with one interview session. After completing the baseline measurement, intervention were applied on group-A for about 7-10 sessions (7-10 weeks). Finally 6 clients from group-A, three follow-up measurements were also taken for one month and 15 days interval after the termination but 1 client did not want to continue their 2nd and 3rd follow up participation in the study. Also 6 clients from group-B, three follow-up measurements were taken for one month and 15 days interval after the termination but 1 client did not want to continue their 2nd and 3rd follow up participation in the study.

2.3: Measures used:

For the present research the following instruments were used-

A. Adult initial assessment form for in-depth interview
B. Anxiety Scale (Deeba & Begum, 2004)
C. Depression Scale (Uddin & Rahman, 2005)
D. Dhaka University Obsessive Compulsive Scale (Mozumder & Begum, 2005)
E. Self-rating measurement scale(11 point verbal rating scale)
F. Observational report

All the assessment tools were applied before treatment and again following the treatment.

2.3.1: In-depth interview:

For collecting qualitative data, in-depth interview is very important. Qualitative interview is considered first for three reasons.

First, most qualitative researchers at some stage use some form of qualitative interviewing. Many use this as their main method for generating data.

Secondly, many of the principles and issues raised in a discussion of qualitative interviewing are relevant to other methods also.

Thirdly, qualitative interviewing actually can involve some techniques more commonly associated with other methods, for example, observing, generating and using visual data.

Adult initial assessment form was used to collect demographic information and some aspects of personal, social, family, occupation and medical history of the clients. The interview also focused on the description of the specific stressful incidents or precipitating factors, other major life events, previous mental health status or childhood history and predisposing factors. Effect of the present problem and other maintaining factors were known through the interview. Maximum open-ended questions were used during the interview. Adult initial assessment form is attached in Appendix no-7.5.

2.3.2: Anxiety Scale:

To assess the base line anxiety and severity of the problems of the OCD clients and to monitor progress during intervention phase, anxiety scale was used.

Anxiety scale was used among the professional clinical psychologists or by trainees in Bangladesh. Decba and Begum (2004) developed Anxiety Scale (AS) to assess symptoms of anxiety for Bangladeshi population. It is a 36-item scale that measures the presence and severity of anxiety in an individual of Bangladesh. The initial scale consisted of 39 items in 5-point Likert format. Item analysis was done using 102 clinical and 102 non clinical subjects. 36 items were selected for the final scale on the basis of item-total correlation and discrimination value (both significant at $\alpha = 0.01$). Experimental try-out was conducted on 410 participants (207 clinical and 203 non-clinical). Split-half reliability of the scale was 0.916 ($\alpha = 0.01$) and the cronbach- alpha reliability was 0.9468. The test-retest correlation ($r = 0.688$) was also found to be significant ($\alpha = 0.01$). The content validity of the scale was measured by strictly following the sequential system model of scale development and by expert's input in different stages of item construction. Three external criterion were found to be positively correlated with the present scale score (Psychiatrists' rating, $r = 0.317$; patient's self rating, $r = 0.591$; HADS, $r = 0.628$; $p<.01$). Construct validity was assessed by discriminality of the scale among clinical and non-clinical samples ($f = 60.275$ at $\alpha = 0.01$), and item-total correlation (which ranged from $r = 0.399$ to $r = 0.748$, $p = 0.01$). Both severity and screening norms were developed for the current Anxiety Scale.

2.3.3: Depression Scale:

To assess the base line depression and severity of the problems of the OCD clients and to monitor progress during intervention phase, depression scale was used.

Uddin and Rahman (2005) developed depression Scale (DS) to assess the symptoms of depression for Bangladeshi population. It is a 30-item scale that measures the presence and severity of depression in an individual. The split-half reliability was 0.7608 and test-retest reliability was 0.599 (significant at $\alpha = 0.01$). The scale was positively correlated with the psychiatrists' rating of depression ($r = 0.377$, significant at $\alpha = 0.01$), on a group

of 73 adult depressed subjects. Similarly, current depression scale was also found to have positive correlation with patients' self-rating of depression ($r = 0.558$, significant at $\alpha = 0.01$). Current depression scale discriminated between depressed and non-depressed subjects ($f = 85.86$, significant at $\alpha = 0.001$) on a group of 104 subjects (52 depressed and non depressed subjects). Construct validity of current scale estimated by computing correlation between current depression scale and depression sub-scale of translated version of Hospital Anxiety and Depression (Zigmond and Snaith, 1983, translated in Bengali by Chowdhury, 2000) on a group of 73 depressed subjects and it was found that these two scales were positively correlated ($r = 0.716$, significant at $\alpha = 0.01$), Reliability and validity of the current scale were ensured. A percentile norm assessing severity of depression was developed based on responses of 124 depressed subjects. A screening norm for depression identification was also developed based on responses of the total 124 subjects (124 depressed subjects and 124 non depressed subjects). Depression scale was developed in the cultural context of Bangladesh.

2.3.4: Dhaka University Obsessive compulsive Scale (DUOCS):

To assess the baseline obsession/compulsion disorder as well as to monitor the change of OCD symptoms after intervention, Dhaka University Obsessive Compulsive Scale was used. It is a 20-item scale that measures the presence and severity of OCD in an individual. Mozumder & Begum (2005) developed this scale to assess the symptoms of OCD for Bangladeshi population. The computation was done on the data collected on a sample of 316 participants. The split-half reliability was 0.8913 which was highly significant ($\alpha <= 0.01$). Alpha for the part-1 was 0.9146 and for part-2 it was 0.9090. Cronbach Alpha was 0.9478, which is usually termed as excellent level of internal consistency (DeVellis, 1991). A total of 76 non diagnosed incidentally selected individuals participated as subject for test-retest reliability. The final scale was administered to the participants two times with an interval of two to three weeks. The correlation coefficient ($r=0.918$) between the scores of two administration was significant with 99% confidence interval ($\alpha<=0.01$). The current scale and the translated version of the MOCI (Mozumder & Begum, 2005) were administered concurrently to a group of 86 OCD diagnosed clients. The correlation between the scores of two scales

was calculated using Pearson product-moment coefficient. Significant correlation was (r= 0. 746, α <= 0.01). Construct validity of the current scale was assessed using convergent and divergent (or discriminant) validation. In the process of discriminant validity, the present scale's ability to discriminate between two distinct groups (group of OCD diagnosed clients and normal control group) of samples was explored. The scale was able to discriminate between the two groups with a discrimination value of F=336.29 which was significant at α <=0.01. Both severity and screening norms were developed for the current DUOCS. The norms were developed based on 158 OCD diagnosed cases and 158 normal control. The optimal cut-off score for the present scale to be used as a screening tool is 17, which achieved a sensitivity of 87% and specificity of 90%. The area of the present scale was 0.923 which was significant at α <=0.01 level.

2.3.5: Self rating measurement scale:

A self rating measurement scale was used by the clients and by the care giver, to determine the base line level of problem (OCD symptoms) and to monitor change or improvement after applying psychological intervention (CBT). This is an 11-point rating scale, ranged from 1 to 10. In which "o" was considered as "no problem" and "10" indicated "highest level of problem".

2.3.6: Observational report:

To determine the observable features of the clients for their disorder and to monitor the change occurred after applying the psychological management, an observable report was prepared by the researcher. OCD symptoms in the maximum case are observable, so to observe the presenting symptom and its severity before and after the treatment was also observable issue. Therapist had direct observation of OCD symptoms, client's facial expression, appearance, mood, speech, tone/ volume, eye contact, and body movement etc. at the first session, at the last session and at the follow up session to assess the change or effectiveness of treatment.

2.4: Procedure:

Written permission to collect data was taken from the authority of the Psychiatry outpatient and/ or inpatient department of Bangabandhu Sheik Mujib Medical University (BSMMU) in Dhaka and Dhaka Medical College Hospital (DMCH). In BSMMU, the clients were collected from the weekly allocation meeting and in DMCH; the clients were collected from outpatients departments. The clients were referred by a Psychiatrist when they did not find any physical basis in the presenting problem. After the referral of the 14 clients covering all of the inclusion criteria were selected for the present research. All the clients were divided randomly into two groups. 7 clients were in group-A, they were non responders to medication and received CBT and other 7 clients were in group-B, they were also non responders to medication but they continue medication and received no CBT. The researcher took informed consent from the subject verbally and explained the purpose of the present research to the subjects. Moreover it was explained to each participant about how they could cooperate. The confidentiality of the data given by them was also promised by the researcher.

2.4.1 Treatment plan:

Based on the format of the initial sessions and the consecutive sessions a basic structure, a tentative plan of homework and content are developed for working with the clients with OCD which is attached in the appendix no-7.9 and 7.10. Here, first three sessions were considered as the baseline assessment for both groups and the subsequent 7-10 sessions were counted as intervention for the experimental group (Group-A). Length, frequency and total number of sessions were presented in the following table.

Table-1.2: Length, frequency and total number of sessions

Length of the session	Approximately 1 hour
Frequency of the session	1 session per week from first week to termination
Total number of sessions	4-18 sessions were provided
Follow-up	Three follow-up sessions were conducted after two weeks interval and one follow up session was conducted after one month interval where follow-up measurement was taken

At first, the researcher started session in a calm and quiet place, but it was not always possible to maintain such environment. Sometimes the researcher used doctor's room and sometimes used ECT room. The duration of each session was nearly 1 hour. In all 4-18 sessions were given including three follow up. First three sessions were pre-assessment measures for both groups. After pre-assessment measure the researcher gave CBT for 7-10 sessions. During 8 sessions of experimental group, mid-assessment measure was taken and after 5 weeks of pre-assessment of control group, mid-assessment measure was taken. At the same time both group continue medication. After terminating intervention 1 session were post-test measures for both groups. Then three follow up measurements were done. First two follow up measurements were taken after two weeks and last follow up measurement was taken one month interval for both the groups. The number of treatment sessions and the length of treatment of Group-A and B are given in the Table no-1.3.

Table no-1.3: Number of treatment sessions and length of treatment of Group-A and B

	No. of Sessions	Length of treatment	1st Follow up	2nd Follow up	3rd Follow up
Group-A	10-19	5-6 months	Two weeks	Two weeks	1 month
Group-B	6-8	5-6 months	Two weeks	Two weeks	1 month

2.5: Ethical considerations:

In the present research, the following measures were taken to maintain the maximum well-being of the research participants.

First, informed consent was taken mentioning the research purposes.

Second, precaution was taken to protect client confidentiality.

Finally, the clients were not gaining any financial benefit from this study.

2.6: Informed consent:

Written permission was taken from the head of the Psychiatry Department of BSMMU and DMCH, Dhaka. Then every participant was informed verbally and written consent form about the research. They clearly understood that it was a part of a research work. Participants were also clearly informed that their information would be used in research purpose but their identity would be kept confidential. The session notes and transcripts will not be shared and discussed with others except the case supervisor and the research supervisor but their real name would not be disclosed. The researcher provided a consent form for the participants and a format of it was attached in the appendix no-7.1.

2.7: Data analysis:

Qualitative data is not so straightforward and requires a more word-based style of presentation. Qualitative data is usually presented as a written discussion. Researchers tend to make use of short verbatim quotes of what respondents said or wrote. They do this to provide evidence of typical or particularly important responses and statements. It is also possible to make use of other devices, such as images, tape recordings, diagrams and flowcharts.

From the beginning of the data collection with assessment tools, almost all of the session conversation were written and transcribed in Bengali immediately after completing the session and then translated it into English. The transcript was revised several times for better understanding and to rule out the actual meaning of what the participants wanted to say. When the researcher fully conceptualized the data, analysis was started.

The major categories were identified according to the research objectives and themes were written under the categories. The broad categories that were made to fulfill the research objectives were as follows-

Category-1: Cognition and its changes after intervention
Category-2: Emotion and its changes after intervention
Category-3: Physiological reaction and its changes after intervention
Category-4: Behavioural response and its changes after intervention
Category-5: Social position and its changes after intervention
Category-6: Occupational condition and its changes after intervention
Category-7: Psychometric scale score and its changes after intervention
Category-8: Subjective rating and its changes after intervention

Analysis was done in the next step. Qualitative data analysis is very challenging. Before placing the content under the broad category, the researcher read very carefully the entire transcripts so that the actual meaning of the participants could not be distorted. Individual summary was then made for each participant of both groups and based on the individual summary; a combined summary was done separately for both groups. The individual summary showed the differences among all participants and combined summary reflected the similarities and contrast feature of the participants of within and between groups. Besides analyzing the data according to the research objectives, concise case summary of both groups was also presented to have in-depth understanding about the client's psychological problems and the level of changes after providing intervention.

Chapter-3

RESULTS

RESULTS

The findings of this research were presented according to the broad category of the research objectives along with the concise case summary. So, this chapter consisted of two parts.

Part-I: Case summary of Group-A and Group-B

Part-II: Presentation of findings in tables and graphs

3.1-Part-I: Case summary of Group-A and Group-B

7 cases of Group-A (Experimental-Non respondents to medication who received CBT) and 7 cases of Group-B (Control-Non respondents to medication who were not given CBT), total 14 case summary have been presented in this part. Each individual case was presented by their code number. The researcher maintained confidentiality so that their personal information is not disclosed. The summary of the cases are as follows:

GROUP-A (Experimental Group)

Case: A-1

Mr. A-1, 43 years old, married, muslim male client from lower middle class status was referred from psychiatry out-patient department of DMCH. He was diagnosed as having OCD by referring agency and he was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from his problems for 18 years.

Current medicine status:

The client's current medicine status is displayed in Table-2.1.1.

Table no-2.1.1: Current medicine status of Mr. A-1

Name of medicine	Group of medicine	Dose
Clofranil	Tri-cyclic Anti Depressant (TCA)	25mg
Oleanz	Atypical Anti Psychotics	10mg
Prodep	Serotonin Re-uptake Inhibitors (SSRI)	20mg
Pase	Benzodiazepine (Short acting/ high potency)	

History of present illness:

The client was 43 years old and he had a religious minded family from his early life but his family was financially solvent. Suddenly their family became poor during 1973-1976. His father's garments shops were in chokbazar when he was fourteen years old but due to failure of garments business they became poor. During that period they stayed with his grandmother's (Maternal) house. At that time they had to face severe financial crisis. He used to feel pressure on his head and recurrent intrusive thoughts occurred. He became restless and his education stopped. Then he joined in a plastic company as a manager (salary per month-400Tk). From early age he wanted to do everything perfectly. After 4 years their financial condition improved but his mental problems did not solve.

Family and Personal history:

Family history: According to the client, his mother died at the age of 50. She was a house wife and her educational level was class five. His father, aged 74 was still alive. He was a businessman and his educational level was class nine. He had three younger sisters and three younger brothers aged 40, 37, 35, 32, 29 and 28 respectively who got married and lived separately but one of his brothers was unmarried. His three sister's educational level were class eight and two brothers educational level were class ten and one was class eight. The client's wife was a house wife, aged 35 and her educational level was class seven. He had a daughter and a son, aged 14 and 9 respectively and their educational level were class nine and class three.

Birth history: The client had birth complication. When he was born, he had breathing problem. For this reason, he had to take an injection to breath normally but his mother was completely ok.

Schooling and education: He was not a good student. So that he could not attend S.S.C exam. He had no interest to read and he had sleep problem from early age. He could not wake up in the early morning.

Occupational history: In 1979-1983, he was a manager of plastic industry. Then he became a Video salesman. After 1987, he established a cosmetic industry. In 1991, he established a churi shop at Chokbazar. After that he used to sell Indian luggage for two years and now he is a sanitary businessman.

Marital history: The client got married in 1991 at the age of 25. From the very beginning his conjugal life was happy but now-a-days he had a conflicting relationship with his wife. He mentioned that he had no satisfactory sexual relationship with his wife.

Past medical history: For this problem he took medicine eighteen years ago. He had appendicitis and now he is cured by operation. When he was fifteen years old, he had typhoid fever for one month.

Relationship among family members: He was the eldest son of his parents. So they loved him. He had many friends when they were rich and now he had few friends.

Family history of mental illness: There was no family history of mental illness.

Formulation

From the in-depth interview and exploration of his thought it revealed that he was suffering from obsessive compulsive disorder. After obtaining information on different areas of client's problem, the therapist formulated his problem on the basis of the following cognitive case conceptualization diagram-

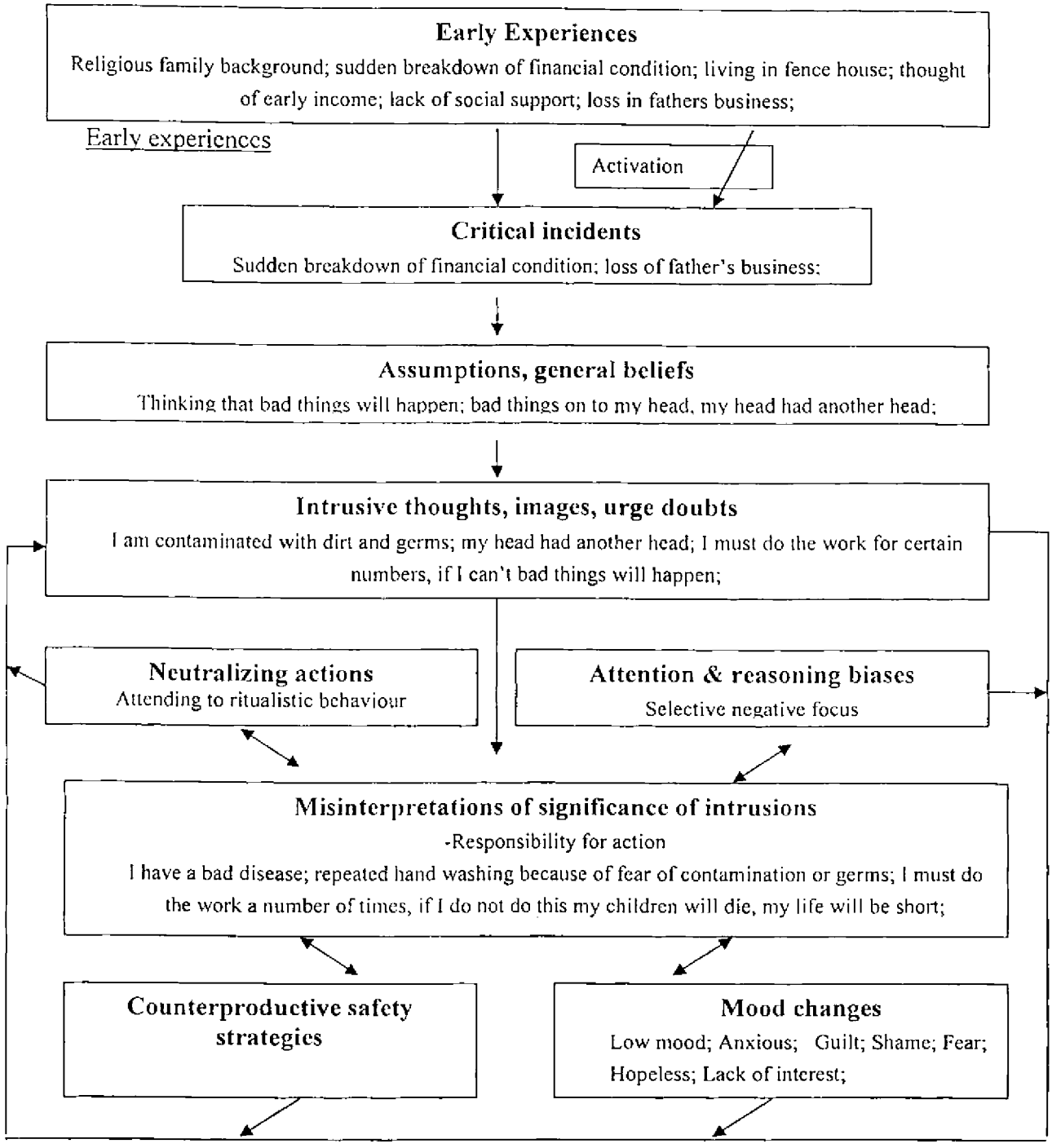

Figure-3.1: Problem formulation of the client using case conceptualization model for obsessive compulsive disorder developed by Salkovskis, Forrester and Richards (1998).

Most distressing thoughts list of the client:

Most distressing thoughts list of the client are displayed at Table-2.1.2.

Table no-2.1.2: Most distressing thoughts list of Mr. A-1

No.	Most distressing thoughts
1.	I am contaminated with dirt and germs;
2.	My head has another head;
3.	I must do the work for a certain number of times, if I can not do bad things will happen;
4.	I have a serious disease;
5.	I must do the work for a certain number of times, if do not do this my children will die, my life will be short

Intervention and result:

Intervention goal:

In the initial three assessment sessions and before the intervention started, assessment of the problems and level of functioning of different areas were done. After assessing the problems goals of intervention were set collaboratively with Mr.A-1, which were as follows:

1. To ventilate the suppressed feelings
2. To remove his obsessional thoughts
3. To regain his daily activities and confidence
4. To reduce physical symptoms
5. To reduce behavioural problems
6. To increase interest level in occupation
7. To reduce sleep difficulties
8. To reduce emotional disturbance
9. To increase communication skill

Treatment plan:

A treatment plan was prepared for each of the problems or symptoms by the therapist. On the basis of full consent of the client, treatment strategies which were applied are given in Table 2.1.3:

Table no-2.1.3: Treatment plan for Mr. A-1

No.	Treatment Goals	Treatment techniques
1.	To ventilate the suppressed feelings	Psycho-education, empathetic listening, breathing relaxation
2.	To remove his obsessional thoughts	Habituation training, thought challenge, distraction, downward arrow technique
3.	To regain his daily activities and confidence	Scheduling activities, monitoring activities
4.	To reduce physical symptoms	Relaxation
5.	To reduce behavioural problems	Relaxation, exposure and response prevention, analogical evidence, modeling, habituation training, monitoring activities
6.	To increase interest level in occupation	Relaxation, cognitive restructuring, problem solving skill
7.	To reduce sleep difficulties	Relaxation, distraction
8.	To reduce emotional disturbance	Problem solving skills , cognitive restructuring, psycho education, relaxation, monitoring activities, graded task
9.	To increase communication skill	Social skill training, relaxation

Intervention:

The following cognitive and behavioural techniques were used in the treatment of the client:

1. Empathetic listening: The therapist established a good rapport with the client and listened empathetically to his distressful thoughts about the past. The empathetic therapeutic atmosphere helped him to release his pent-up emotion.

2. Psycho-education: Psycho-education was given the client about his disorder (OCD).Psycho-education is crucial in starting to generate a different way of making sense of the problem and it was provided about the nature of the therapy to socialize the client in the therapeutic principles and process of CBT. As a psycho-education, the present therapist provided definition of OCD, types/characteristics of OCD, treatment and prognosis of OCD.

3. Relaxation: Relaxation technique was applied to reduce anxiety symptoms of client. Breathing and imaginal relaxation techniques were applied for release his tension, stress and anxiety related other symptoms.

4. Thought challenge: The present therapist used Dysfunctional Thought Record Sheet (DTR) for fighting client irrational, intrusive and unwanted negative thoughts. The client was asked to practice this technique as homework assignment and this technique helped him to increase self-confidence.

5. Distraction: Distraction technique was used to reduce his most distressing thoughts. The client was very much distress about his life.

6. Exposure with response prevention (ERP): Exposure and response prevention are the most commonly used treatment technique for OCD client. ERP was administered for the client to provoke the compulsive urge and to refrain from engaging in his usual compulsive behaviour. Before starting the ERP session, the present therapist explained the rationale and the client agreed for imaginal exposure first. Modeling was done by the therapist before the client practiced ERP and the therapist asked to practice ERP for the client as a homework assignment.

7. Habituation technique: This technique was used to reduce his unwanted recurrent intrusive thoughts and the client practiced successfully. He felt less discomfort for using this technique.

8. Analogical evidence: This technique was used for helping the client change his dysfunctional thinking pattern. It also helped the client to evaluate the meaning of his thoughts from an objective perspective and with great relief he realized for the first time that he was not responsible for having the intrusive thoughts.

9. Downward arrow technique: This technique was used for revealing the underlying 'core' meaning of the negative interpretation of the client.

10. Scheduling activities: The therapist asked the client to record his daily activities and these records can increase activity levels of the client.

11. Problem solving skills: To increase his interest level in occupation and to reduce emotional disturbance the present therapist taught him about problem solving skills.

12. Social skill training (SST): To improve his communication skill the therapist gave him SST.

Pre, mid, post and follow-up assessment result of the problems

A. Findings based on Interview and Observation:

Mr. A-1's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no-2.1.4.

Table no-2.1.4: Problems mentioned in pre-assessment and reduction/improvement/ increase of problems found during mid, post and follow-up assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement /increase of the problem in Post-assessment	Reduction/ improvement /increase of the problem in Follow-up assessment
Cognitive	I am contaminated with dirt and germs, touching animals; became ill from contaminated	Reduced up to 20 to 50%	Reduced up to 50 to 100%	Reduced up to 80 to 100%
	I must do my work for certain numbers, if I can not bad things will happen	Reduced up to 10 to 70%	Reduced up to 80 to 100%	Reduced up to 80 to 100%
	Nobody understand my pain, life is meaningless and worthless, world is full of dust, life is finished, future is dark	Reduced up to 10 to 50%	Reduced up to 50 to 70%	Reduced up to 75 to 85%
	Lack of concentration, difficulty in making decision, low self esteem	Improved up to 10 to 60%	Improved up to 30 to 90%	Concentration level improved up to 50 to 85%; decision making capacity improved up to 60 to 70%; and self esteem improved up to 50 to 90%
	Reassurance seeking behaviour	Reduced up to 10%	Reduced up to 50%	Reduced up to 70% to 80%
	He speaks alone; he had no quality; his head has a bad thing; his head has another head	Reduced up to 70%	Reduced up to 70%	Reduced up to 75 to 90%
	If I go one step then I back two steps, I must getup the chair from the same side, if I can not do that danger will happen	Reduced up to 70%	Reduced up to 99%	Reduced up to 99%

	I am concern with religious beliefs; hopeless about marital life	Reduced a little bit	Hopeful about marital life	Hopeful about marital life
	Soap water going to abdomen and became sick and burning sensation felt all abdomen; can not touch children, wardrobe, bed, sofa set, window, door etc because of insects poison; all time advertisement and music was running my head	Reduced up to 55%	Reduced up to 85%	Reduced up to 100%
	I will fail my exams; suicidal ideation	Reduced up to 40%	Reduced up to 100%	Reduced up to 100%
	Urge to collect useless things	Reduced up to 40%	Reduced up to 65%	Reduced up to 75%
	Preoccupation with symmetry, exactness and order; excessive concern with aligning papers, books, cloths, bag, toys, show pieces, household materials and other items a certain perfect way	Reduced up to 20%	Reduced up to 60%	Reduced up to 90%
	Preoccupation and excessive, illogical fear of harming self, harming fathers	Reduced up to 50%	Reduced up to 80%	Reduced up to 100%
	Doing something embarrassing; worry about losing things; worry about fathers remarriage	Not reduced	Doing something embarrassing reduced up to 50%; worry about losing things; worry about fathers remarriage reduced up to 80%	Reduced up to 80% and 90%
	She is going to die and fear to die	Reduced up to 40%	Reduced up to 50% to 80%	Reduced up to 90%
	I am a bad looking person, everybody laughed to seem me	Reduced up to 60%	Reduced up to 70%	Reduced up to 80%
	I have a serious disease "I wish I will die"	Reduced up to 5%	Reduced up to 50%	Reduced up to 90%
	I have a skin disease due to using soap	Reduced up to 20%	Reduced up to 40%	Reduced up to 40%
Emotional	Felt fear; hopeless, sad, worthless, distressed, restless, confused and vulnerable	Reduced up to 15 to 50%	Reduced up to 25 to 100%	Reduced up to 25 to 100%
	Guilt feeling; no interest to do	Reduced a little	Reduced up to	Reduced up to

	anything; irritated; frustrated about life; crying spell; hot tempered	bit	60%	80%
Physiological	Drowsiness, palpitation, sweating, sleep difficulties, , dryness of throat, headache and loss of energy	Reduced up to10 to 50%	Reduced up to 40 to 90%	Reduced up to 75 to 80%
	Burning sensation all over the body; weight gradually reduced	Reduced up to 10 to 40%	Reduced up to 50 to 75%	Reduced up to 75 to 80%
	Appetite reduced	Improved up to10 to 50%	Improved up to 50 to 100%	Improved up to 90 to 100%
	Jerking all over the body	Reduced up to 30%	Reduced up to 40%	Reduced up to 80%
	Hot and pain in abdomen, dehydrations problem, felt weak, hand and body tremor	Reduced up to 20%	Reduced up to 40%	Reduced up to 80%
Behavioural	Repeated washing, often performed in a ritualistic way	Reduced up to 15 to 80%	Reduced up to 50 to 100%	Reduced up to 85 to 100%
	Avoiding places feared for possible contamination	Reduced up to 5 to 55%	Reduced up to 50 to 70%	Reduced up to 60 to 90%
	repeated showering or bathing	Reduced up to 25 to 40%	Reduced up to 20 to 100%	Reduced up to 85 to 100%
	Decreased activity level	Improved up to 5 to 50%	Improved up to 20 to 80%	Improved up to 45 to 85%
	Repeating and rereading things	Reduced up to 15 to 40%	Reduced up to 100%	Reduced up to 100%
	Checking stoves, locks, food pot, fan switches, windows over and over and doing certain activities in a particular number of times	Reduced up to 10 to 50%	Reduced up to 50 to 100%	Reduced up to 70 to 100%
	Counting tiles	Reduced up to 80%	Reduced up to 100%	Reduced up to 100%
	He had no quality of stage performance at all; writing often performed in a ritualistic way; bathing several time; can not bathing through a month; cleaning objects and household items by using with special cleansers and cleaning techniques; avoidance of objects considered contaminated	Reduced up to 20%	Reduced up to 60%	Reduced up to 90%
	Preoccupation with symmetry, exactness or order	Reduced up to 40%	Reduced up to 30%	Reduced up to 70%

	Withdraw from social activity now days; assertiveness problems not removed	Withdraw from social activity now days; assertiveness problems not removed	Not removed significantly	Reduced up to 35%
Social	Disrupted social interaction decreased relationship with neighbors, relatives and family members	Improved up to 10 to 50%	Social interaction improved up to 40 to 60%; relationship with neighbors, relatives and family members improved up to 55 to 100%	Social interaction improved up to 50 to 70%; relationship with neighbors, relatives and family members improved up to 55 to 100%
	Annoyed with family members and decreased relationship with customers	Now a day she annoyed with her father 50% and improved relationship with customers a little bit	10% and improved 50%	10% and improved 50%
Occupational	Poor business and job performance	Improved up to 15%	Improved up to 55%	Improved up to 60 to 75%
	Decreased relationship with colleagues	Improved up to 20 to 30%	Improved up to 40 to 70%	Improved up to 50 to 80%
	Lack of concentration about business task, lack of interest, decreased level of interest, reduced attention span and reduced body strength;	Improved up to 20%	Concentration about business task improved up to 50 to 65%; attention span and body strength improved up to 60%	Improved up to 60% to 70%
	Can not do any household activities; lack of concentration about study and loss of memory	Improved up to 45%	Improved up to 45%	Improved up to 50%
	Decreased relationship with class mates and teachers	Not improved	Improved a little bit	Improved up to 50%
Observation	The client came with a clean well dress up and his appearance and behaviour	The clients ..... appropriate	The clients	The clients ....appropriat

	appeared to be culturally appropriate		appropriate	e
	He was very much anxious and wanted immediate solution for his problem	His sufferings seemed to be less than before	He Felt relax and facial expression was smiling	He felt .....s miling
	He could make eye contact normally	Normal	Normal	Normal
	His body posture was normal but body movement was restless	Almost normal	Almost normal	Almost normal
	His amount of speeches was almost normal and mood was low	Normal	Normal	Normal

B. Objective rating of Mr. A-1:

Anxiety scale (AS); (Deeba, F. and Begum, R. 2004), Depression scale (DS); (Uddin, Z. and Rahman, M. 2005) and Dhaka University Obsessive Compulsive Scale (DUOCS); (Mozumder, K. and Begum, R. 2005) were applied to get an objective measure of the severity of the client's anxiety, depression and OCD. Scores of the above mentioned scales are displayed at Table no-2.1.5.

Table no-2.1.5: General trend of objective score of Mr. A-1

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	40 (Mild)	110 (Mild)	57 (Profound)
Mid-assessment	54 (Mild)	101 (Mild)	49 (Severe)
Post-assessment	07 (Mild)	32 (Minimal)	12 (Below cut off score)
1st Follow- up	03 (Mild)	32 (Minimal)	13 (Below cut off score)
2nd Follow- up	03 (Mild)	32 (Minimal)	08 (Below cut off score)
3rd Follow- up	03 (Mild)	31 (Minimal)	08 (Below cut off score)

C. Subjective rating of Mr. A-1:

The client and his wife rated his overall problem in (0-10) 11 point rating verbal scale, where '0' indicates no problem at all and '10' indicates highest level of problem. Ratings of the verbal scale are displayed at Table no-2.1.6.

Table no-2.1.6: General trend of subjective rating of Mr. A-1

	Client's Subjective Rating Score	Care giver's Subjective Rating Score
Pre-assessment	8	10
Mid-assessment	4	
Post-assessment	3	3
1st Follow- up	3	
2nd Follow- up	4	
3rd Follow- up	2	

(**Note:** The care giver did not attend the mid and follow-up sessions.)

Prognostic criteria:

There were some prognostic criteria, due to which some changes in the client mental health. Those were as follows-

1. The client was highly motivated, interested and co-operative to his therapy session.
2. His care giver (wife) was more co-operative. For this reason it was easy for the therapist to run the therapy smoothly.
3. He was very much committed to the session's activities.
4. The duty psychiatrist referred the client from out door immediately when he did not find any result of medicine.
5. After one month he came back to have follow-up session.

Therapist's comment:

Mr. A-1 was extremely anxious during the pre-assessment sessions. He attended 16 sessions including three follow-up sessions and he was complying the therapy by his own. He gave his informed consent very willingly and started participating in the session. He agreed with the researcher's formulation and provided feedback. After total 16 sessions, his anxiety, depression and OCD score was low. His short term prognosis is good but if he does not practice the techniques learned in the session while facing any difficult situation relapse may occur. So, the long term prognosis depends on the client's internalization.

Responsible Psychiatrist's comments:

At the last and follow-up session the responsible psychiatrist talked with Mr. A-1. According to the psychiatrist evaluation/ remarks, patients states that obsessional rituals has gone away, magical thinking also has slowed down but obsessional thought is still persisting in mild intensity. He is working normally and problem in relationship is also much better in position. Finally, the responsible psychiatrist reported 75% as improvement rating feedback.

Case: A-2

Mrs. A-2, 37 years old, married, muslim female client from middle class status was referred from psychiatry in-patient department of BSMMU. She was diagnosed as having OCD by referring agency and she was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from her problems for 25 years.

Current medicine status:

The client's current medicine status is displayed in Table no-2.2.1.

Table no-2.2.1: Current medicine status of Mrs. A-2

Name of medicine	Group of medicine	Dose
Clofranil	TCA	25mg
Oleanz	Atypical Anti Psychotics	10mg
Prodep	SSRI	20mg

History of present illness:

The client was grown up in a restricted family environment. In childhood, she was over protected. Suddenly insect's bite her mother, when she was 10 years old. Due to insects bite, her mothers hand became black and at that time the client felt insects fear. At that time she thought that her son would die by touching insect poison. Her elder sister lived with her. When her daughter was born, her sister got married and the client became alone. Her mood was always low at that time and she felt loss of appetite and pain in chest at the same time. As a result she had to go to doctor for endoscope and the test

report indicated alser. Doctor advised her not to take any kind of spicy food. As a result she was fearful. At that time she became weak and thin and her fear with insect poison began. One day her maid servant killed an insect under water tap in her kitchen. She thought that poisonous water fell into her plate and then she began washing. She started washing her cloth, cookeries, furniture several time in a day after that event. She bath several times and hours because of the fear of contamination. She avoided social relationships, social gathering and food intake in another house. When anyone used to come to her house, she felt discomfort. Her another obsession was with the insect's killer like calk. She thought that calk would touch her body, go to her abdomen and she would die. On August 4, 1989, she got married, at the age of 17 but after 28 days of her marriage, her husband went to Saudi Arabia. Her husband was a rich man in their village but her in laws and used to torture her very much. All of these factors promoted her problem development and maintenance.

Family and Personal history:

Family history: According to the client, her mother and father were still alive; their age was 60 and 70 respectively and their educational level was class five and S.S.C. Her father was a village doctor. She had two sisters and two brothers aged 41, 34, and 28 respectively who got married and lived separately. The educational levels of her two sisters were class ten and S.S.C and two brothers were graduates. The client's husband was a businessman aged 52 and his educational level was MA. She had a daughter and a son aged 13 and 18 respectively and their educational levels were class six and S.S.C.

Birth history: The client had no birth complications.

Schooling and education: The client was a medium category student. She started her schooling at 5/6 years of age. She used to go to school regularly and had a few friends. The client's performance was good in school. In 1988, she had passed her S.S.C examination with 2nd division.

Marital history: When she was 17 years old, her husband chose her to marry. Though her father did not like her husband's family she got married in 1989, August 4. After 28 days of her marry, her husband had to go Saudi Arabia.

Past medical history: For this problem she took medicine 15 years ago. She had two seizure babies. Her husband had cardiac and diabetic problems. Her husband became very sick and then hospitalized for two times. As a consequence he had to lying in bed for about four months and the client had to take care of her husband very much but now her husband sometimes gets angry with her for obsessional problem.

Relationship among family members: Her parents loved her very much but her in laws did not like her. All the time her husband loved her very much but she used to be tortured by her in laws all the time.

Family history of mental illness: There was a family history of mental illness. Her father had an animal phobia but he did not receive any psychological treatment.

Formulation

From the in-depth interview and exploration of her thought it revealed that she was suffering from obsessive compulsive disorder. After obtaining information on different areas of client's problem, the therapist formulated her problem on the basis of the following cognitive case conceptualization diagram-

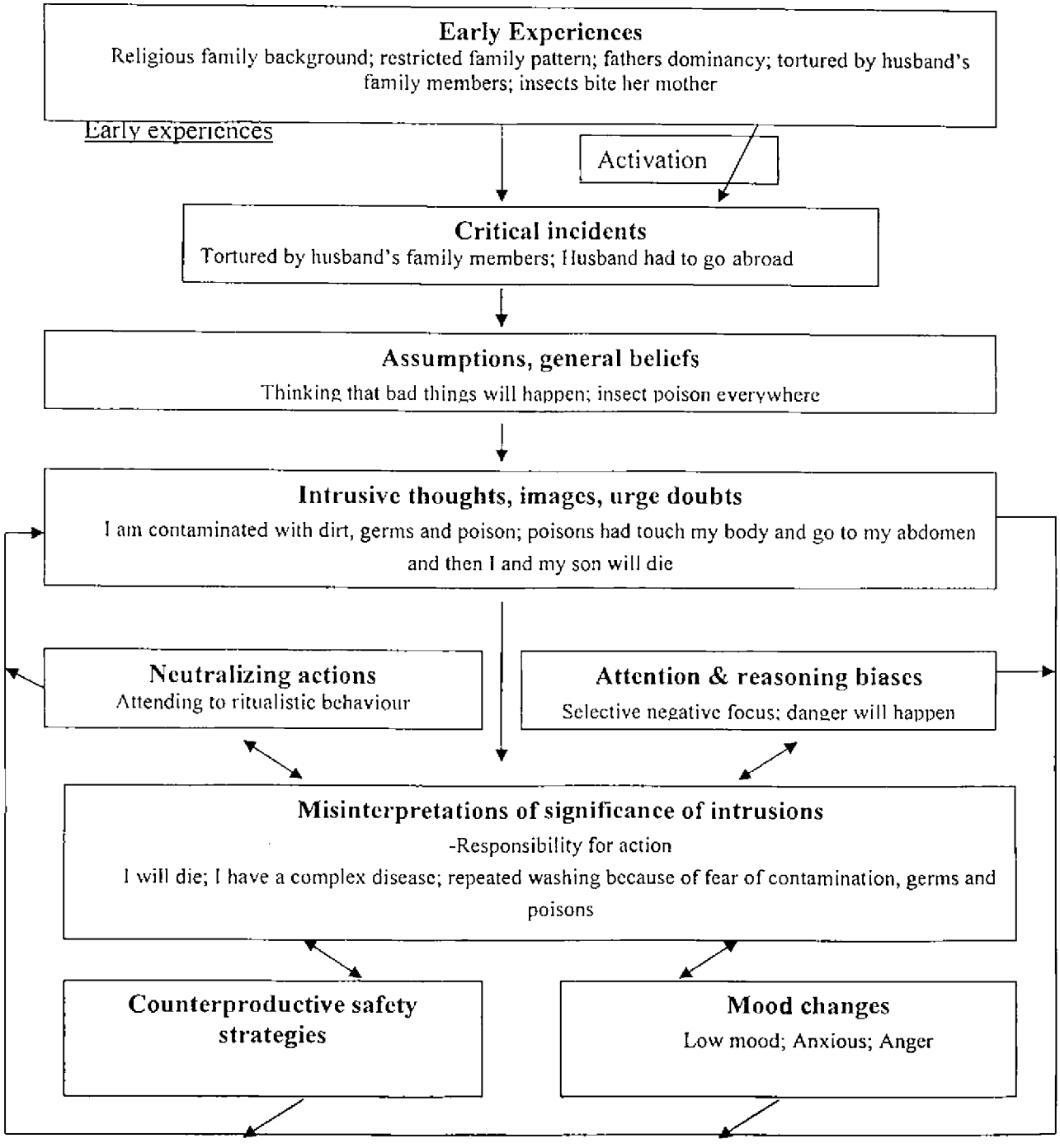

Figure-3.2: Problem formulation of the client using case conceptualization model for obsessive compulsive disorder developed by Salkovskis, Forrester and Richards (1998).

Most distressing thoughts list of the client:

Most distressing thoughts list of the client are displayed on Table no-3.2.2.

Table no-3.2.2: Most distressing thoughts list of Mrs. A-2

No.	Most distressing thoughts
1.	I am contaminated with dirt, germs and poison;
2.	I have a complex disease;
3.	I and my son will die by touching insects poison;

Intervention and result:

Intervention goal:

In the initial three sessions and before the intervention started, assessment of the problems and level of functioning of different areas were done. After assessing the problems goals of intervention were set collaboratively with Mrs.A-2, which were as follows:

1. To ventilate the suppressed feelings
2. To remove her obsessional thoughts
3. To regain her daily activities and confidence
4. To reduce physical symptoms
5. To reduce behavioural problems
6. To reduce sleep difficulties
7. To reduce emotional disturbance
8. To increase communication skill

Treatment plan:

A treatment plan was prepared for each of the problems or symptom by the therapist. On the basis of full consent of the client, treatment strategies which were applied are given in Table no-2.2.3.

Table no-2.2.3: Treatment plan for Mrs. A-2

No.	Treatment Goals	Treatment techniques
1.	To ventilate the suppressed feelings	Psycho-education, empathetic listening, breathing relaxation
2.	To remove her obsessional thoughts	Thought stopping, habituation training, thought challenge, distraction,

		cognitive restructuring, downward arrow technique, pros and cons
3.	To regain her daily activities and confidence	Problem solving skills , social skill training, scheduling activities, monitoring activities
4.	To reduce physical symptoms	Relaxation
5.	To reduce behavioural problems	Relaxation, exposure and response prevention, systematic desensitization, analogical evidence, modeling, avoidance reduction, habituation training, monitoring activities
6.	To reduce sleep difficulties	Relaxation, distraction
7.	To reduce emotional disturbance	Problem solving skills , cognitive restructuring, psycho-education, relaxation, monitoring activities, graded task
8.	To increase communication skill	Social skill training, relaxation

Intervention:

The following cognitive and behavioural techniques were used in the treatment of the client:

1. Empathetic listening: From the first session, the therapist established a good rapport with the client for disclose her problems. The therapist listened empathetically to her distressful thoughts about the past. The empathetic therapeutic atmosphere helped her to release her pent-up emotion.

2. Psycho-education: Psycho-education had been given the client about her disorder (OCD).Psycho-education is crucial in starting to generate a different way of making sense of the problem and it was provided about the nature of the therapy to socialize the client in the therapeutic principles and process of CBT. As a psycho-education; the present therapist provided definition of OCD, types/characteristics of OCD, treatment and prognosis of OCD.

3. Analogical evidence: This technique was used for helping the client change her dysfunctional thinking pattern. It also helped the client to evaluate the meaning of her thoughts from an objective perspective and with great relief she realized for the first time that she was not responsible for having the intrusive thoughts.

4. Relaxation: Relaxation technique had been given to reduce client's anxiety symptoms. Breathing and imaginal relaxation techniques were applied for release her tension, stress and anxiety related other symptoms. Breathing and imaginal relaxation has practiced in the session by modeling and was suggested to practice regularly.

5. Distraction: Distraction technique was used to reduce her most distressing thoughts. The client was very much distress about her life.

6. Thought challenge: Thought challenge was used to help her to view the situation alternatively as negative automatic thoughts were activating the client's dysfunctional assumption and thereby maintained the problem. The present therapist used Dysfunctional Thought Record Sheet (DTR) for fighting client irrational, intrusive and unwanted negative thoughts. The client was asked to practice this technique as homework assignment and this technique helped her to increase self-confidence.

7. Exposure with response prevention (ERP): ERP was administered for the client to provoke the compulsive urge and to refrain from engaging in her usual compulsive behaviour. Before starting the ERP session, the present therapist explained the rationale and the client agreed for imaginal exposure first. Modeling was done by the therapist before the client practiced ERP and the therapist asked to practice ERP for the client as a homework assignment.

8. Habituation technique: This technique was used to reduce her unwanted recurrent intrusive thoughts and the client practiced successfully. She felt comfort for using this technique.

9. Downward arrow technique: This technique was used for revealing the underlying 'core' meaning of the negative interpretation of the client.

10. Problem solving skills: To increase her interest level in occupation and to reduce emotional disturbance the present therapist taught her about problem solving skills.

11. Scheduling activities: The therapist asked the client to record her daily activities and these records can increase activity levels of the client.

12. Social skill training (SST): To improve her communication skill the therapist gave her SST. Assertiveness training had been given and practiced in the session by modeling as well as through flooding technique.

Pre, mid, post and follow-up assessment result of the problems

A. Findings based on Interview and Observation:

Mrs. A-2's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no 2.2.4.

Table no-2.2.4: Problems mentioned in pre-assessment and reduction/ improvement/ increase of problems found during mid, post and follow-up assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement/ increase of the problem in Post-assessment	Reduction/ improvement/ increase of the problem in Follow-up assessment
Cognitive	I am contaminated with dirt, germs and poison, touching insects; became ill from contaminated; going to die by touching insects; must do my work for certain numbers	Reduced up to 20%	Reduced up to 70%	Reduced up to 90%
	Nobody understands her pain, life is meaningless and worthless, life is finished and future is dark	Reduced up to 20%	Reduced up to 60%	Reduced up to 80%
	Felt lack of concentration, difficulty in making decision and low self esteem	Not improved	Improved up to 50%	Improved up to 70%
	Reassurance seeking behaviour	Not reduced	Reduced up to 40%	Reduced up to 80%
	She can not touch her children, wardrobe, bed, sofa set, window, door etc because of insects poison	Now touches sometimes	Touches sometimes	Touches sometimes
	Felt that she was going to senseless and loss of memory	Reduced up to 10%	Reduced up to 50%	Reduced up to 70%
Emotional	Felt irritation all the time	Felt irritation sometimes	Felt irritation sometimes	Reduced significantly
	Felt fear, hopeless, sad, worthless, distressed, restless, confused and vulnerable	Reduced up to 15%	Reduced up to 55%	Reduced up to 75%
	Not interest to do anything	Not interest to do anything	Interest to do something and	Interest to do something

		now a days	now she cooks food and takes care for her family	and now she cooks food and takes care for her family
Physiological	Palpitation, sweating, sleep difficulties, drowsiness	Reduced up to 20%	Reduced up to 50%	Reduced up to 75%
	Felt weak	Not reduced at all	Reduced but not up to satisfactory level	Reduced up to 60%
	Loss of appetite	Increased a little bit up to 5%	Increased up to 50%	Increased up to 65%
	Dryness of throat, headache, hand and body tremor, burning sensation all over the body	Reduced up to 10%	Reduced up to 60%	Reduced up to 80%
	Loss of energy	Increased up to 10%	Increased up to 60%	Reduced up to 70%
Behavioural	Repeated washing, showering and bathing often performed in a ritualistic way	Reduced up to 25%	Reduced up to 80%	Reduced up to 85%
	Avoiding places feared for possible contamination and poison explosion;	Reduced up to 5%	Reduced up to 50%	Reduced up to 60%
	Decreased activity level	Not improved significantly	Increased up to 30%	Increased up to 50%
	Withdrawal from social activity	Now a day	Increased up to 30%	Increased up to 50%
	Checking gas stoves, locks, food pot and taking medicine again and again and doing certain activities in a particular number of times	Reduced up to 30%	Reduced up to 50%	Reduced up to 70%
Social	Decreased social interaction	Increased a little bit up to 10%	Increased up to 60%	Increased up to 70%
	Decreased relationship with neighbors, relatives and family members	Not improved	Improving	Improving
	She can not mix with other and avoids other's house	Mixes with other now a days but she avoids other's house	Mixes with other now a days but she avoids other's house	Mixes with other now a days but she avoids other's house
Occupational	She can not do any household activities	Tries to do something	Tries to do something	Tries to do something
	Whole day she lies in bed and her husband manages her family. She mentioned that her relationship with other family members were	Increased up to 30%	Increased up to 70% and 60%	Increased up to 80% and 70%

	decreased accept with her husband, she has no interest in any activities, her attention span and body strength reduced significantly			
Observation	The client came with a religious dress up with her husband and her appearance and behaviour appeared to be culturally appropriate and she was a very good looking woman	Came..... appropriate.	Came..... appropriate	Came..... appropriate
	She could make eye contact normally but she was looking very sad and anxious	Normal	Shining	Shining
	Her body posture and movement was restless which expressed her anxiety and tiredness about her life	Restless	Restless a little bit	Normal
	She speaks very slowly and her amount of speech was very little which indicates that she was very much depressed	Slowly	Normal	Normal
	Her mood was low and she felt restlessness	Low and restlessness	Fresh	Fresh

B. Objective rating of Mrs. A-2:

Scores of AS, DS and DUOCS are displayed at Table no-2.2.5.

Table no-2.2.5: General trend of objective score of Mrs. A-2

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	81 (Profound)	109 (Mild)	53 (Profound)
Mid-assessment	66 (Moderate)	98 (Minimal)	41(Severe)
Post-assessment	69(Severe)	78(Minimal)	26 (Moderate)
1st Follow- up	31 (Mild)	62 (Minimal)	24 (Moderate)
2nd Follow- up	44 (Mild)	73 (Minimal)	24 (Moderate)
3rd Follow- up	15 (Mild)	35 (Minimal)	17 (Cut off score)

C. Subjective rating of Mrs.A-2:

Ratings of the verbal scale are displayed at Table no-2.2.6.

Table no-2.2.6: General trend of subjective rating of Mrs.A-2

	Client's Subjective Rating Score	Care giver's Subjective Rating Score
Pre-assessment	9	8
Mid-assessment	4	4

Post-assessment	3	3
1st Follow- up	2	2
2nd Follow- up	2	2
3rd Follow- up	2	2

Prognostic criteria:

There were some prognostic criteria, due to which some changes in the client mental health. Those were as follows-

1. The client was compliant, motivated, interested, co-operative and psychological minded to her therapy session; she attended regularly in the therapy session.
2. Her care giver, husband and other family members were co-operative.
3. The client lived far away from hospital but she came in time for session. For this reason it was easy for the therapist to run the therapy smoothly.
4. She was very much committed to the session's activities.
5. After one month she came back to have follow-up session.

Therapist's comment:

Mrs. A-2 terminated the session after attending 15 sessions including three follow-up sessions and she was complying the therapy by her own and her husband motivation and co-operation. She was extremely anxious and depressed during the pre-assessment sessions but gave her informed consent very willingly and started participating in the session. She agreed with the researcher's formulation and provided feedback. After total 15 sessions, her anxiety, depression and OCD score was low. Her short term prognosis is good but if she does not practice the techniques learned in the session while facing any difficult situation relapse may occur. So, the long term prognosis depends on the client's internalization.

Responsible Psychiatrist's comments:

At the last and follow-up session the responsible psychiatrist talked with her. According to the psychiatrist evaluation/ remarks, the client was improving and finally, reported 80% as improvement rating feedback.

Case: A-3

Mr. A-3, 28 years old, unmarried, muslim male client from lower middle class status was referred from psychiatry out-patient department of DMCH. He was diagnosed as having OCD by referring agency and he was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from his problems for 18 years and took medicine for 8 years.

Current medicine status:

The client's current medicine status is displayed in Table no-2.3.1.

Table no-2.3.1: Current medicine status of Mr. A-3

Name of medicine	Group of medicine	Dose
Telazine	Traditional Anti Psychotics	1 mg
Xionil	Anxiolytic	3mg
Prodep	SSRI	20mg

History of present illness:

From early age, the client was basically lazy nature and he was not caring child at that time. He could not wash his cloth and his body. He had always negative automatic and recurrent intrusive thoughts. Sometime he bathed several hours and several (4/5) times a day but he did not take his bath daily. He had regular irritating mood at that time and he did not like anybody. He could not understand right or wrong and he had an aimless life. When he was a student of class ten, his parents quarreled with him without any reason and the client did not like any quarrel and complexity. Due to his parents negative attitude he got very much angry and ran away from his home. After that event his problems started gradually.

Family and Personal history:

Family history: According to the client, his father died at the age of 80 and he was a Government service holder and his educational level was class S.S.C. His mother aged 60, was still alive. She was a house wife and she was illiterate. He had two younger

brothers aged 26 and 24 respectively. Among them one was illiterate and another one's educational level was class eight.

Birth history: The client had no birth complication.

Schooling and education: He was not a good student and he had no interest to read. He had sleep problem from early age. He could not wake up in the early morning and could not go to school at all. He had no friend and always used to fight with other classmates.

Occupational history: He had been working as a supervisor in a cotton Company from 2007. In the company, he had no job satisfaction. His colleagues and co-workers did not like him because of his agitation. He could not mix with his colleagues.

Past medical history: For this problem he took medicine 8 years ago. He could not enjoy anything and he thought that he had become a mental patient. Always his concentrations used to go to negative way. He could not stop this kind of thought.

Relationship among family members: He was the eldest son of his parents but they did not love him.

Family history of mental illness: His father had the same problem. Furthermore, his mother, maternal uncle and brother in law were mentally disordered.

Formulation

From the in-depth interview and exploration of his thought it revealed that he was suffering from obsessive compulsive disorder. After obtaining information on different areas of client's problem, the therapist formulated his problem on the basis of the following cognitive case conceptualization diagram-

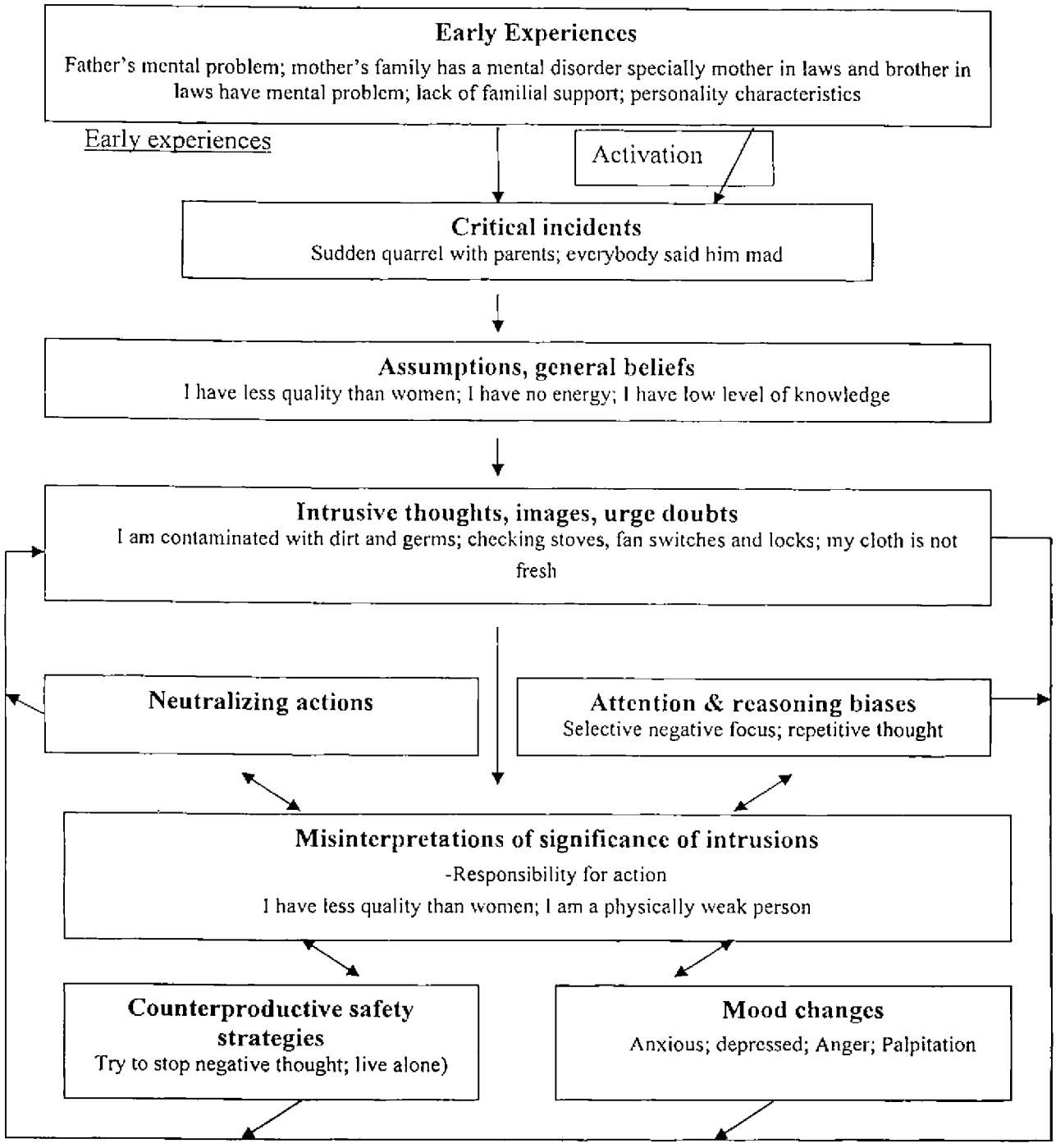

Figure-3.3: Problem formulation of the client using case conceptualization model for obsessive compulsive disorder developed by Salkovskis, Forrester and Richards (1998).

Most distressing thoughts list of the client:

Most distressing thoughts list of the client are displayed at Table no-2.3.2.

Table no-2.3.2: Most distressing thoughts list of Mr. A-3

No.	Most distressing thoughts
1.	Contaminated with dirt and germs;
2.	Everybody is better quality than me, they are knowledgeable than me
3.	Lack of concentration very much
4.	I am a bad looking person

Intervention and result:

Intervention goal:

In the initial three sessions and before the intervention started, assessment of the problems and level of functioning of different areas were done. After assessing the problems goals of intervention were set collaboratively with Mr.A-3, which were as follows:

1. To remove his obsessional thoughts
2. To regain his daily activities and confidence
3. To reduce physical symptoms
4. To reduce behavioural problems
5. To increase problem solving skills
6. To increase interest level in occupation
7. To reduce emotional disturbance
8. To increase communication skill

Treatment plan:

A treatment plan was prepared for each of the problems or symptoms by the therapist. On the basis of full consent of the client, treatment strategies which were applied are given in Table no-2.3.3.

Table no-2.3.3: Treatment plan for Mr. A-3

No.	Treatment Goals	Treatment techniques
1.	To remove his obsessional thoughts	Habituation training, thought challenge, distraction, cognitive restructuring, downward arrow

		technique, pros and cons
2.	To regain his daily activities and confidence	Problem solving skills , social skill training, scheduling activities, monitoring activities
3.	To reduce physical symptoms	Relaxation, cognitive restructuring
4.	To reduce behavioural problems	Relaxation, exposure and response prevention, analogical evidence, modeling, habituation training, monitoring activities
5.	To increase problem solving skills	Problem solving skills , social skill training, relaxation
6.	To increase interest level in occupation	Problem solving skills , social skill training, relaxation, cognitive restructuring
7.	To reduce emotional disturbance	Problem solving skills , cognitive restructuring, psycho education, relaxation, monitoring activities, graded task
8.	To increase communication skill	Social skill training, relaxation

Intervention:

The following cognitive and behavioural techniques were used in the treatment of the client:

1. Empathetic listening: His all problems were heard by full attention and reflection. The therapist established a good rapport with the client and listened empathetically to his distressful thoughts about the past. The empathetic therapeutic atmosphere helped him to release his pent-up emotion.

2. Psycho-education: Psycho-education was given the client about his disorder (OCD).Psycho-education is crucial in starting to generate a different way of making sense of the problem and it was provided about the nature of the therapy to socialize the client in the therapeutic principles and process of CBT. As a psycho-education; the present therapist provided definition of OCD, types/characteristics of OCD, treatment and prognosis of OCD.

3. Relaxation: Relaxation technique was applied to reduce anxiety symptoms of client. Breathing and imaginal relaxation techniques were applied to release his tension, stress and anxiety related other symptoms and these techniques were practiced in the session by modeling and were suggested to practice regularly.

4. Downward arrow technique: This technique was used for revealing the underlying 'core' meaning of the negative interpretation of the client.

5. Thought challenge: He was helped to challenge his negative thoughts primarily only through finding alternative. The present therapist used Dysfunctional Thought Record Sheet (DTR) for fighting client irrational, intrusive and unwanted negative thoughts. The client was asked to practice this technique as homework assignment and this technique helped him to increase self-confidence.

6. Distraction: Distraction technique was used to reduce his most distressing thoughts. The client was very much distress about his life.

7. Analogical evidence: This technique was used for helping the client change his dysfunctional thinking pattern. It also helped the client to evaluate the meaning of his thoughts from an objective perspective and with great relief he realized for the first time that he was not responsible for having the intrusive thoughts.

8. Exposure with response prevention (ERP): Exposure and response prevention are the most commonly used treatment technique for OCD client. ERP was administered for the client to provoke the compulsive urge and to refrain from engaging in his usual compulsive behaviour. Before starting the ERP session, the present therapist explained the rationale and the client agreed for imaginal exposure first. Modeling was done by the therapist before the client practiced ERP and the therapist asked to practice ERP for the client as a homework assignment.

9. Habituation technique: This technique was used to reduce his unwanted recurrent intrusive thoughts and the client practiced successfully. He felt comfort for using this technique.

10. Scheduling activities: The therapist asked the client to record his daily activities and these records can increase activity levels of the client.

11. Problem solving skills: Problem solving skills were taught to deal with him real life problems. To increase his interest level in occupation and to reduce emotional disturbance the present therapist taught him about problem solving skills.

12. Social skill training (SST): To improve his communication skills tlte therapist referred him to indoor department of psychiatry, BSMMU in Dhaka for receiving SST.

Pre, mid, post and follow-up assessment result of the problems

A. Findings based on Interview and Observation:

Mr. A-3's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no- 2.3.4.

Table no-2.3.4: Problems mentioned in pre-assessment and reduction/improvement/ increase of problems found during mid, post and follow-up assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement/ increase of the problem in Post-assessment	Reduction/ improvement/ increase of the problem in Follow-up assessment
Cognitive	I am contaminated with dirt and germs, touching others (90%)	Reduced up to 50%	Reduced up to 80%	Reduced up to 85%
	I must do my work for certain numbers; if I can not bad things will happen (70%)	Reduced up to 50%	Reduced up to 80%	Reduced up to 85%
	The client thought that everything of the world is full a dust and nobody understands his pain and world is polluted (80%)	Reduced up to 40%	Reduced up to 70%	Reduced up to 75%
	He also felt lack of concentration (100%)	Increased up to 30%	Increased up to 50%	Increased up to 60%
	Difficulty in making decision (90%)	Increased up to 30%	Increased up to 60%	Increased up to 70%
	Hopeless, low self esteem (80%) and lack of confidence (80%)	Increased up to 20%	Increased up to 70%	Increased up to 75%
	He is a bad looking person, everybody laughs at him (70%)	Reduced up to 60%	Reduced up to 70%	Reduced up to 80%
Emotional	The client was very much anxious about his problem. He also felt fear, hopeless, sad, worthless, distressed, restless, confused and vulnerable (50%)	Reduced up to 10%	Reduced up to 25%	Reduced up to 15%

Physiological	Palpitation (90%)	Reduced up to 50%	Reduced up to 70%	Reduced up to 80%
	Sweating, weakness, dryness of throat, burning sensation all over the body	Reduced up to 40%	Reduced up to75%	Reduced up to75%
	Loss of energy (50%)	Increased up to 40%	Increased up to 60%	Increased up to 70%
Behavioural	Avoiding places feared for possible contamination (100%)	Reduced up to 30%	Reduced up to 70%	Reduced up to 80%
	Decreased activity level	Increased activity level up to 10%	Increased up to 80%	Increased up to 80%
	Withdrawal from social activity	Increased social skill up to 30%	Increased up to 50%	Increased up to 60%
	Checking stoves, locks and fan switches again and again (70%)	Reduced up to 20%	Reduced up to 90%	Reduced up to 95%
Social	Disrupted social interaction (100%), disrupted family relationship, decreased relationship with neighbors, relatives, family members specially brother and friends (60%)	Increased up to 20%	Increased up to 50%	Increased up to 60%
Occupational	Poor job performance (90%), decreased relationship with colleagues, lack of concentration about office task, lack of interest, decreased level of interest, reduced attention span and reduced body strength (80%)	Increased up to 15%	Increased up to 55%	Increased up to 75%
Observation	The client came alone in the hospital with uncleaned dress up but his appearance and behaviour appeared to be culturally appropriate	Came with .....appropriate	Came with .....appropriate	Came with .....appropriate
	He could not make eye contact normally; he was looking very anxious and minimum eye contact was present in the first session	Poor eye contact	Normal	Normal
	His body posture was not normal. He was exchanging his body posture in front side and back side continuously and body movement was restless which expressed his	Restless	Normal	Normal

	anxiety			
	His amount of speech was not normal. He speaks very first and loud	First and loud	Normal	Normal
	His mood was very anxious and he felt restlessness	Anxious and restlessness	Normal	Normal

B. Objective rating of Mr. A-3:

Scores of AS, DS and DUOCS are displayed at Table no-2.3.5.

Table no-2.3.5: General trend of objective score of Mr. A-3

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	89 (Profound)	123 (Moderate)	41 (Severe)
Mid-assessment	16 (Mild)	42 (Minimal)	10 (Below cut off score)
Post-assessment	22 (Mild)	69 (Minimal)	09 (Below cut off score)
1st Follow- up	03 (Mild)	36 (minimal)	02 (Below cut off score)
2nd Follow- up	07 (Mild)	41 (Minimal)	02 (Below cut off score)
3rd Follow- up	06 (Mild)	36 (Minimal)	02 (Below cut off score)

C. Subjective rating of Mr.A-3:

Ratings of the verbal scale are displayed at Table no-2.3.6.

Table no-2.3.6: General trend of subjective rating of Mr.A-3

	Client's Subjective Rating Score
Pre-assessment	8
Mid-assessment	2.5
Post-assessment	2.5
1st Follow- up	2
2nd Follow- up	2
3rd Follow- up	1.5

(**Note:** The care giver did not attend the sessions.)

Prognostic criteria:

There were some prognostic criteria, due to which some changes in the client mental health. Those were as follows-

1. The client was compliant, motivated, co-operative in the therapy session; he attended regularly in the therapy session.
2. He was very much devoted to the treatment process and practiced the skills he learnt from the session to reduce his symptoms.
3. Although he had acute financial crisis but he continued session regularly for which the current trainee clinical psychologist could run therapy session smoothly.
4. After one month he came back to have follow-up session.
5. The duty psychiatrist referred the client from out door immediately when he did not find any result of medicine.

Therapist's comment:

Mr. A-3 was extremely anxious and depressed during the initial sessions. He attended 15 sessions including three follow-up sessions and he was complying the therapy by his own. He gave his informed consent very willingly and started participating in the session. He agreed with the researcher's formulation and provided feedback. After 15 sessions, his anxiety, depression and OCD scores were found to be low. His short term prognosis is good but if he does not practice the techniques learned in the session while facing any difficult situation relapse may occur. So, the long term prognosis depends on the client's internalization.

Responsible Psychiatrist's comments:

At the last and follow-up session the responsible psychiatrist talked to the client. According to the psychiatrist evaluation/ remarks, the client has developed control over ruminations. Emotionally now he is stable and he can perform his daily activities smoothly. Finally, the responsible psychiatrist reported 80% as improvement rating feedback.

Case: A-4

Mrs. A-4, 32 years old, married, muslim female client from upper class status was referred from a psychiatrist in DMCH. She was diagnosed as having OCD by psychiatrist and she was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from her problems for 25 years.

Current medicine status:

The client's current medicine status is displayed in Table no-2.4.1.

Table no-2.4.1: Current medicine status of Mrs. A-4

Name of medicine	Group of medicine	Dose
Clofranil	TCA	25mg
Relafin	SSRI	50mg
Sizodon	Atypical Anti Psychotic	5mg
Perkinil	Anti Parkinson's drugs	5mg
Disopan	Benzodiazepine	.5gm
Inj. Fluanxol Depot	Long Acting Anti Psychotic	40gm

History of present illness:

From her very early age, the client noticed conjugal problem between her parents. As a result, she was very much anxious about her family and she was not a caring child. She had conflicting relationships with her mother and her mothers had dictator's attitude. Her mother had dominant behavior at that time and she always ignored the client. Her father had character problems and her siblings misbehaved with her from the very beginning. She belonged to a distorted family. As her mother was an outgoing lady she did not love and care her. She did not have responsibility for her family and for her child but the client had very much attached feelings for her mother but she was deprived of her mothers love. Due to her mother's ignorance, her recurrent intrusive thoughts started. Besides her father had a sexual relationship with their maid servant. The client was Pakistani and she was a tall, smart, fashionable and good looking woman. As a result she was proud from early age. Also she wanted to do everything in a right and perfect way from early age.

Family and Personal history:

Family history: According to the client, her parents aged 64 and 70 were still alive and their educational level was class nine and FCA respectively. Her father had a CA firm and mother was a house wife. She had four sisters and two brothers aged 46, 44, 42, 40, 38 and 32 respectively who got married and lived separately. Two of her sisters passed H.S.C and another two's educational level were MS and BA. One of her brother was major and another one was engineer. The client's husband, aged 35 was a senior executive a foreign based firm and his education level was MS.

Birth history: The client had no birth complication.

Schooling and education: She was a medium category student. She started her schooling at the age of 6 years. She used to go to school regularly and had few friends. When she was a student of a reputed school, her friends involved in a sexual relationship with many boys. The client's performance was normal in school. In 1992, she passed S.S.C examination with 1st division. In 1994 and 1997, she passed H.S.C and B.Com with 1st division and 3rd class respectively.

Marital history: The client got married three times. In 1998, when she was 20 years old, her first husband chose her for marriage. He was uneducated, lived in Canada and was a hotel boy but the client did not know about his qualification and status. Her parents gave first marriage and the client loved him very much. Due to her mental disorder, her husband divorced her after 8 months of her marriage. In 2000-2002, she made an affair with an Indian boy. The client was a front desk executive at that time. In 2003, she got her second marriage with that boy. Due to her mental disorder she misbehaved with her mother in law. One day she bit her mother in law. As a result her second husband divorced her in 2005. In 2008, her third husband chose her and in 2009 she got her third marriage. Her third husband was very helpful and she had a happy family with him.

Sexual history: She was three times sexually abused by her friends. The client mentioned that she had high sexual desire and indicated it as a problem. When she had to mix with friend, she could not control herself and she took initiative to develop sexual relationships.

Past medical history: For this problem she took medicine 10 years ago.

Relationship among family members: Her parents did not love her but her present husband loves her very much.

Family history of mental illness: The client believed that all of her family members were abnormal and problematic.

Formulation

From the in-depth interview and exploration of her thought it revealed that she was suffering from obsessive compulsive disorder. After obtaining information on different areas of client's problem, the therapist formulated her problem on the basis of the following cognitive case conceptualization diagram-

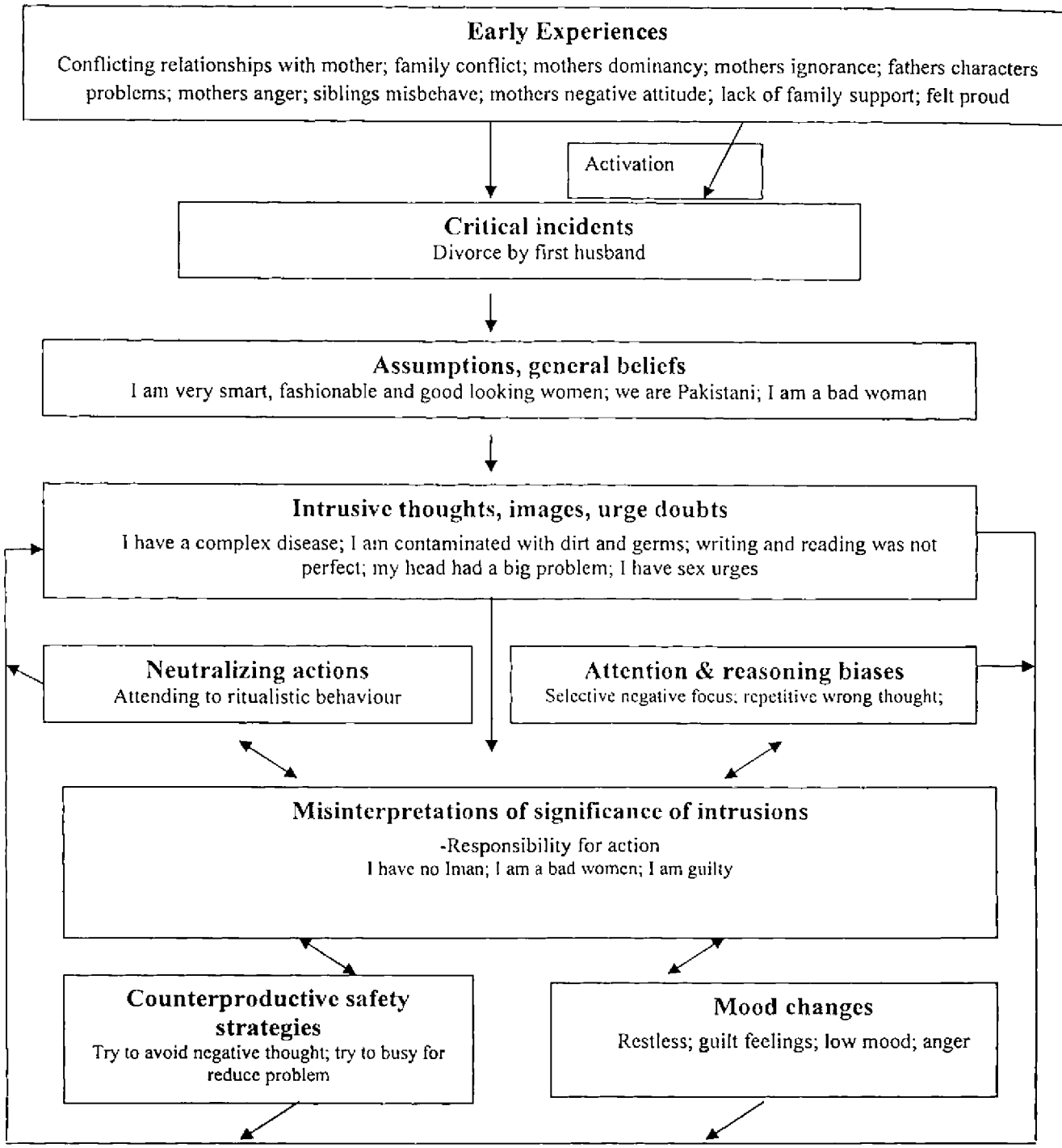

Figure-3.4: Problem formulation of the client using case conceptualization model for obsessive compulsive disorder developed by Salkovskis, Forrester and Richards (1998).

Most distressing thoughts list of the client:

Most distressing thoughts list of the client are displayed at Table no-2.4.2.

Table no-2.4.2: Most distressing thoughts list of Mrs. A-4

No.	Most distressing thought
1.	I am a bad women
2.	I have a complex disease
3.	I will not recover from my problem

Intervention and result:

Intervention goal:

In the initial three sessions and before the intervention started, assessment of the problems and level of functioning of different areas were done. After assessing the problems goals of intervention were set collaboratively with Mrs.A-4, which were as follows:

1. To ventilate the suppressed feelings
2. To remove her obsessional thoughts
3. To regain her daily activities and confidence
4. To reduce physical symptoms
5. To reduce behavioural problems
6. To reduce sleep difficulties
7. To reduce emotional disturbance
8. To improve communication skills

Treatment plan:

A treatment plan was prepared for each of the problems or symptoms by the therapist. On the basis of full consent of the client, treatment strategies which were applied are given in Table no-2.4.3.

Table no-2.4.3: Treatment plan for Mrs. A-4

No.	Treatment Goals	Treatment techniques
1.	To ventilate the suppressed feelings	Psycho-education, empathetic listening, breathing relaxation
2.	To remove her obsessional thoughts	Thought stopping, habituation training, thought challenge, distraction,

		cognitive restructuring, downward arrow technique
3.	To regain her daily activities and confidence	Problem solving skills , social skill training, scheduling activities
4.	To reduce physical symptoms	Relaxation, cognitive restructuring
5.	To reduce behavioural problems	Relaxation, exposure and response prevention, analogical evidence, modeling, avoidance reduction, habituation training, monitoring activities
6.	To reduce sleep difficulties	Relaxation, distraction
7.	To reduce emotional disturbance	Problem solving skills , cognitive restructuring, psycho education, relaxation, monitoring activities, graded task
8.	To improve communication skills	Relaxation, social skill training

Intervention:

The following cognitive and behavioural techniques were used in the treatment of the client:

1. Empathetic listening: From the first session, the therapist heard her all problem with full attention and reflection and established a good rapport to disclose her problems. The empathetic therapeutic atmosphere helped her to release her pent-up emotion.

2. Psycho-education: Psycho-education had been given the client about her disorder (OCD). Psycho-education is crucial in starting to generate a different way of making sense of the problem and it was provided about the nature of the therapy to socialize the client in the therapeutic principles and process of CBT. As a psycho-education; the present therapist provided definition of OCD, types/characteristics of OCD, treatment and prognosis of OCD.

3. Analogical evidence: This technique was used for helping the client change her dysfunctional thinking pattern. It also helped the client to evaluate the meaning of her thoughts from an objective perspective and with great relief she realized for the first time that she was not responsible for having the intrusive thoughts.

4. Relaxation: Relaxation technique had been given for reduce her anxiety symptoms. Breathing and imaginal relaxation has practiced in the session by modeling and was suggested to practice regularly.

5. Distraction: Distraction technique was used to reduce her most distressing thoughts. The client was very much upset about her life.

6. Thought challenge: Thought challenge was used to help her to view the situation alternatively as negative automatic thoughts were activating the client's dysfunctional assumption and thereby maintained the problem. The present therapist used Dysfunctional Thought Record Sheet (DTR) for fighting client irrational, intrusive and unwanted negative thoughts. The client was asked to practice this technique as homework assignment and this technique helped her to correct her personalization errors and increase self esteem and self-confidence.

7. Exposure with response prevention (ERP): ERP was administered for the client to provoke the compulsive urge and to refrain from engaging in her usual compulsive behaviour. Before starting the ERP session, the present therapist explained the rationale and the client agreed for imaginal exposure first. Modeling was done by the therapist before the client practiced ERP and the therapist asked to practice ERP for the client as a homework assignment.

8. Habituation technique: This technique was used to reduce her unwanted recurrent intrusive thoughts.

9. Downward arrow technique: This technique was used for revealing the underlying 'core' meaning of the negative interpretation of the client.

10. Problem solving skills: To increase her interest level in occupation and to reduce emotional disturbance and to deal with her real life problems, the present therapist taught her about problem solving skills.

11. Scheduling activities: The therapist asked the client to record her daily activities and these records can increase activity levels of the client.

12. Social skill training (SST): To improve her communication skills, the therapist gave her SST. Assertiveness training had been given and practiced in the session by modeling as well as through flooding technique.

Pre, mid, post and follow-up assessment result of the problems

A. Findings based on Interview and Observation:

Mrs. A-4's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no- 2.4.4.

Table no-2.4.4: Problems mentioned in pre-assessment and reduction/improvement/ increase of problems found during mid, post and follow-up assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement/ increase of the problem in Post-assessment	Reduction/ improvement/ increase of the problem in Follow-up assessment
Cognitive	I am contaminated with dirt and germs; became ill from contaminated	Reduced up to 30%	Reduced up to 60%	Reduced up to 80%
	I must do my work in certain number	Reduced up to 10%	Reduced up to 50%	Reduced up to 90%
	Life is meaningless, worthless and finished and future is dark	Reduced up to 25%	Reduced up to 55%	Reduced up to 85%
	"I have a bad disease", "I wish I could die"	Reduced up to 5%	Reduced up to 50%	Reduced up to 90%
	She felt lack of concentration (90%)	Increased a little bit up to 20%	Increased a little bit up to 40%	Increased up to 60%
	Difficulty in making decision and low self esteem	Not improved	Increased a little bit	Increased up to 50%
	Reassurance seeking behaviour	Reduced up to 10%	Reduced up to 50%	Reduced up to 70%
Emotional	She felt fear, anger, hopeless, sad, worthless, distressed, confused and vulnerable (100%)	Reduced up to 20%	Reduced up to 50%	Reduced up to 80%
	She felt irritation all the time	Not reduced at all	Reduced up to 30%	Reduced up to 60%
Physiological	Palpitation	Reduced up to 15%	Reduced up to 65%	Reduced up to 75%
	Sleep difficulties	Reduced up to 40%	Reduced up to 60%	Reduced up to 80%
	Drowsiness and weakness	Reduced up to 20%	Reduced up to 60%	Reduced up to 80%
	Full loss of appetite	Increased up to 30%	Increased up to 70%	Increased up to 80%
Behavioural	Repeated washing, reading	Reduced up to	Reduced up to	Reduced up to

	various form the Quran and writing often performed in a ritualistic way	15%	65%	85%
	Decreased activity level	Increased a little bit	Increased up to 30%	Increased up to 60%
	She has crying spell	Not reduced	Not reduced	Not reduced
Social	Disrupted social interaction	Not improved significantly	Increased up to 50%	Increased up to 70%
	Decreased relationship with neighbors, relatives and family members	Not improved	Improved a little bit	Increased up to 50%
Occupational	She could not do any household activities	Now she can do some household activities but her husband helps her	Now she can do some household activities but her husband helps her	Now she engaged and involved in household activities
	She mentioned that she had no interest at any activities	Increased a little bit	Increased up to 50%	Increased up to 70%
	Attention span and body strength reduced significantly	Increased up to 20%	Increased a little bit	Increased up to 50%
Observation	The client came with a clean well dress up and her appearance and behaviour appeared to be culturally appropriate	Came .....appropriate	Came .....appropriate	Came .....appropriate
	She was a very smart and good looking woman but she had crying spell very much and her facial expression was blank in the session	She was crying spell in the session	She was crying spell in the session	Encouraging
	She could not make eye contact normally and she was looking very sad and anxious	Normal	Normal	Normal
	Her body posture and movement was restless which expressed her anxiety	Restless	Normal	Normal
	Her amount of speech was very little, most of the answer she gave by one or two words	Very little	Normal	Normal
	Her mood was low and she felt restlessness	Low and restlessness	Low	Low

B. Objective rating of Mrs. A-4:

Scores of AS, DS and DUOCS are displayed at Table no-2.4.5.

Table no-2.4.5: General trend of objective score of Mrs. A-4

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	97 (Profound)	134 (Severe)	68 (Profound)
Mid-assessment	62 (Moderate)	101 (Mild)	42 (Severe)
Post-assessment	54 (Mild)	80 (Minimal)	32 (Moderate)
1st Follow- up	32 (Mild)	72 (Minimal)	30 (Moderate)
2nd Follow- up	28 (Mild)	70 (Minimal)	20 (Mild)
3rd Follow- up	27 (Mild)	59 (Minimal)	19 (Mild)

C. Subjective rating of Mrs. A-4:

Ratings of the verbal scale are displayed at Table no-2.4.6.

Table no-2.4.6**:** General trend of subjective rating of Mrs. A-4

	Client's Subjective Rating Score
Pre-assessment	9
Mid-assessment	7.5
Post-assessment	6
1st Follow- up	3
2nd Follow- up	4
3rd Follow- up	2.5

(**Note:** The care giver did not attend the sessions.)

Prognostic criteria:

There were some prognostic criteria, due to which some changes in the client mental health. Those were as follows-

1. The client was compliant, motivated and co-operative to her therapy session; so that she attended regularly in the therapy session.
2. She was very much committed to the treatment process and practiced the skills she learnt from the session to reduce her symptoms.
3. After one month she came back to have follow-up session.
4. Her care giver, husband and her father were more co-operative.
5. The client lived far away from hospital but she came time for session. For this reason it was easy for the therapist to run the therapy smoothly.

Therapist's comment:

Mrs. A-4 was referred by a psychiatrist private chamber for providing CBT. She was extremely anxious and depressed during the initial sessions and it was difficult for the researcher to structure the session at that time. Her assessment was completed within the first 4 sessions. She attended 19 sessions including three follow-up sessions and she was complying the therapy by her own. She gave her informed consent very willingly and started participating in the session. She agreed with the researcher's formulation and provided feedback. After total 19 sessions, her anxiety, depression and OCD score was low. Her short term prognosis is good but if she does not practice the techniques learned in the session while facing any difficult situation relapse may occur. So, the long term prognosis depends on the client's internalization. The client came after long time for psychological management, although she had referred early time by the psychiatrist. For this reason, her problem increased and had a long term history. Her improvement also delayed for the same reason.

Responsible Psychiatrist's comments:

At the last and follow-up session the responsible psychiatrist talked to Mrs. A-4. According to the psychiatrist evaluation/ remarks, on the entry of the session, she was very much obsessed along with the rituals. She was severely depressed also. Now the intensity of obsessive thoughts and rituals is moderate to mild and still a bit depressed and anxious. Finally, the responsible psychiatrist reported 65-70% as improvement rating feedback.

Case: A-5

Mr. A-5, 20 years old, unmarried, muslim male client from upper middle class status was referred from psychiatry out-patient department of DMCH. He was diagnosed as having OCD by referring agency and he was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from his problems for five years and took medicine for two years.

Current medicine status:

The client's current medicine status is displayed in Table no-2.5.1.

Table no-2.5.1: Current medicine status of Mr. A-5

Name of medicine	Group of medicine	Dose
Clofranil	Tri-cyclic Anti Depressant	25mg
Prodep	SSRI	20mg

History of present illness:

The client was 20 years old and was an intelligent, high ambitious and good student from early age. His parents had a dictatorship attitude. In childhood, he was over protected child. He had a religious minded family and he wanted to do everything in a right and perfect way. When he was a student of class ten, vice principal of his school gave fear every student of his class. He said that if anyone who failed pre-test exam will not be able to attended board exam. At that time the client exam was good and he had passed the exam with very high marks but maximum students of his class had failed that exam. But from that time exams phobia started in him due to lack of his confidence and low self esteem. His recurrent intrusive thought started about has to face exams.

Family and Personal history:

Family history: According to the client, his parents were alive, aged 65 and 55 respectively. His father was a businessman and mother was a house wife. Their educational level was M. Ed and S.S.C. He had three elder sisters, aged 35, 28 and 23 respectively and their educational levels were MS, MBA and BBA. His one sister was married and lived separately.

Birth history: The client had no birth complication.

Schooling and education: The client was an intelligent, high ambitious and good student from early age. He had interest to read and used to go to school regularly. In 2006 and 2008, he passed S.S.C and H.S.C exam with Golden A+. Now he was a 1st year computer science and engineering student of a private University.

Past medical history: The client had appendicitis when he was student of class three. After appendicitis operation he took lot of medicine.

Relationship among family members: He was the only and younger son of his parents, so that his parents and his elder daughters very much loved him.

Family history of mental illness: The client's grandfather had mental problem but he did not take any psychiatric medicine.

Formulation

From the in-depth interview and exploration of his thought it revealed that he was suffering from obsessive compulsive disorder. After obtaining information on different areas of client's problem, the therapist formulated his problem on the basis of the following cognitive case conceptualization diagram-

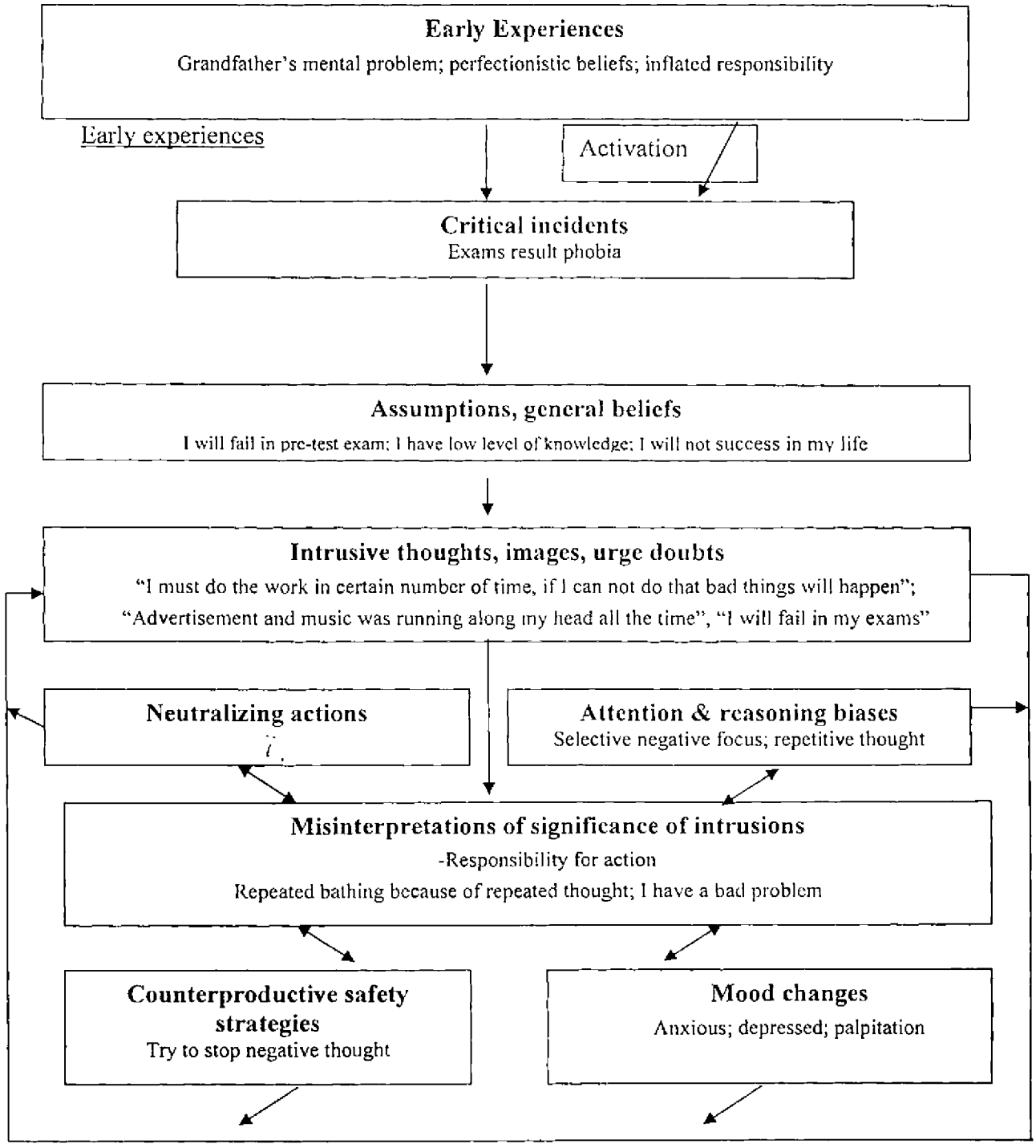

Figure-3.5: Problem formulation of the client using case conceptualization model for obsessive compulsive disorder developed by Salkovskis, Forrester and Richards (1998).

Most distressing thoughts list of the client:

Most distressing thoughts list of the client are displayed at Table no-2.5.2.

Table no-2.5.2: Most distressing thoughts list of Mr. A-5

No.	Most distressing thoughts
1.	I can not success my life
2.	Lack of concentration very much
3.	I must do the work for certain numbers, if I can not do that bad things will happen
4.	Advertisement and music was running along my head all the time

Intervention and result:

Intervention goal:

In the initial three sessions and before the intervention started, assessment of the problems and level of functioning of different areas were done. After assessing the problems goals of intervention were set collaboratively with Mr.A-5, which were as follows:

1. To remove his obsessional thoughts
2. To reduce physical symptoms
3. To reduce behavioural problems
4. To increase problem solving skills
5. To reduce emotional disturbance

Treatment plan:

A treatment plan was prepared for each of the problems or symptoms by the therapist. On the basis of full consent of the client, treatment strategies which were applied are given in Table no-2.5.3.

Table no-2.5.3: Treatment plan for Mr. A-5

No.	Treatment Goals	Treatment techniques
1.	To remove his obsessional thoughts	Thought stopping, habituation training, thought challenge, distraction, cognitive restructuring, downward arrow technique, pros and cons
2.	To reduce physical symptoms	Relaxation, cognitive restructuring
3.	To reduce behavioural problems	Relaxation, scheduling activities, monitoring activities
4.	To increase problem solving skills	Problem solving skills , relaxation
5.	To reduce emotional disturbance	Problem solving skills , psycho education, relaxation, monitoring activities, graded task

Intervention:

The following cognitive and behavioural techniques were used in the treatment of the client:

1. Empathetic listening: The therapist listened empathetically to the distressful thoughts about the past of the client.

2. Psycho-education: Psycho-education was given to the client about his disorder (OCD).Psycho-education is crucial in starting to generate a different way of making sense of the problem and it was provided about the nature of the therapy to socialize the client in the therapeutic principles and process of CBT. As a psycho-education; the present therapist provided definition of OCD, types/characteristics of OCD, treatment and prognosis of OCD.

3. Relaxation: Relaxation technique was applied to reduce client's anxiety symptoms. Breathing and imaginal relaxation techniques were applied to release his tension, stress and anxiety related other symptoms.

4. Thought challenge: He was helped to challenge his negative thoughts primarily only through finding alternative. The present therapist used Dysfunctional Thought Record Sheet (DTR) for fighting client irrational, intrusive and unwanted negative thoughts. The client was asked to practice this technique as homework assignment and this technique helped him to increase self-confidence.

5. Distraction: Distraction technique was used to reduce his most distressing thoughts. The client was very much distressed about his life.

6. Habituation technique: This technique was used to reduce his unwanted recurrent intrusive thoughts and the client practiced successfully. He felt comfort for using this technique.

7. Downward arrow technique: This technique was used for revealing the underlying 'core' meaning of the negative interpretation of the client.

8. Scheduling activities: The therapist asked the client to record his daily activities and these records can increase activity levels of the client.

9. Problem solving skills: To increase his problem solving skills and to reduce emotional disturbance the present therapist taught him about problem solving skills.

Pre, mid, post and follow-up assessment result of the problems

A. Findings based on Interview and Observation:

Mr. A-5's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no-2.5.4.

Table no-2.5.4: Problems mentioned in pre-assessment and reduction/ improvement/ increase of problems found during mid, post and follow-up assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement/ increase of the problem in Post-assessment	Reduction/ improvement/ increase of the problem in Follow-up assessment
Cognitive	I must do my work for certain number of time, if I can not do this bad thing will happen (80%)	Reduced up to 50%	Reduced up to 80%	Reduced up to 95%
	Advertisement and music was running along my head all the time	Reduced up to 55%	Reduced up to 85%	Reduced up to 100%
	He felt lack of concentration (60%) and his decision making capacity was low and felt hopeless (50%)	Increased up to 60%	Increased up to 80%	Increased up to 80%
Emotional	He felt hopeless, sad, worthless, distressed, restless, confused and vulnerable (50%) and he had crying spell	Reduced up to 50%	Reduced up to 75%	Reduced up to 85%
Physiological	Palpitation (70%), weakness and headache	Reduced up to 50%	Reduced up to 80%	Reduced up to 80%
	Sleep difficulties	Reduced up to 50%	Reduced up to 75%	Reduced up to 80%
	Lack of appetite	Increased up to 50%	Increased up to 60%	Increased up to 60%
Behavioural	Decreased activity level	Increased up to 50%	Increased up to 80%	Increased up to 85%
	Doing certain activities in a particular number of times (70%)	Reduced up to 50%	Reduced up to 80%	Reduced up to 80%

Social	Disrupted social interaction (40%)	Increased a little bit	Increased up to 55%	Increased up to 65%
	Decreased relationship with neighbors and relatives (50%)	Increased up to 35%	Increased up to 55%	Increased up to 65%
Occupational	Relationship with friends decreased significantly	Increased up to 20%	Increased up to 40%	Increased up to 50%
	His attention span, concentration and interest about class task reduced (70%)	Increased up to 45%	Increased up to 65%	Increased up to 85%
Observation	The client came with a religious dress up and his appearance and behaviour appeared to be culturally appropriate	Came..... . appropriate	Came..... . appropriate	Came..... . appropriate
	His sufferings seemed to reflect in the first assessment session	Less than before	Normal and smiley	
	He had minimum eye contact	Normal	Normal	Normal
	His body posture and body movement was quite normal	Normal	Normal	Normal
	His amount of speeches were normal	Normal	Normal	Normal
	His mood was sad	Low	Fresh	Fresh

B. Objective rating of Mr. A-5:

Scores of AS, DS and DUOCS are displayed at Table no-2.5.5.

Table no-2.5.5: General trend of objective score of Mr. A-5

	Anxiety Score	**Depression Score**	**OCD Score**
Pre-assessment	55 (Moderate)	78 (Minimal)	43 (Severe)
Mid-assessment	38 (Mild)	60 (Minimal)	28 (Moderate)
Post-assessment	18 (Mild)	38 (Minimal)	17 (Cut off score)
1st Follow- up	16 (Mild)	34 (Minimal)	08 (Below cut off score)
2nd Follow- up	0	30 (Minimal)	02 (Below cut off score)
3rd Follow- up	10 (Mild)	34 (Minimal)	02 (Below cut off score)

C. Subjective rating of Mr. A-5:

Ratings of the verbal scale are displayed at Table no-2.5.6.

Table no-2.5.6: General trend of subjective rating of Mr. A-5

	Client's Subjective Rating Score
Pre-assessment	7
Mid-assessment	3
Post-assessment	2
1st Follow- up	1.5
2nd Follow- up	0
3rd Follow- up	1

(**Note:** The care giver did not attend the sessions.)

Prognostic criteria:

There were some prognostic criteria, due to which some changes were found in the client mental health. Those were as follows-

1. The client was highly compliant, motivated, co-operative and psychological minded to his therapy session; he attended regularly in the therapy session.
2. He was very much devoted to the treatment process and practiced the skills he learnt from the session to reduce his symptoms.
3. After one month he came back to have follow-up session.
4. The duty psychiatrist referred the client from out door immediately when he did not find any result of medicine.

Therapist's comment:

The client terminated the session after attending 13 sessions and he was anxious during the pre-assessment sessions. He was complying the therapy by his own and he gave his informed consent very willingly and started participating in the session. He agreed with the researcher's formulation and provided feedback. After total 13 sessions, his anxiety, depression and OCD score was low. His short term prognosis is good but if he does not practice the techniques learned in the session while facing any difficult situation relapse may occur. So, the long term prognosis depends on the client's internalization.

Responsible Psychiatrist's comments:

At the last and follow-up session the responsible psychiatrist talked with the client. According to the responsible psychiatrist evaluation/ remarks, he is alright and has full control over his mind. There is no unwanted thinking with was prevailing in the past. The patient was emotionally stable and can resume his daily activities normally. Finally, the responsible psychiatrist reported 90% as improvement rating feedback.

Case: A-6

Mr.A-6, 21 years old, unmarried, muslim male client from lower middle class status was referred from psychiatry out-patient department of DMCH. He was diagnosed as having OCD by referring agency and he was selected as a participant of the present study according to the inclusion criteria.

Duration of the problem:

The client was suffering from his problems for seven years and took medicine for six years.

Current medicine status:

The client's current medicine status is displayed in Table no-2.6.1.

Table no-2.6.1: Current medicine status of Mr. A-6

Name of Medicine	Group of medicine	Dose
Oleanz	Atypical Anti Psychotics	10mg
Amafranil	TCA	25mg
Amit/Amilin	TCA	25mg
Prodep	SSRI	20mg
Lozicum	Hypnotic	1mg

History of present illness:

The client was 21 years old. In 2003, he was reading in class nine and at that time suddenly he was thinking that he was going thin and his body colour was turning into black. He had jaundice at that time and one village doctor prescribes him to taking enough water and cold food. To reduce this problem he was bathing into a pond and dive 200 times at a time. When he was finishing his bathing, he was feeling headache in the left side and feeling hot flushes in the head. His maximum problems were developed

at that time. But at that time his food habit was normal. The client was irritated nature from early age. So that his mood was always low and his was behaviour was destructive in nature. One day his mother and his brother in law made quarrel and at that time his test exam was near. He said them do not make quarrel but his father misbehaves with him. His father said him that he has many problems and he will not recover forever. The client had a bad experience about his family from early age. He had a religious family background and his father was very much conservative. He did not like quarrel and always avoid quarrel, gathering and fighting but his family members were always made quarrel. For the above reason the client problems started.

Family and Personal history:

Family history: According to the client, his parents, aged 65 and 56 were still alive. His mother was a house wife and her educational level was class four and his father was a farmer and his educational level was class five. He had an elder sister and three brothers aged 35, 32, 25 and 19 respectively. His two brothers and sister were married. His sister educational level was class five and two of his brothers were eight pass and another one's educational level was class five.

Birth history: The client had no birth complication.

Schooling and education: He was not a good student from early age. He had no interest to go to school regularly and he had sleep and appetite problems from early age. He could not wake up in the early morning.

Occupational history: The client was an electrician. He has been working in a shop as an electrician but he did not get any salary in this job because of the shop belonged to his sister in law.

Past medical history: For this problem he took medicine six years ago. He had jaundice and now he is cured by treatment.

Relationship among family members: He was the eldest son of his parents but they did not love him. Now a day his younger sister loves him and helps him to solve his problems.

Family history of mental illness: There was no family history of mental illness.

Formulation

From the in-depth interview and exploration of his thought it revealed that he was suffering from obsessive compulsive disorder. After obtaining information on different areas of client's problem, the therapist formulated his problem on the basis of the following cognitive case conceptualization diagram-

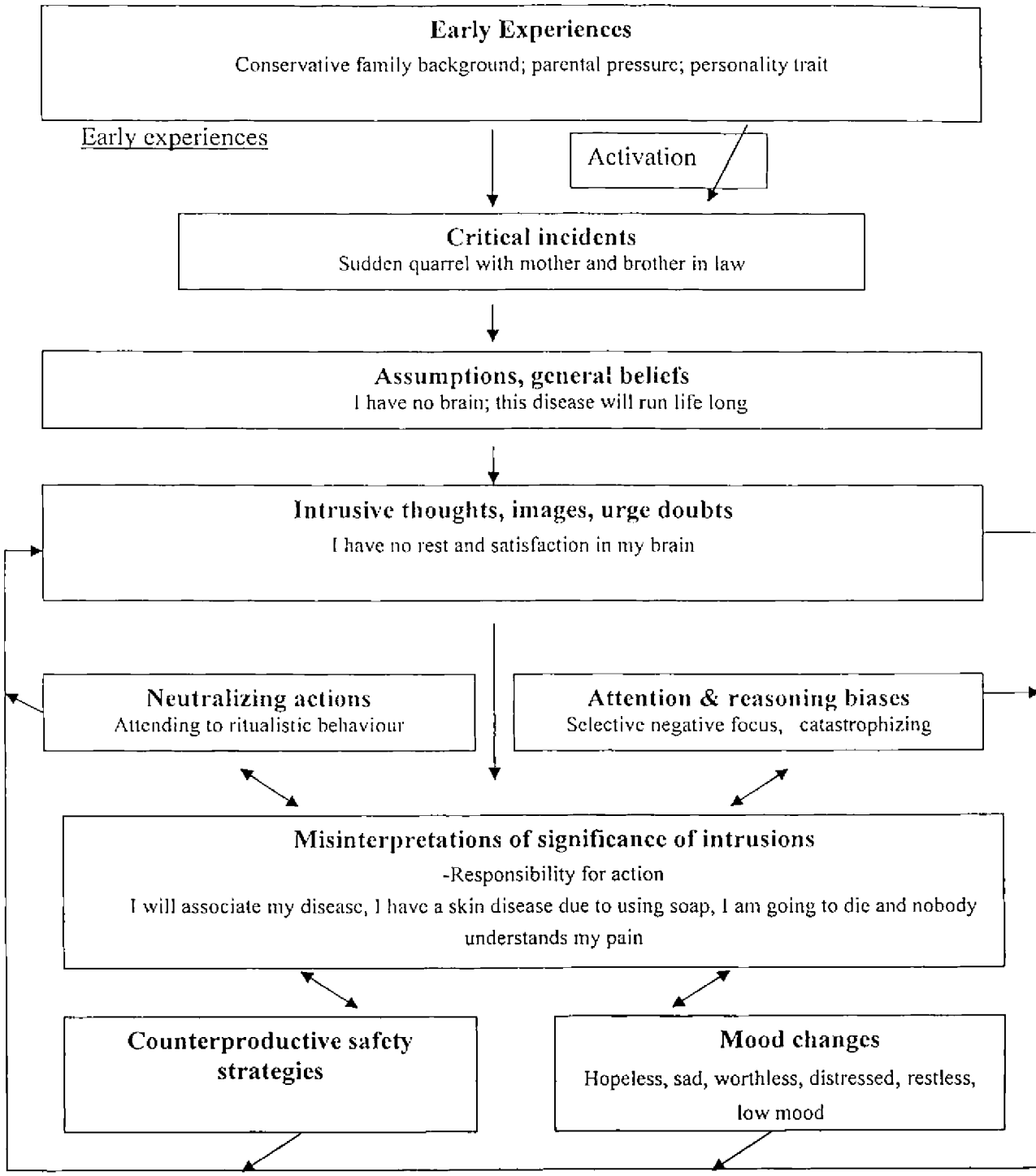

Figure-3.6: Problem formulation of the client using case conceptualization model for obsessive compulsive disorder developed by Salkovskis, Forrester and Richards (1998).

Most distressing thoughts list of the client:

Most distressing thoughts list of the client are displayed at Table no-2.6.2.

Table no-2.6.2: Most distressing thoughts list of Mr. A-6

No.	Most distressing thoughts
1.	I have no satisfaction when sleeping
2.	I have no brain
3.	I have a skin disease due to using soap

Intervention and result:

Intervention goal:

In the initial three assessment sessions and before the intervention started, assessment of the problems and level of functioning of different areas were done. After assessing the problems goals of intervention were set collaboratively with Mr.A-6, which were as follows:

1. To ventilate the suppressed feelings
2. To remove his obsessional thoughts
3. To regain his daily activities and confidence
1. To reduce physical symptoms
2. To reduce behavioural problems
3. To reduce sleep difficulties
4. To reduce emotional disturbance
5. To increase communication skill

Treatment plan:

A treatment plan was prepared for each of the problems or symptoms by the therapist. On the basis of full consent of the client, treatment strategies which were applied are given in Table no-2.6.3.

Table no-2.6.3: Treatment plan for Mr. A-6

No.	Treatment Goals	Treatment techniques
1.	To ventilate the suppressed feelings	Psycho-education, empathetic listening, breathing relaxation
2.	To remove his obsessional thoughts	Habituation training, thought challenge, distraction, downward arrow

		technique
3.	To regain his daily activities and confidence	Scheduling activities, monitoring activities
4.	To reduce physical symptoms	Relaxation
5.	To reduce behavioural problems	Relaxation, exposure and response prevention, analogical evidence, modeling, habituation training, monitoring activities
6.	To reduce sleep difficulties	Relaxation, distraction
7.	To reduce emotional disturbance	Problem solving skills , cognitive restructuring, psycho education, relaxation, monitoring activities, graded task
8.	To increase communication skill	Social skill training, relaxation

Intervention:

The following cognitive and behavioural techniques were used in the treatment of the client:

1. Empathetic listening: The therapist listened empathetically about the past distressful thoughts of the client. The empathetic therapeutic atmosphere helped him to release his pent-up emotion.

2. Psycho-education: Psycho-education was given the client about his disorder (OCD).Psycho-education is crucial in starting to generate a different way of making sense of the problem and it was provided about the nature of the therapy to socialize the client in the therapeutic principles and process of CBT. As a psycho-education; the present therapist provided definition of OCD, types/characteristics of OCD, treatment and prognosis of OCD.

3. Analogical evidence: This technique was used for helping the client to change his dysfunctional thinking pattern. It also helped the client evaluate the meaning of his thoughts from an objective perspective and with great relief he realized for the first time that he was not responsible for having the intrusive thoughts.

4. Relaxation: Relaxation technique was applied to reduce client's anxiety symptoms. Breathing and imaginal relaxation techniques were applied to release his tension, stress and anxiety related other symptoms.

5. Thought challenge: Thought challenge was used to help the client to view the situation alternatively and to correct his personalization errors and increase self-esteem. The present therapist used Dysfunctional Thought Record Sheet (DTR) for fighting client irrational, intrusive and unwanted negative thoughts. The client was asked to practice this technique as homework assignment and this technique helped him to increase self-confidence and self-esteem.

6. Distraction: Distraction technique was used to reduce his most distressing thoughts. The client was very much distress about his life.

7. Downward arrow technique: To reveal his underlying more 'core' meaning of the negative interpretation and expose a more fundamental underlying assumption, this technique was used.

8. Scheduling activities: The therapist asked the client to record his daily activities and these records can increase activity levels of the client.

Pre, mid and post- assessment result of the problems

A. Findings based on Interview and Observation:

Mr. A-6's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no-2.6.4.

Table no-2.6.4: Problems mentioned in pre-assessment and reduction/improvement/ increase of problems found during mid and post-assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement/ increase of the problem in Post-assessment
Cognitive	I have no rest and satisfaction in my brain	Not reduced significantly	Not reduced significantly
	I have no brain, this disease will be running life long	Reduced up to 15%	Reduced up to 30%
	I have a skin disease due to use of soap, I will die soon	Reduced up to 50%	Reduced up to 40%
	Nobody understands his pain and his life is meaningless, finished and his future is dark.	Reduced up to 25%	Reduced up to 50%
	He felt lack of concentration, difficulty in making	Increased a	Increased up to

	decision and low self esteem	little bit	30%
	He had a suicidal ideation but he did not attempt to suicide	Reduced	Reduced up to 100%
Emotional	He felt fear, hopeless, sad, worthless, distressed, restless, guilt feeling, irritated, confused and vulnerable	Reduced up to 40%	Reduced up to 40%
Physiological	Jerking all over the body, palpitation, sweating and sleep difficulties very much	Reduced up to 30%	Reduced up to 40%
	Low appetite	Increased a little bit	Increased up to 50%
	Dryness of throat	Reduced up to 40%	Reduced up to 45%
	Headache (Left side)	Not reduced	Reduced a little bit
	Hot and pain in abdomen and dehydrations problem	Reduced up to 20%	Reduced up to 40%
	Felt weakness in leg	Reduced up to 60%	Reduced up to 60%
	Loss of energy	Increased a little bit	Increased up to 40%
Behavioural	Activity level decreased	Increased a little bit	Increased a little bit
	Withdrawal from social activity and non assertive	Withdraw from social activity now days and he had assertiveness problems also	Withdraw from social activity now days and he had assertiveness problems also
	Repeated showering or bathing due to hot flushes	Not reduced	Reduced up to 20%
	Checking locks over and over, preoccupation with symmetry, exactness or order and doing certain activities in a particular number of times	Reduced up to 10%	Reduced up to 30%
Social	Disrupted social interaction	Not increased significantly	Increased up to 20%
	Decreased relationship with neighbors, relatives, family members, customers and friends	Increased a little bit	Increased up to 20%
Occupational	Poor business performance and decreased relationship with colleagues	Increased a little bit	Increased a little bit
	Lack of concentration about business task, decreased level of interest, reduced attention span and body strength	Not improved	Increased a little bit
Observation	The client came with a dirty cloth but his appearance and behaviour appeared to be culturally appropriate	Came .....app ropriate	Came ..... appropriate
	In the first assessment session seemed to reflect his sufferings, very much anxious and depressed and wants immediate solution for his problem	Less than before	Less than before

	He could not make eye contact normally and he was looking very sad	Normal	Normal
	His body posture was normal but body movement was restless which expressed his anxiety	Normal	Normal
	His amount of speech was very little, most of the answer he gave by one or two words	Quite normal	Normal
	His mood was low and he felt restlessness	Low and restlessness	Low and restlessness

B. Objective rating of Mr. A-6:

Scores of AS, DS and DUOCS are displayed at Table no-2.6.5.

Table no-2.6.5: General trend of objective score of Mr. A-6

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	84 (Profound)	123 (Moderate)	64 (Profound)
Mid-assessment	69 (Severe)	114 (Mild)	50 (Profound)
Post-assessment	67(Severe)	115 (Moderate)	50 (Profound)

C. Subjective rating of Mr. A-6:

Ratings of the verbal scale are displayed at Table no-2.6.6.

Table no-2.6.6: General trend of subjective rating of Mr. A-6

	Client's Subjective Rating Score
Pre-assessment	9
Mid-assessment	7
Post-assessment	6

(**Note:** The care giver did not attend the sessions.)

Prognostic criteria:

There were some prognostic criteria, due to which some changes occurred in the client's mental health. Those were as follows-

1. The client lived far away from hospital and works in sister in laws shop but he came in time for session
2. Although he had acute financial crisis but he continued 11 session
3. Some behavioural change was also observed by the therapist later in the session
4. He practiced the skills he learnt from the session to reduce his symptoms
5. The duty psychiatrist referred the client from out door immediately when he did not find any result of medicine.

Therapist's comment:

The client was non-compliant and his motivation level was low and he terminated the session after attending 11 sessions. He was not co-operative to his therapy session. He was not devoted to the treatment process and he was anxious and depressed during the pre-assessment sessions but he gave his informed consent willingly and started participating in the session. He agreed with the researcher's formulation and provided feedback. If the client attends his session regularly he will recover from his problem.

Case: A-7

Miss.A-7, 20 years old, unmarried, muslim female client from middle class status was referred from psychiatry in-patient (Ward no-37, Bed no-04) department of DMCH. He was diagnosed as having OCD by referring agency and he was selected as a participant of the present study according to the inclusion criteria.

Duration of the problem:

The client was suffering from her problems for 5 years and took medicine for 5 years.

Current medicine status:

The client's current medicine status is displayed in Table no-2.7.1.

Table no-2.7.1: Current medicine status of Miss. A-7

Name of Medicine	Group of Medicine	Dose
Inj. Clopixol Depot	Long Acting Anti Psychotic	200mg
Perkinil	Anti Parkinson's drugs	5mg
Relafin	SSRI	50mg
Sedil	Benzodiazepine	5mg
Lopez	Atypical Anti Psychotic	10mg
Gepin	Ranitidine (Anti ulcerant)	150mg
Indever	Anxiolytic	10mg
Laxxena	Laxative	
Vitamin B Complex		1 PC

History of present illness:

From early age, the client was aggressive nature and she did not like to mix with other people, relatives, neighbors and friends. She had preferred to live alone. She was the only daughter of her parents and they love her very much but in childhood, the client

complains that she was not caring child. She did not prefer to read and go to school from early age. Her school performance was not satisfactory. But when she was a student of class-VIII, suddenly her mother felt sick. Due to her sickness the client father's admitted her mother in a hospital and her mother diagnosed as a cancer patient and this type of news was very unfortunate for the client. After that news she felt very sick and her all problems started. She mentioned that her father was very much careless about her mother's treatment and their relationships were not good. They always quarrel with each other. Due to lack of treatment and her father's irresponsible behaviours, her mother died. For this reason, she did not forgive her father. She always complained about her father's attitude. She added that her father did not love her and he always loves his sisters and their family members.

Family and Personal history:

Family history: According to the client, her father, aged 50 was still alive and her mother died 6 years ago. Her mother was a Government service holder and her educational level was class three. Her father was also a Government service holder and his educational level was S.S.C. The client was the only daughter of her parents.

Birth history: The client was a seizure baby but she had no birth complication.

Schooling and education: She was not a good student from early age. She had no interest to go to school regularly but she had many friends. She had sleep and appetite problems from early age.

Past medical history: For this problem she took medicine five years ago.

Relationship among family members: Relationship among family members was not good. She had no relationships with her relatives because of her problems.

Family history of mental illness: There was no family history of mental illness.

Formulation

From the in-depth interview and exploration of her thought it revealed that she was suffering from obsessive compulsive disorder. After obtaining information on different areas of client's problem, the therapist formulated her problem on the basis of the following cognitive case conceptualization diagram-

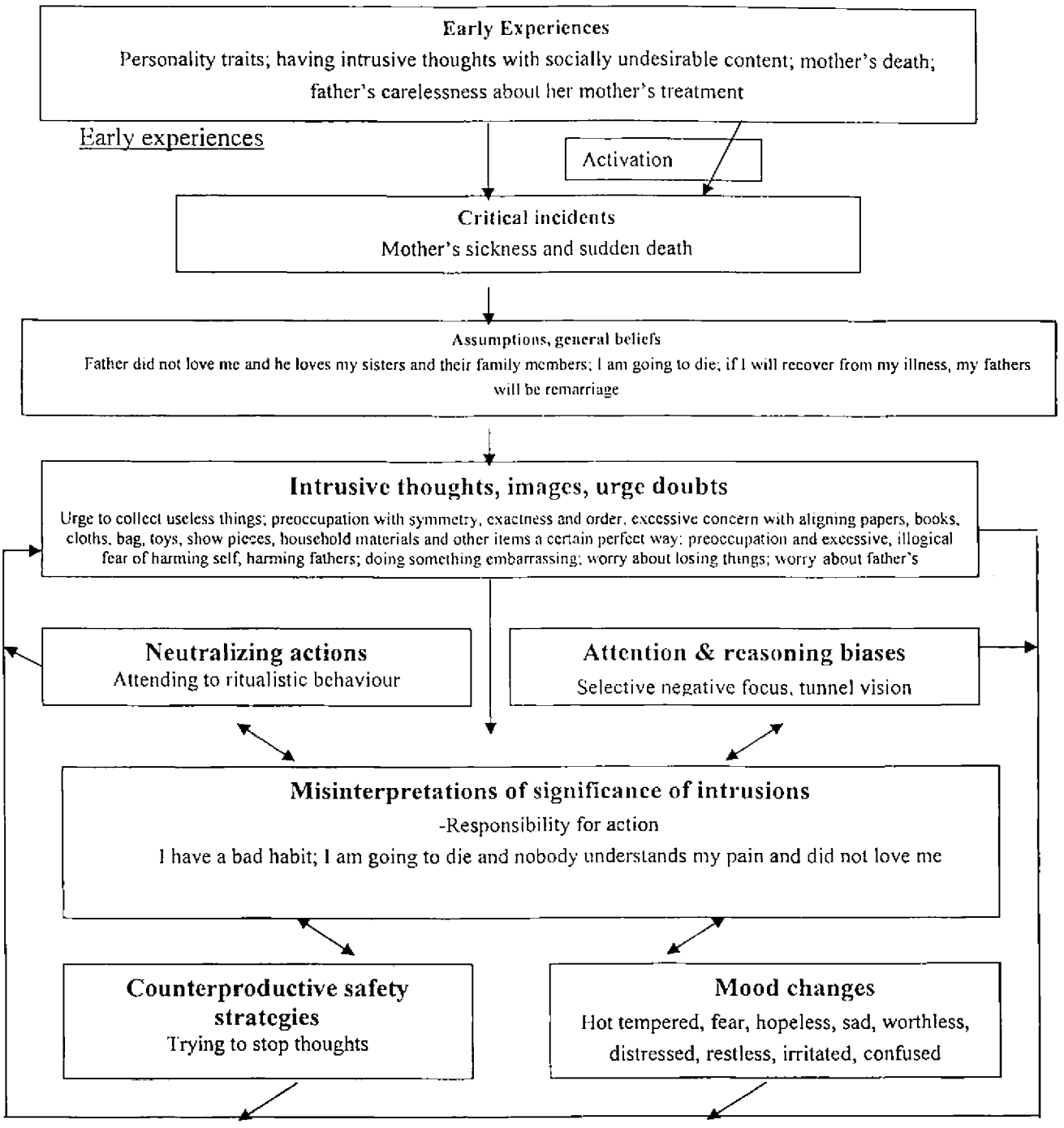

Figure-3.7: Problem formulation of the client using case conceptualization model for obsessive compulsive disorder developed by Salkovskis, Forrester and Richards (1998).

Most distressing thoughts list of the client:

Most distressing thoughts list of the client are displayed at Table no-2.7.2.

Table no-2.7.2: Most distressing thoughts list of Miss. A-7

No.	Most distressing thoughts
1.	Father did not love me and he loves my sisters and other family members
2.	I will die
3.	If I recover from my illness, my father will marry again
4.	Doing certain activities in a particular number of times, if I can not do, bad things will happen

Intervention and result:

Intervention goal:

In the initial three assessment sessions and before the intervention started, assessment of the problems and level of functioning of different areas were done. After assessing the problems goals of intervention were set collaboratively with Miss.A-7, which were as follows:

1. To ventilate the suppressed feelings
2. To remove her obsessional thoughts
3. To reduce physical symptoms
4. To reduce behavioural problems
5. To reduce sleep difficulties
6. To reduce emotional disturbance
7. To increase concentration on study
8. To increase social interaction

Treatment plan:

A treatment plan was prepared for each of the problems or symptoms by the therapist. On the basis of full consent of the client, treatment strategies which were applied are given in Table no-2.7.3.

Table no-2.7.3: Treatment plan for Miss. A-7

No.	Treatment Goals	Treatment techniques
1.	To ventilate the suppressed feelings	Psycho-education, empathetic listening, breathing relaxation

2.	To remove her obsessional thoughts	Habituation training, thought challenge, distraction, downward arrow technique
3.	To reduce physical symptoms	Relaxation
4.	To reduce behavioural problems	Relaxation, exposure and response prevention, analogical evidence, modeling, habituation training, monitoring activities
5.	To reduce sleep difficulties	Relaxation, distraction, stimulus control, sleep hygiene
6.	To reduce emotional disturbance	Problem solving skills , cognitive restructuring, psycho education, relaxation, monitoring activities,
7.	To increase concentration on study	Relaxation, Problem solving skills
8.	To increase social interaction	Assertiveness training, relaxation

Intervention:

The following cognitive and behavioural techniques were used in the treatment of the client:

1. Empathetic listening: The therapist heard all her problems with full attention and reflection. The empathetic therapeutic atmosphere helped her to release her pent-up emotion.

2. Psycho-education: Psycho-education was given to the client about her disorder (OCD).Psycho-education is crucial in starting to generate a different way of making sense of the problem and it was provided about the nature of the therapy to socialize the client in the therapeutic principles and process of CBT. As a psycho-education; the present therapist provided definition of OCD, types/characteristics of OCD, treatment and prognosis of OCD.

3. Relaxation: Relaxation technique was applied to reduce client anxiety symptoms. Breathing and imaginal relaxation has practiced in the session by modeling and was suggested to practice regularly for release of her tension; stress and anxiety related other symptoms.

4. Thought challenge: Thought challenge was used to help her to view the situation alternatively as negative automatic thoughts. The present therapist used Dysfunctional Thought Record Sheet (DTR) for fighting client irrational, intrusive and unwanted

negative thoughts. The client was asked to practice this technique as homework assignment and this technique helped her to increase self-confidence and self-esteem.

5. Distraction: Distraction technique was used to reduce her most distressing thoughts. The client was very much distressed about her life.

6. Exposure with response prevention (ERP): ERP was administered for the client to provoke the compulsive urge and to refrain from engaging in her usual compulsive behaviour. Before starting the ERP session, the present therapist explained the rationale and the client agreed for imaginal exposure first. Modeling was done by the therapist before the client practiced ERP and the therapist asked to practice ERP for the client as a homework assignment.

7. Habituation technique: This technique was used to reduce her unwanted recurrent intrusive thoughts and the client practiced. She felt comfort for using this technique.

8. Downward arrow technique: This technique was used for revealing the underlying 'core' meaning of the negative interpretation of the client.

9. Scheduling activities: The therapist asked the client to record her daily activities and these records can increase activity levels of the client.

10. Assertiveness training: To improve her social interaction the therapist gave her assertiveness training.

11. Stimulus control and sleep hygiene: To solve her sleep problem the present therapist said her to practice stimulus control and sleep hygiene. The goal of stimulus control is to re-associate the bed and bedroom with successful sleep attempts. Stimulus control achieves this by curtailing sleep-incompatible activities in the bed and bedroom and by establishing a consistent sleep-wake schedule. In practice, the therapist said the client to go to bed only when sleepy, establish a standard wake-up time, get out of bed whenever awake for more than 15-20 minutes, avoid reading, watching TV, eating, worrying and other sleep-incompatible behaviours in the bed and bedroom, eliminate caffeine and other stimulants, refrain from daytime napping, ensure an adequate sleep environment.

12. Analogical evidence: This technique was used for helping the client change her dysfunctional thinking pattern. It also helped the client evaluate the meaning of her thoughts from an objective perspective and with great relief she realized for the first time that she was not responsible for having the intrusive thoughts.

Pre, mid, post and follow-up assessment result of the problems

A. Findings based on Interview and Observation:

Miss. A-7's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no-2.7.4.

Table no-2.7.4: Problems mentioned in pre-assessment and reduction/improvement/ increase of problems found during mid, post and follow-up assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement/ increase of the problem in Post-assessment	Reduction/ improvement/ increase of the problem in Follow-up assessment
Cognitive	Urge to collect useless things (100%)	Reduced up to 40%	Reduced up to 65%	Reduced up to 75%
	Preoccupation with symmetry, exactness and order; excessive concern with aligning papers, books, cloths, bag, toys, show pieces, household materials and other items a certain perfect way (100%)	Reduced up to 20%	Reduced up to 60%	Reduced up to 90%
	Preoccupation and excessive, illogical fear of harming self, harming fathers (90%)	Reduced up to 50%	Reduced up to 80%	Reduced up to 100%
	Doing something embarrassing (90%); worry about losing things and worry about father's remarriage (100%)	Not reduced	Reduced up to 80%	Reduced up to 90%
	Life is meaningless and future is dark (100%)	Reduced up to 10%	Reduced up to 50%	Reduced up to 65%
	She felt lack of concentration, difficulty in making decision and low self esteem (90%)	Increased up to 10%	Increased a little bit	Increased up to 50%
	She always thought that she is going to die and she has also fear to die (80%)	Reduced up to 40%	Reduced up to 80%	Reduced up to 90%

Emotional	She felt hot tempered, fear, hopeless, sad, worthless, distressed, restless, irritated, confused and vulnerable (90%)	Reduced up to 20%	Reduced up to 60%	Reduced up to 80%
Physiological	Burning sensation and hot flushes all over the body (100%)	Not decreased	Decreased up to 50%	Decreased up to 80%
	Palpitation, sweating and sleep difficulties (90%)	Reduced up to 10%	Reduced up to 40%	Reduced up to 70%
	Low appetite	Increased up to 45%	Increased up to 85%	Increased up to 85%
	Dryness of throat	Reduced up to 30%	Reduced up to 50%	Reduced up to 60%
	Headache (90%)	Reduced up to 10%	Reduced up to 55%	Reduced up to 75%
	Weakness	Not reduced	Reduced up to 50%	Reduced up to 60%
	Loss of energy (90%)	Not improved	Increased a little bit	Increased up to 50%
Behavioural	Excessive, illogical and uncontrollable washing household materials, often performed in a ritualistic way (100%) but she can not bathing through a month; she cleans objects and household items by using with special cleansers and cleaning techniques (100%)	Not reduced	Reduced up to 50%	Reduced up to 80%
	She avoidances objects which are considered contaminated (100%)	Reduced up to 20%	Reduced up to 50%	Reduced up to 70%
	She checks over and over physical surroundings such as locks, stoves and windows (100%); she does certain activities in a particular number of times (100%)	Reduced up to 30%	Reduced up to 70%	Reduced up to 70%
	Her activity level decreased (100%)	Not increased significantly	Increased a little bit	Increased up to 45%
	She withdraw from social activity (100%)	Withdraw from social activity now days	Withdraw from social activity now a day	Increased now a day
	She had assertiveness problems (100%) and she crying spell (90%)	Not removed	Reduced up to 20%	Reduced up to 35%
Social	Disrupted social interaction,	Increased a	Increased up to	Increased up to

	decreased relationship with neighbors, relatives, fathers and friends (100%)	little bit	40%	55%
	She always annoyed with her fathers (90%)	Annoyed with her fathers (50%)	Annoyed with her fathers (10%)	Reduced
Occupational	Poor performance about study (100%) and lack of concentration about study	Not increased	Increased up to 20%	Increased up to 50%
	Decreased relationship with class mates and teachers (100%)	Not increased	Increased a little bit	Increased up to 50%
	Reduced attention span and body strength (100%) and loss of memory (95%)	Increased up to 20%	Increased up to 30%	Increased up to 65%
Observation	The client came with a dirty dress up with her father and her appearance and behaviour appeared to be culturally appropriate	Came..... ..... appropriate	Came..... ..... appropriate	Came..... ..... appropriate
	In the first assessment session seemed to reflect her sufferings, very much anxious and depressed	Less than before	Less than before	Less than before
	She could not make eye contact normally and she was looking very sad and anxious	Quite normal	Normal	Normal
	Her body posture and movement was restless which expressed her anxiety and tiredness about her life	Normal	Normal	Normal
	She could not speak clearly. She had a stuttering problem and her amount of speech was very little which indicates that she was very much depressed	Not improved	Not improved	Not improved
	Her mood was low and she felt restlessness	Low and restlessness	Better than before	Better than before

B. Objective rating of Miss. A-7:

Scores of AS, DS and DUOCS are displayed at Table no-2.7.5.

Table no-2.7.5: General trend of objective score of Miss. A-7

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	101 (Profound)	125 (Severe)	48 (Severe)
Mid-assessment	82 (Profound)	114 (Mild)	41 (Severe)

Post-assessment	69 (Severe)	80 (Minimal)	23 (Mild)
1st Follow- up	56 (Moderate)	62 (Minimal)	20 (Mild)
2nd Follow- up	42 (Mild)	48 (Minimal)	14 (Below cut off score)
3rd Follow- up	32 (Mild)	36 (Minimal)	08 (Below cut off score)

C. Subjective rating of Miss. A-7:

Ratings of the verbal scale are displayed at Table no-2.7.6.

Table no-2.7.6: General trend of subjective rating of Miss. A-7

	Client's Subjective Rating Score	Care giver's Subjective Rating Score
Pre-assessment	9	9
Mid-assessment	6	
Post-assessment	4	5
1st Follow- up	4	
2nd Follow- up	2	
3rd Follow- up	2	2

(**Note:** The care giver did not attend the mid, 1st and 2nd follow-up sessions.)

Prognostic criteria:

There were some prognostic criteria, due to which some changes in the client mental health. Those were as follows-

1. The client was compliant, motivated and co-operative to her therapy session; so that she attended regularly in the therapy session.
2. She was very much committed to the treatment process and practiced the skills she learnt from the session to reduce her symptoms.
3. After one month she came back to have follow-up session.
4. Her care giver was more co-operative.

Therapist's comment:

Miss. A-7 was extremely anxious and depressed during the initial sessions and it was difficult for the researcher to structure the session at that time. Her assessment was completed within the first 4 sessions. She attends 17 sessions including three follow-up sessions and she was complying the therapy by her own. She gave her informed consent

very willingly and started participating in the session. She agreed with the researcher's formulation and provided feedback. After total 17 sessions, her anxiety, depression and OCD score was low. Her short term prognosis is good but if she does not practice the techniques learned in the session while facing any difficult situation relapse may occur. So, the long term prognosis depends on the client's internalization.

Responsible Psychiatrist's comments:

At the last and follow-up session the responsible psychiatrist talked to Miss. A-7. According to the psychiatrist evaluation/ remarks, on starting of the session, she was severely obsessed with intrusive rituals. Now, she is much better and stable regarding her emotional status, ruminations and rituals has become mild in intensively. Finally, the responsible psychiatrist reported 65-70% as improvement rating feedback.

Group-B (Control Group)

Case: B-1

Mr. B-1, 38 years old, unmarried, muslim male client from lower middle class status was referred from psychiatry out-patient department of DMCH. He was diagnosed as having OCD by referring agency and he was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from his problems for eighteen years.

Current medicine status: The client's current medicine status is displayed in Table no-2.8.1.

Table no-2.8.1: Current medicine status of Mr. B-1

Name of medicine	Group of medicine	Dose
Clofranil	TCA	25mg
Citapram	SSRI	10mg
Sizodon	Atypical Anti Psychotics	4mg
Perkinii	Anti Parkinson's drugs	5mg
Zolium		0.5mg

History of present illness:

The client was not a good student from the very early age. In 1998, his problems were started due to his four times failure in H.S.C exam. From early age the client noticed that his family members were not supportive to him. He had a conflicting and distorted family from the very beginning. He seeked help from her elder sister for mathematics but she refused and became very angry with him and looked at him furiously. As a result the client's feelings were fear and anger. The client reported that day's scenery was memorable for him; he could not forget that scenery. For that reason, his anxiety symptoms developed gradually. His fear feelings were also about table and chair. He thought that table and chair will beat him. He was always afraid of his family members, especially his younger sister. Once, one of his uncles came to his house but he did not love the client. At that time his uncle and his two sisters beat him with a scale without any reason. The client added that they always laughed at him. He mentioned that nobody mixed with him and he had no friend from early age. The client suffered from a chronic dehydrations problem when he was nine months old. As a result he thought that he had no brain in his head and an important material was gone from his head due to dehydrations. Besides before his H.S.C exam a road accident occurred and he was fallen under a tampu car. Due to the accident, he was admitted in a Hospital in Dhaka city and his washing rituals started after two months treatment. Furthermore, his physical problems developed gradually. For his mental disorder he could not continue his job. In 2002, his father died and he felt very pressure from his distorted family members after his father's death. His problems developed rapidly at that time.

Family and Personal history:

Family history: According to the client, his father died in 2002, aged 60 and he was a banker and his educational level was H.S.C. His mother was still alive, aged 53 and she was a house wife and her educational level was class ten. He had three sisters aged 35, 32 and 18 respectively who were unmarried and lived together. His three sister's educational level was MS, BA and H.S.C.

Birth history: The client had no birth complication but after few days of his birth, he had pneumonia fever. But his mother was completely ok.

Schooling and education: In 1992, the client failed S.S.C exam and in 1993, he passed S.S.C exam with second division. But he failed H.S.C exam four times and in 1998, at last he passed H.S.C exam with second division. He was not a good student and had no interest to read regularly and attentively. He had sleep problem and could not wake up in the early morning from early age.

Occupational history: In 2000-2004, the client worked in a low post at an office, but he was not satisfied about his job. His problems were severe at that time. So he was reigned the job.

Past medical history: For this problem he took medicine ten years ago. The client suffered a chronic dehydrations problem when he was nine months old. He could not enjoy anything. He thought that he had a big diseases and he became a mental patient. Always his concentration had gone to negative way and he could not stop this kind of thought.

Relationship among family members: He was the eldest son of his parents but from early age his parents did not love him. His relationships among family members were not good.

Family history of mental illness: There was no family history of mental illness.

Pre, mid, post and follow-up assessment result of the problems

A. Findings based on Interview and Observation:

Mr. B-1's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no-2.8.2.

Table no-2.8.2: Problems mentioned in pre-assessment and reduction/improvement/ increase of problems found during mid, post and follow-up assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement/ increase of the problem in Post-assessment	Reduction/ improvement/ increase of the problem in Follow-up assessment
Cognitive	Contaminated with dirt and germs, touching animals and insects; became ill from contaminated; excessive fear and preoccupation with avoiding dirt and germs, insects, mosquito; easily bothered by certain sounds; intrusive nonsense sounds	Not reduced	Not reduced	Not reduced
	Nobody understands his pain and nobody loves him; life is meaningless and worthless, world is dusty, life is finished and future is dark	Not reduced at all	Not reduced at all	Not reduced at all
	Felt lack of concentration, difficulty in making decision and low self esteem	Not increased	Not increased	Not increased
	He Can not speak well, people things bad about him	Not reduced	Not reduced	Not reduced
	Had an intellectual disability	Not reduced	Not reduced	Not reduced
Emotional	Felt lack of confidence, no motivation and interest to do anything	Not increased	Not increased	Not increased
	Felt fear, hopeless, sad, worthless, distressed, restless, guilt feeling, irritated, confused and vulnerable	Not reduced	Not reduced	Not reduced
Physiological	Drowsiness and palpitation	Not reduced significantly	Not reduced significantly	Reduced up to 40%
	Excessive sweating	Reduced up to 5%	Reduced up to 15%	Reduced up to 30%
	Sleep difficulties	Not reduced	Reduced up to 5%	Reduced up to 5%
	Low appetite	Increased up to 5%	Increased up to 15%	Increased up to 50%
	Dryness of throat, burning sensation all over the body	Not reduced	Reduced up to 10%	Reduced up to 10%
	Headache	Reduced up to	Reduced up to	Reduced up to

		5%	25%	25%
	Hand and leg tremor	Reduced up to 10%	Reduced up to 30%	Reduced up to 30%
	Hot flushes in head, weakness	Not reduced	Not reduced	Reduced up to 10%
	Vomiting tendency	Reduced up to 10%	Reduced up to 40%	Reduced up to 30%
	Loss of energy	Not increased	Not increased	Not increased
Behavioural	Excessive, illogical and uncontrollable repeated washing, often performed in a ritualistic way	Not reduced	Not reduced	Not reduced
	Showering or bathing, often performed in a ritualistic way	Not reduced	Not reduced	Not reduced
	Avoiding places feared for possible contamination	Not reduced	Not reduced	Not reduced
	Decreased activity level	Not increased	Not increased	Not increased
	Withdrawal from social activity	Not improved	Not improved	Not improved
	Rereading things and doing certain activities in a particular number of times	Not reduced	Not reduced	Reduced up to 10%
Social	Disrupted social interaction	Not improved at all	Not improved at all	Not improved at all
	Decreased relationship with neighbors, relatives and family members	Not improved at all	Not improved at all	Not improved at all
	He Can not talk and mix with other people	Now a days	Now a days	Now a days
Occupational	Job loses for this problem	Now jobless	Now jobless	Now jobless
	Not interest about his job and his attention span and body strength was reduced significantly	Not increased	Not increased	Not increased
Observation	He came with his mother in a well dress up and his appearance and behaviour appeared to be culturally appropriate	Came..... appropriate	Came..... appropriate	Came..... appropriate
	He Could not make eye contact normally	Not normal	Poor	Minimum
	His body posture and body movement was restless which expressed his anxiety	Restless	Restless	Restless
	Amount of speech was low in the first session, most of the answer he gave by one or two words and with fear and	Fear and rigidity	Fear and rigidity	Fear and rigidity

	rigidity			
	Mood was low	Low and felt restlessness	Low and felt restlessness	Low and felt restlessness

B. Objective rating of Mr. B-1:

Anxiety scale (AS); (Deeba, F. and Begum, R. 2004), Depression scale (DS); (Uddin, Z. and Rahman, M. 2005) and Dhaka University Obsessive Compulsive Scale (DUOCS) (Mozumder, K. and Begum, R. 2005) were applied to get an objective measure of the severity of the client's anxiety, depression and OCD. Scores of the above mentioned scales are displayed at Table no-2.8.3.

Table no-2.8.3: General trend of objective score of Mr. B-1

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	108 (Profound)	126 (Severe)	66 (Profound)
Mid-assessment	103 (Profound)	131 (Severe)	77 (Profound)
Post-assessment	101(Profound)	128 (Severe)	70 (Profound)
1st Follow- up	102 (Profound)	132 (Severe)	71 (Profound)
2nd Follow- up	99 (Profound)	124 (Severe)	68 (Profound)
3rd Follow- up	101 (Profound)	130 (Severe)	69 (Profound)

C. Subjective rating of Mr. B-1:

The client and his mother rated his overall problem in (0-10) 11 point rating verbal scale, where '0' indicates no problem at all and '10' indicates highest level of problem. Ratings of the verbal scale are displayed at Table no-2.8.4.

Table no-2.8.4: General trend of subjective rating of Mr. B-1

	Client's Subjective Rating Score	Care giver's Subjective Rating Score
Pre-assessment	10	10
Mid-assessment	10	10
Post-assessment	10	10
1st Follow- up	10	10
2nd Follow- up	10	10
3rd Follow- up	10	10

Responsible Psychiatrist's comments:

At the last and follow-up session the responsible psychiatrist talked to Mr. B-1. According to the psychiatrist evaluation/ remarks, the patient did not improve in his

disease process or symptoms. Occasional improvement is poorly sustained which made him frustrated. He did not maintain his daily activities properly and in time. Finally, the responsible psychiatrist reported 20% as improvement rating feedback.

Case: B-2

Mr. B-2, 28 years old, unmarried, muslim male client from lower middle class status was referred from psychiatry out-patient department of DMCH. He was diagnosed as having OCD by referring agency and he was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from his problems for 3 years and took medicine from 2 years.

Current medicine status:

The client's current medicine status is displayed in Table no-2.9.1.

Table no-2.9.1: Current medicine status of Mr. B-2

Name of medicine	Group of medicine	Dose
Clofranil	TCA	25mg
Epilim Chrono	Antiepileptic/ Mood stabilizer	500mg
Olanep	Atypical antipsychotic	10mg

History of present illness:

Mr. B-2 was 28 years old muslim client. He was religious minded from the very beginning. He was a Madrasha student but was not a good student and did not go to Madrasha regularly from early life. Also his parents were not educated and had lower middle class status. From early age he had some behavioural problems. He did not like to mix with others. He preferred to live alone all the time. When he was a student of Madrasha, he had no friend. In 2005, one of his colleagues showed him blue film and after that his sexual thoughts were developed. He could not forget that scenery and his sleep and appetite problems started then. In 1999, the client made an affair but his affair broke after two years because of his poverty. Furthermore, the client lived in a village at that time and his girl friend's father refused him. He loved her very much and he could

not forget that girl. He became very much anxious and depressed after that event and his all obsessional problems started gradually.

Family and Personal history:

Family history: According to the client, his parents were still alive and both of them were illiterate. His father was a businessman, aged 60 and his mother was a house wife, aged 55. He had two sisters and three brothers, aged 35, 34, 30, 22 and 20 respectively. His two sisters and a brother were married. One of his brother was H.S.C pass and another two's educational level were class seven and class eight. One of his sisters read up to class seven and another one read up to class eight.

Birth history: The client was a seizure baby.

Schooling and education: The client was a Madrasha student and he was not a good student from early age. He had no interest to read and go to Madrasha regularly. In 2000, the client passed hafeji exam.

Occupational history: The client was an electrician. He had been working as an electrician in a shop from 2000.

Past medical history: For this problem he took medicine two years ago. From early life he was a healthy and wealthy person. He had no serious illness in the past but now he thought that he had mental problems and these mental problems would not cure.

Relationship among family members: He was the youngest son of his parents and all of his family members were well behaved with him. His relationships among family members were good.

Family history of mental illness: There was no family history of mental illness.

Pre, mid and post-assessment result of the problems

A. Findings based on Interview and Observation:

Mr. B-2's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no-2.9.2.

Table no-2.9.2: Problems mentioned in pre-assessment and reduction/ improvement/ increase of problems found during mid and post-assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement/ increase of the problem in Post-assessment
Cognitive	Contaminated with dirt and germs	Reduced a little bit up to 10%	Reduced a little bit up to 10%
	Excessive fear and preoccupation with avoiding dirt and germs	Reduced a little bit up to 10%	Reduced a little bit up to 10%
	Unwanted, worrisome and intrusive sexual thoughts and impulses	Not reduced	Not reduced
	Thoughts about being or becoming a homosexual	Not reduced	Not reduced
	Felt lack of concentration at work	Increased a little bit	Increased a little bit
	Decision making capacity reduced up to 80%	Not improved	Not improved
	Low self esteem	Not increased	Not increased
	He can not speak well, life is bore and did not do well his life and day by day his life goes to danger	Reduced up to 20%	Reduced up to 30%
Emotional	Felt lack of confidence	Not improved	Improved a little bit
	Fear, hopeless, sad, worthless, restless, guilt feeling and irritated	Reduced a little bit	Reduced a little bit up to 5%
Physiological	Palpitation	Reduced up to 20%	Reduced up to 20%
	Sweating	Reduced a little bit	Reduced a little bit
	Sleep difficulties	Increased a little bit	Increased a little bit
	Low appetite	Not increased	Increased a little bit
	Headache and hot flushes in head	Not reduced	Not reduced
	Weakness	Not reduced	Not reduced
	Loss of energy	Not increased	Increased a little bit

Behavioural	Excessive, illogical and uncontrollable repeated showering or bathing, often performed in a ritualistic way	Reduced a little bit	Reduced up to 10%
	Avoiding places feared for possible contamination	Reduced a little bit	Reduced up to 10%
	Decreased activity level	Increased a little bit	Increased up to 20%
	Withdrawal from social activity	Now a day	Now a day
	Non assertive	Not improved	Not improved
	Checking tap, locks and fan switches again and again	Not reduced	Not reduced
	Doing certain activities in a particular number of times	Not reduced	Not reduced
Social	Disrupted social interaction	Improved a little bit	Improved a little bit up to 10%
	Disrupted relationship with neighbors, relatives and family members	Improved a little bit	Improved a little bit up to 10%
	He can not mix easily with other people	Not improved	Not improved
Occupational	Not interest about his job and his attention span and body strength was reduced significantly	Not increased significantly	Not increased significantly
Observation	He came with a religious dress up and his appearance and behaviour appeared to be culturally appropriate	Came.... appropriate	Came.... appropriate
	He could make eye contact poorly	Normal	Normal
	His body posture and body movement was restless which expressed his anxiety	Restless	Restless
	Amount of speeches were not normal	Normal	Normal
	Mood was low	Low	Low

B. Objective rating of Mr. B-2:

Scores of AS' DS and DUOCS are displayed at Table no-2.9.3.

Table no-2.9.3: General trend of objective score of Mr. B-2

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	95 (Profound)	110 (Mild)	43 (Severe)
Mid-assessment	87 (Profound)	112 (Mild)	41(Severe)
Post-assessment	85 (Profound)	113 (Mild)	41(Severe)

C. Subjective rating of Mr. B-2:

Ratings of the verbal scale are displayed at Table no-2.9.4.

Table no-2.9.4: General trend of subjective rating of Mr. B-2

	Client's Subjective Rating Score
Pre-assessment	9.5
Mid-assessment	7
Post-assessment	7

(**Note:** The client did not attend the follow-up sessions.)

Case: B-3

Mr. B-3, 20 years old, unmarried, muslim male client from middle class status was referred from psychiatry out-patient department of DMCH. He was diagnosed as having OCD by referring agency and he was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from his problems for five years and took medicine from three years ago.

Current medicine status:

The client's current medicine status is displayed in Table no-2.10.1.

Table no-2.10.1: Current medicine status of Mr. B-3

Name of medicine	Group of medicine	Dose
Clofranil	TCA	25mg

History of present illness:

The client was very sincere about his study and he was very high ambitious student in his early age. When he was a student of class four, at first he felt headache. Once in a rainy season he felt back side headache. His father took him to a doctor for this problem but doctor said that he had no problem. The client reported that his problems were started at that time. In 2007, during his H.S.C final exam he mentioned that his botany exam was not good and he believed that he would fail in H.S.C exam. He always wanted to read in a reputed medical college and his aim in life was to be a doctor. Due to his aim, his tension increased before H.S.C exam result and to reduce his tension he went a doctor.

His exam result was published after few days and he achieved good result but his tension was not reduced. The client got admitted in a coaching center for admission in medical college or university but he did not got chance in any medical college, Dhaka university and Jahangirnagar university. For this reason, he was admitted in Jagannath University but he had no satisfaction there and his unwanted recurrent intrusive thoughts developed gradually. He thought that he was not a qualified student and he had no quality. Furthermore, he was a religious family background and from early age he used to pray regularly. His mother always wished him to be a Maolana and she wanted him to read in a Madrasha line. At the client's perception, the above factors contributed to develop this present condition.

Family and Personal history:

Family history: According to the client, his parents were still alive. His father was a retired primary school teacher, aged 67 and his educational level was MS. His mother was a house wife, aged 58 and her educational level was class eight. He had five sisters and two brothers aged 38, 32, 30, 26, 23, 21 and 18 respectively. His three sisters and two brothers were married. One of his sisters was mentally retarded and she had no educational qualification. Three of his sisters passed S.S.C and another one's educational level was H.S.C. One of his brother's educational levels was BA and another one was H.S.C.

Birth history: The client had no birth complication.

Schooling and education: The client was good student from early life. In 2005, he passed S.S.C exam with GPA-5 and in 2007, he passed H.S.C exam with GPA-5. He had interest to read and used to go to school regularly but he had sleep problem from the very beginning. He had no friends at school and he did not like to mix with other.

Past medical history: For this problem he took medicine three years ago. When he was student of class one, suddenly his right leg was broken. Due to his treatment he was admitted in a Medical Hospital. His leg was recovered after three months.

Relationship among family members: He was the youngest son of his parents and from early age his parents loved him very much. His relationships among family members were good.

Family history of mental illness: The client mentioned that his elder sister was mentally retarded. His mother had chronic headache and his mothers and family members of his father have mental problems. One of his second grandfathers was mad and he was treated in Pabna mental hospital.

Pre, mid, post and follow-up assessment result of the problems

A. Findings based on Interview and Observation:

Mr. B-3's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no-2.10.2.

Table no-2.10.2: Problems mentioned in pre-assessment and reduction/ improvement/ increase of problems found during mid, post and follow-up assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement/ increase of the problem in Post-assessment	Reduction/ improvement/ increase of the problem in Follow-up assessment
Cognitive	I am not a good student; I will not be successful in my life	Reduced a little bit	Reduced up to 10%	Reduced up to 15%
	Excessive fear, worry and preoccupation: having blasphemous thoughts; being punished for blasphemous thoughts	Not reduced	Not reduced	Not reduced
	He thought that his roommates did not understand his pain	Now a day	Now a day	Now a day

	Life is meaningless, worthless and future is dark	Reduced a little bit	Reduced a little bit	Reduced up to 20%
	Lack of concentration at all	Not increased	Increased up to 15%	Increased up to 25%
	Decision making capacity was extremely reduced	Not increased	Increased up to 15%	Increased up to 25%
	Low self esteem	Not increased	Not increased	Not increased
Emotional	Felt lack of confidence	Not increased	Not increased	Increased a little bit
	Fear and hopeless, sad, worthless, distressed, restless, guilt feeling, irritated and vulnerable	Not reduced	Reduced up to 10%	Reduced up to 10%
	He had no motivation and interest to reading	Not increased	Increased a little bit	Increased a little bit
Physiological	Drowsiness	Reduced up to 20%	Reduced up to 20%	Reduced up to 30%
	Pain and palpitation in the chest	Reduced up to 15%	Reduced up to 25%	Reduced up to 30%
	Excessive sweating	Not reduced	Reduced up to 20%	Reduced up to 40%
	Irregular sleep	Not improved	Not improved	Not improved
	Low appetite	Increased up to 20%	Increased up to 25%	Increased up to 35%
	Dryness of throat	Reduced a little bit	Reduced a little bit	Reduced a little bit
	Headache, pain and burning sensation in the scalp	Reduced up to 10%	Reduced up to 10%	Reduced up to 20%
	Burning sensation all over the body	Reduced up to 30%	Reduced up to 30%	Reduced up to 35%
	Vomiting tendency, weakness and hot flushes in head	Not reduced	Not reduced	Not reduced
	Weight loss	Not improved	Not improved	Not improved
	Loss of energy	Increased a little bit	Increased a little bit	Increased a little bit
Behavioural	Excessive, illogical and uncontrollable repeated checking locks, pen, admit card and file again and again and doing certain activities in a particular number of times	Not reduced	Reduced a little bit	Reduced a little bit
	Decreased activity level	Increased a little bit	Increased up to 15%	Increased up to 25%
	Withdrawal from social activity	Now a day	Now a day	Now a day
	Non assertive	Not improved	Not improved	Not improved
	Always avoids social	Now a day up	Now a day up	Now a day up

	gathering	to 80%	to 80%	to 80%
Social	Disrupted social interaction	Not increased	Not increased significantly	Not increased significantly
	Decreased relationship with neighbors, relatives and room mates	Not improved	Not improved	Not improved
	Did not prefer to mix with other people	Now a day	Now a day	Now a day
Occupational	Not interest about his study and his attention span and body strength was reduced significantly	Increased a little bit now a day	Increased a little bit now a day	Increased up to 15% now a day
Observation	He came with a usual dress up and his appearance and behaviour appeared to be culturally appropriate	Came.....appr opriate	Came.....appr opriate	Came.....appr opriate
	He could make eye contact poorly	Normal	Normal	Normal
	His body posture and body movement were normal	Normal	Normal	Normal
	Amount of speeches was very much	Enough	Normal	Normal
	Mood was low and he felt restlessness	low and restlessness	low and restlessness	Low and restlessness

B. Objective rating of Mr. B-3:

Scores of AS, DS and DUOCS are displayed at Table no-2.10.3.

Table no-2.10.3: General trend of objective score of Mr. B-3

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	102 (Profound)	113 (Mild)	44 (Severe)
Mid-assessment	75 (Severe)	93 (Minimal)	41 (Severe)
Post-assessment	74 (Severe)	90 (Minimal)	40 (Moderate)
1st Follow- up	76 (Severe)	101 (Mild)	41 (Severe)
2nd Follow- up	73 (Severe)	98 (Minimal)	40 (Moderate)
3rd Follow- up	74 (Severe)	91 (Minimal)	40 (Moderate)

C. Subjective rating of Mr. B-3:

Ratings of the verbal scale are displayed at Table no-2.10.4.

Table no-2.10.4: General trend of subjective rating of Mr. B-3

	Client's Subjective Rating Score
Pre-assessment	8
Mid-assessment	7.5

Post-assessment	7.5
1st Follow- up	7
2nd Follow- up	8
3rd Follow- up	7.5

Responsible Psychiatrist's comments:

At the last and follow-up session the responsible psychiatrist talked to Mr. B-3. According to the psychiatrist evaluation/ remarks, previously patient represented with obsessive ruminations along with some physical complains. At present his somatic complaints subsided but obsessional features are persisting, emotionally also a bit depressed. Finally, the responsible psychiatrist reported 35 % as improvement rating feedback.

Case: B-4

Mr. B-4, 20 years old, unmarried, muslim male client from upper middle class status was referred from psychiatry in-patient department of BSMMU. He was diagnosed as having OCD by referring agency and he was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from his problems for four years and took medicine from three years ago.

Current medicine status:

The client's current medicine status is displayed in Table no-2.11.1.

Table no-2.11.1: Current medicine status of Mr. B-4

Name of medicine	Group of medicine	Dose
Prodep	SSRI	20mg
Epiclon	Benzodiazepine	0.5mg

History of present illness:

The client had grown up in an upper middle class family and from his early life he had no problem. When he was 7 years old, his father discovered that he did not touch the calling bell. His problems developed gradually. The client had gone to "Tablig" after his

S.S.C exam and there he mixed with different types of people. They shared one another many things but the client did not like them. In that situation, he did not ignore them but he felt discomfort. For that reason his problems were triggered. The client and his family members were always in tension about these problems. The client's mother had a washing rituals and she could not control her problems.

Family and Personal history:

Family history: According to the client, his parents were still alive. His father was an audit and accounts officer, aged 45 and his educational level was MA LLB. His mother was a Government service holder, aged 40 and her educational level was BA. He had a younger brother and sister aged 16 and 8 respectively. Their educational level was S.S.C and class three.

Birth history: The client had no birth complication and he was a normal born child.

Schooling and education: In 2006, the client passed S.S.C exam with A (-) and in 2008, he passed H.S.C exam with B grade. He was a medium category student and from early age he had few friends but he did not like to mix with them.

Past medical history: For this problem he took medicine three years ago. The client suffered from a fever convulsion when he was three years old and he took one year treatment to solve his problems.

Relationship among family members: He was the eldest son of his parents and their parents loved him very much. His relationships among family members were good.

Family history of mental illness: There was no family history of mental illness.

Pre, mid, post and follow-up assessment result of the problems

A. Findings based on Interview and Observation:

Mr. B-4's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no-2.11.2.

Table no-2.11.2: Problems mentioned in pre-assessment and reduction/ improvement/ increase of problems found during mid, post and follow-up assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement/ increase of the problem in Post-assessment	Reduction/ improvement/ increase of the problem in Follow-up assessment
Cognitive	I am contaminated with dirt and germs, touching dustbin, poor people, tree leafs, handshake with other and touching football; became ill from contaminated; excessive fear and preoccupation with avoiding dirt and germs (100%)	Not reduced at all	Not reduced at all	Not reduced at all
	Life is meaningless and worthless, world is dusty, world is polluted, life is finished and future is dark (100%)	Not reduced	Not reduced	Not reduced
	No concentration at all	Not increased	Not increased	Not increased
	Decision making capacity was extremely reduced and self esteem was low	Not increased	Not increased	Not increased
	Suicidal ideation and two times attempted to suicide with sleeping pill	Reduced up to 100%	Reduced up to 100%	Reduced up to 100%
	He thought that bad things will happen as bad as doing so (90%)	Not reduced	Not reduced	Not reduced
Emotional	He felt lack of confidence (95%)	Not increased	Not increased	Not increased
	Fear, hopeless, sad, worthless, distressed, restless, irritated, confused and vulnerable (100%)	Not reduced	Not reduced	Not reduced
	No motivation and interest to	Not increased	Not increased	Not increased

	do anything			
	Crying spell	Not reduced	Not reduced	Not reduced
Physiological	Palpitation (100%), sweating, sleep difficulties, dryness of throat, headache, burning sensation all over the body and hot flushes in head (85%)	Reduced a little bit up to 20%;	Reduced a little bit up to 20%;	Reduced a little bit up to 30%;
	Low appetite	Increased a little bit	Increased up to 20%	Increased up to 30%
Behavioural	Excessive, illogical and uncontrollable repeated cloth, doors, windows, balcony, lone, sandal, mobile, bag, money bag, tap etc. washing and cleaning, often performed in a ritualistic way (100%)	Not reduced at all	Not reduced at all	Not reduced at all
	Showering or bathing, often performed in a ritualistic way (100%)	Not reduced at all	Not reduced at all	Not reduced at all
	Avoiding places such as toilet, dustbin, shoe self, others house, drain etc. feared for possible contamination (100%)	Not reduced at all	Not reduced at all	Not reduced at all
	Decreased activity level (95%)	Increased a little bit	Increased a little bit	Increased a little bit
	Withdrawal from social activity (100%) and non assertive (90%)	Not increased	Not increased	Not increased
Social	Disrupted social interaction (95%)	Not increased significantly	Not increased significantly	Not increased significantly
	Decreased relationship with neighbors, relatives and family members and friends (95%)	Not increased significantly	Not increased significantly	Not increased significantly
Occupational	Not interest about his study and his attention span and body strength were reduced significantly	Increased up to 10%	Increased up to 15%	Increased up to 25%
Observation	He came with his father by wearing a usual dress up and appearance and behaviour appeared to be culturally appropriate	Came..... appropriate	Came..... appropriate	Came..... appropriate
	He could make eye contact normally but he was looking	Normal	Normal	Normal

	very sad and anxious			
	His body posture was normal but body movement was restless which expressed his anxiety	Normal	Normal	Normal
	Amount of speeches were almost normal	Normal	Normal	Normal
	Mood was low and he felt restlessness	Low and restlessness	Low and restlessness	Low and restlessness

B. Objective rating of Mr. B-4:

Scores of AS, DS and DUOCS are displayed at Table no-2.11.3.

Table no-2.11.3: General trend of objective score of Mr. B-4

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	129 (Profound)	134 (Severe)	71 (Profound)
Mid-assessment	119 (Profound)	125 (Severe)	70 (Profound)
Post-assessment	118 (Profound)	125 (Severe)	70 (Profound)
1st Follow- up	111 (Profound)	122 (Moderate)	68 (Profound)
2nd Follow- up	116 (Profound)	124 (Severe)	70 (Profound)
3rd Follow- up	128 (Profound)	134 (Severe)	71 (Profound)

C. Subjective rating of Mr. B-4:

Ratings of the verbal scale are displayed at Table no-2.11.4.

Table no-2.11.4: General trend of subjective rating of Mr. B-4

	Client's Subjective Rating Score	Care giver's Subjective Rating Score
Pre-assessment	10	5
Mid-assessment	10	5
Post-assessment	10	
1st Follow- up	10	8
2nd Follow- up	10	7
3rd Follow- up	10	9

Responsible Psychiatrist's comments:

At the last and follow-up session the responsible psychiatrist talked to Mr. B-4. According to the psychiatrist evaluation/ remarks, patient had no significant improvement. Finally, the responsible psychiatrist reported 5% as improvement rating feedback.

Case: B-5

Mrs. B-5, 40 years old, married, muslim female client from middle class status was referred from psychiatry out-patient department of DMCH. She was diagnosed as having OCD by referring agency and she was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from her problems for five years and she took medicine from five years ago.

Current medicine status:

The client's current medicine status is displayed in Table no-2.12.1.

Table no-2.12.1: Current medicine status of Mrs. B-5

Name of medicine	Group of medicine	Dose
Clofranil	TCA	25mg
Ticlon	Hypnotics	2mg
Aluctin	Flurazepam	30mg
Napa extra		

History of present illness:

The client was grown up in a restricted muslim family. In her childhood, she was over protected and not caring. She had headache problem and she wanted to do everything perfectly. She had no son but four daughters. Her problems were started after her daughter's birth, especially after her first daughter's marriage. Her eldest daughters in laws were problematic. Furthermore, her second daughter was divorced and she always felt tension about her daughters because she could not manage them properly. Her mood was always irritable and did not like anybody. All of her daughters did not abide by their mother and her younger daughter misbehaved with her very much. In a word, she had conflicting relationships with her daughters. For all the above mentioned reasons, her problems were developed gradually.

Family and Personal history:

Family history: According to the client, her husband was still alive. He was a Government service holder, aged 47 and his education was primary level. The client reported that she was a house wife and her educational level was class nine. She had no son but she had four daughters, aged 24, 21, 14 and 13 respectively and their educational level was class IV, V, VII and class IX. Her two sisters were married.

Birth history: The client had no birth complication and she was a normal born child.

Schooling and education: The client was not a good student from early age. She was an average category student. She was interest to read but her parents had given her marriage because of their poverty. For that reason she did not attend S.S.C exam. She said that she was sleep problem from early age and she can not wake up in the early morning.

Marital history: In 1984, when she was 14 years old, her husband chose her for marriage and the client got married at that time. She had a very happy family with her husband and her husband was very helpful.

Past medical history: For this problem she took medicine five years ago.

Relationship among family members: Her husband was very much co-operative but her daughters were not helpful. They were always angry with their mother and her relationships among all family members were not good.

Family history of mental illness: There was no family history of mental illness.

Pre and mid-assessment result of the problems

A. Findings based on Interview and Observation:

Mrs. B-5's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no-2.12.2.

Table no-2.12.2: Problems mentioned in pre-assessment and reduction/ improvement/ increase of problems found during mid-assessment.

Category	Problems found during Pre-assessment	Reduction/improvement/ increase of the problem in Mid-assessment
Cognitive	I am contaminated with dirt, became ill from contaminated; excessive fear and preoccupation with avoiding dirt" (100%)	Not reduced
	Life is worthless, world is dusty, world is selfish, life is finished and future is dark (95%)	Not reduced
	Lack of concentration	Not increased
	Low self esteem	Not increased
	Decision making capacity was extremely reduced	Not increased
	She is going to die, she has a big disease, she is funny and doing something embarrassing (95%).	Reduced a little bit up to 20%
Emotional	Lack of confidence (100%)	Increased up to 10%
	Felt fear, anger, hopeless, sad, worthless, distressed, restless, irritated and vulnerable (90%)	Not reduced
Physiological	Drowsiness and palpitation (95%)	Reduced up to 10%
	Sleep difficulties (100%)	Reduced a little bit
	Excessive sweating	Not reduced
	Appetite reduces significantly	Not increased significantly
	Dryness of throat (95%); extreme headache, burning sensation all over the body (100%); hot flushes in head, weakness, vomiting tendency (95%)	Reduced up to 5%
	Loss of energy (100%)	Not increased
Behavioural	Excessive, illogical and uncontrollable repeated washing, often performed in a ritualistic way; avoiding places feared for possible contamination (100%)	Not reduced
	Decreased activity level (98%)	Increased a little bit
	Withdrawal from social activity (100%)	Not increased
	Non assertive (100%)	Not reduced
	Checking stoves, tap, locks, fan and	Not reduced

	television switches, checking under door, bed, almira and midself again and again and doing certain activities in a particular number of times (95%)	
	She had also crying spell	Not reduced
Social	Disrupted social interaction (100%)	Increased a little bit
	Annoyed family members (80%)	Not reduced
	Decreased relationship with neighbors, relatives and family members (85%)	Not increased
Occupational	Not interest about her household activities (100%) and her attention span and body strength was reduced significantly	Not increased
Observation	She came with her younger sister with a usual dress up and her appearance and behaviour appeared to be culturally appropriate	Came…. ……..appropriate
	She could make eye contact normally but she was looking very sad and anxious	Normal
	Her body posture and body movement, amount of speeches and mood was normal	Normal

B. Objective rating of Mrs. B-5:

Scores of AS, DS and DUOCS are displayed at Table no-2.12.3.

Table no-2.12.3: General trend of objective score of Mrs. B-5

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	116 (Profound)	120 (Moderate)	67 (Profound)
Mid-assessment	118(Profound)	124 (Severe)	66(Profound)

C. Subjective rating of Mrs. B-5:

Ratings of the verbal scale are displayed at Table no-2.12.4.

Table no-2.12.4: General trend of subjective rating of Mrs. B-5

	Client's Subjective Rating Score	Care giver's Subjective Rating Score
Pre-assessment	8	8
Mid-assessment	8	8

(**Note:** The client did not attend the post and follow-up sessions.)

Case: B-6

Miss. B-6, 21 years old, unmarried, muslim female client from middle class status was referred from psychiatry out-patient department of DMCH. She was diagnosed as having OCD by referring agency and she was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from her problems for five years and she took medicine from five years ago.

Current medicine status:

The client's current medicine status is displayed in Table no-2.13.1.

Table no-2.13.1: Current medicine status of Miss. B-6

Name of medicine	Group of medicine	Dose
Prodep	SSRI	20mg
Xionil	Anxiolytic	3mg
Aripra	Atypical antipsychotic	10mg

History of present illness:

The client was 21 years old, muslim and she was grown up in a restricted family environment. In her childhood, she was over protected. She had negative automatic and recurrent intrusive thoughts and she had conflicting relationship with one of her elder sister. Sometimes she took bath several hours a day. From her very early age, she saw conjugal problems between her parents. As a result, she was very much anxious about her family. When she was a student of class seven she made an affair but her family did not like that. Due to her affair, her parents were tortured her very much. At the client's perception, the above factors contributed to develop this present condition.

Family and Personal history:

Family history: According to the client, her parents were still alive. Her father was a businessman, aged 62 and his educational level was S.S.C. Her mother was a house wife, aged 57 and her educational level was class five. The client had three brothers and two sisters, aged 40, 30, 25, 23 and 22 respectively and their educational level was H.S.C,

S.S.C, class nine, class eight and five. Her one brother and one sister were married and she was the youngest child of her parents.

Birth history: The client was born on 31 august, 1986 and she was seizure baby of her parents.

Schooling and education: The client was a medium category student from the very beginning. In 2003, she passed S.S.C exam with second division. She had many friends from early age.

Past medical history: For this problem she took medicine five years ago.

Relationship among family members: Her elder sister was very much co-operative and her relationships among all family members were good.

Family history of mental illness: There was no family history of mental illness.

Pre, mid, post and follow-up assessment result of the problems

A. Findings based on Interview and Observation:

Miss. B-6's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no-2.13.2.

Table no-2.13.2: Problems mentioned in pre-assessment and reduction/ improvement/ increase of problems found during mid, post and follow-up assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ improvement/ increase of the problem in Post-assessment	Reduction/ improvement/ increase of the problem in Follow-up assessment
Cognitive	I am contaminated with dirt and germs, became ill from contaminated; excessive fear and	Not reduced	Not reduced	Not reduced

	preoccupation with avoiding dirt (85%)			
	She thought that her life is worthless and she is a sick person	Reduced up to 20%	Reduced up to 30%	Reduced up to 30%
	Lack of concentration	Not increased	Not increased	Not increased
	Low self esteem	Not increased	Not increased	Not increased
	Decision making capacity was extremely reduced	Not increased	Not increased	Not increased
Emotional	Lack of confidence (90%)	Not increased	Not increased	Not increased
	Felt fear, anger, hopeless, sad, worthless, distressed and restless (85%)	Reduced up to 10%	Reduced up to 15%	Reduced up to 20%
Physiological	Palpitation (95%) and sleep difficulties (90%)	Reduced up to 10% and 20%	Reduced up to 10% and 20%	Reduced up to 10% and 20%
	Low appetite	Increased a little	Increased a little	Increased up to 25%
	Weakness	Not reduced	Not reduced	Not reduced
	Pain sensation in leg	Not reduced	Reduced up to 35%	Reduced up to 55%
	Loss of energy (90%)	Not increased significantly	Not increased significantly	Not increased significantly
Behavioural	Excessive, illogical and uncontrollable repeated washing and bathing often performed in a ritualistic way, avoiding places feared for possible contamination (100%)	Reduced up to 15%	Reduced up to 25%	Reduced up to 25%
	Decreased activity level (100%)	Not increased at all	Not increased at all	Not increased at all
	Withdrawal from social activity (100%)	Not increased	Not increased	Not increased
	Checking stoves, pot over and over and doing certain activities in a particular number of times (95%)	Not reduced	Reduced up to 10%.	Reduced up to 10%
Social	Social interaction was disrupted (95%)	Not increased significantly	Not increased significantly	Not increased significantly
Occupational	She mentioned that she had no interest about study and her attention span and body strength was reduced (80%)	Not increased	Not increased	Not increased
Observation	She came with her elder sister by wearing a well dress up and her appearance and behaviour	Came.....appropriate	Came.....appropriate	Came.....appropriate

	appeared to be culturally appropriate			
	She could make eye contact normally but she was looking sad and anxious	Normal	Normal	Normal
	Her body posture and body movement and amount of speeches were normal	Normal	Normal	Normal
	Her mood was low	Low	Low	Low

B. Objective rating of Miss. B-6:

Scores of AS, DS and DUOCS are displayed at Table no-2.13.3.

Table no-2.13.3: General trend of objective score of Miss. B-6

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	77 (Severe)	91 (Minimal)	48 (Severe)
Mid-assessment	69 (Severe)	104 (Mild)	28 (Moderate)
Post-assessment	71 (Severe)	116 (Moderate)	30 (Moderate)
1st Follow- up	77 (Severe)	115 (Moderate)	41 (Severe)
2nd Follow- up	73 (Severe)	108 (Mild)	30 (Moderate)
3rd Follow- up	78 (Profound)	123 (Moderate)	47 (Severe)

C. Subjective rating of Miss. B-6:

Ratings of the verbal scale are displayed at Table no-2.13.4.

Table no-2.13.4: General trend of subjective rating of Miss. B-6

	Client's Subjective Rating Score	Care giver's Subjective Rating Score
Pre-assessment	9	10
Mid-assessment	9	9
Post-assessment	8	9
1st Follow- up	8	8
2nd Follow- up	7	8
3rd Follow- up	8	8

Responsible Psychiatrist's comments:

At the last and follow-up session the responsible psychiatrist talked to Miss. B-6. According to the psychiatrist evaluation/remarks, she is still emotionally unstable with

impulsive outburst. Rituals are a bit slow but fluctuating. Finally, the responsible psychiatrist reported 40% as improvement rating feedback.

Case: B-7

Mrs. B-7, 28 years old, married, muslim female client from middle class status was referred from psychiatry out-patient department of DMCH. She was diagnosed as having OCD by referring agency and she was selected as a participant of the present study according to the inclusion criteria.

Duration of the problems:

The client was suffering from her problems for eleven years and she took medicine from seven years ago.

Current medicine status:

The client's current medicine status is displayed in Table no-2.14.1.

Table no-2.14.1: Current medicine status of Mrs. B-7

Name of medicine	Group of medicine	Dose
Clofranil	TCA	25mg
Relafm	SSRI	50mg
Rispolux	Atypical antipsychotic	1mg
Lonazep	Benzodiazepine	.5mg

History of present illness:

From the very beginning, the client was anxious in nature and she was grown up in a restricted family. At that time, her mother had a dictatorship attitude. In her childhood, she was not a caring child. Her problems were started due to her mother's negative attitude and carelessness. She did not mix with others and avoided social relationships and social interaction. She took bath several times and also took more times because of the fear of contamination. The client had some behavioural problems such as pulling own hair from scalp, acts of self-damage or self-mutilation-picking skin. Furthermore, she got married without informing her family. So that she had always irritating mood and she was frustrated about her husband's job status. The client and her husband did not live together and her husband did not give her enough time. But the client was always missing her husband very much. She also loved her husband very much. When she was

feeling anxious about her distorted family attitude and her husband's deprivation, the above problems occurred.

Family and Personal history:

Family history: According to the client, her parents were still alive. Her father was a businessman, aged 65 and his educational level was B.A. Her mother was a house wife, aged 60 and her educational level was MS. The client had two younger brothers and one elder sister, aged 32, 18 and 15 respectively and their educational level was MS, S.S.C and class eight. Her elder sister was unmarried. The client's husband was a medical representative, aged 29 and he was a graduate.

Birth history: The client had no birth complication and she was a normal born child.

Schooling and education: The client was a medium category student from early age. In 1998, she passed S.S.C exam with first division and in 2000, she passed H.S.C exam with second division. In 2001, the client was admitted in honours course in biochemistry in a reputed College in Dhaka city but due to her mental disorder she had failed twice. As a result, her admission was cancelled. After that she was admitted in private BA course in a well known College. Now she had no concentration at all.

Marital history: In 2008, December, the client got married but her she did not inform her family about marriage. But her in laws was informed about her marriage.

Past medical history: For this problem she took medicine seven years ago.

Relationship among family members: Her relationships among all family members were not good. She did not talk with other family members for a long time ago. She said that her relationship among family members were not normal.

Family history of mental illness: Her parents, sister and younger brothers had OCD problems.

Pre, mid, post and follow-up assessment result of the problems

A. Findings based on Interview and Observation:

Mrs. B-7's problems in different areas (Cognitive, emotional, physiological, behavioural, social and occupational) are presented in Table no-2.14.2.

Table no-2.14.2: Problems mentioned in pre-assessment and reduction/ improvement/ increase of problems found during mid, post and follow-up assessment.

Category	Problems found during Pre-assessment	Reduction/ improvement/ increase of the problem in Mid-assessment	Reduction/ Improvement/ increase of the problem in Post-assessment	Reduction/ improvement/ increase of the problem in Follow-up assessment
Cognitive	I am contaminated with dirt and germs, became ill from contaminated; excessive fear and preoccupation with avoiding dirt (100%)	Not reduced	Not reduced	Not reduced
	Life is worthless and she is a sick person	Not reduced	Not reduced	Not reduced
	Lack of concentration	Not increased	Increased a little bit	Increased up to 15%
	Low self esteem	Not increased	Not increased	Not increased
	Decision making capacity was extremely reduced	Not increased	Not increased	Not increased
Emotional	Lack of confidence	Not increased	Increased up to 5%	Increased up to 5%
	Felt, fear, anger, hopeless, sad, worthless, distressed and restless (95%)	Reduced up to 5%	Reduced up to 10%	Reduced up to 10%
Physiological	Chest pain (40%), abdomen pain (100%),	Reduced up to 20% and 50%	Reduced up to 25% and 70%	Reduced up to 35% and 75%
	Palpitation, sleep difficulties	Reduced up to 5% and 10%	Reduced up to 15% and 40%	Reduced up to 25% and 45%
	Appetite increased (100%)	Decreased (10%)	Decreased (10%)	Decreased (10%)
	Weakness, irritated and vulnerable	Not reduced	Reduced a little bit	Reduced a little bit
Behavioural	Excessive, illogical and uncontrollable repeated	Not reduced	Not reduced	Not reduced

	hand, plate, pot, floor, cloth washing (100%) and bathing (60%) often performed in a ritualistic way, avoiding places feared for possible contamination			
	Decreased activity level	Not increased	Not increased	Not increased
	Withdrawal from social activity	Not increased	Not increased	Not increased
	Non assertive	Not reduced	Not reduced	Not reduced
	Pulling own hair from scalp (100%), acts of self-damage or self-mutilation-picking skin (100%), doing certain activities in a particular number of times (100%)	Not reduced	Reduced up to 10%	Reduced up to 10%
Social	Social interaction was disrupted very much (100%).	Not increased significantly	Not increased significantly	Not increased significantly
	She can not mix with relatives, neighbors, friends and class mates	Not increased significantly	Not increased significantly	Not increased significantly
	Annoyed with family members (100%)	Not reduced	Reduced up to 10%	Reduced up to 5%
Occupational	Not interest about her study and house hold activities (100%)	Not increased	Increased up to 10%	Increased up to 10%
	Her attention span and body strength was reduced significantly	Not increased	Not increased significantly	Not increased significantly
Observation	She came with her younger brother by wearing a religious dress up and her appearance and behaviour appeared to be culturally appropriate	Came..... appropriate	Came..... appropriate	Came..... appropriate
	Her minimum eye contact was present and she was looking very sad and anxious	Minimum	Normal	Normal
	Her body posture and body movement and amount of speeches were normal	Normal	She was exchanging her body posture in front side and back side continuously	Normal
	Her mood was low and she felt restlessness	Low and restlessness	Low and restlessness	Low and restlessness

B. Objective rating of Mrs. B-7:

Scores of AS, DS and DUOCS are displayed at Table no-2.14.3.

Table no-2.14.3: General trend of objective score of Mrs. B-7

	Anxiety Score	Depression Score	OCD Score
Pre-assessment	95 (Profound)	90 (Minimal)	58 (Profound)
Mid-assessment	52 (Mild)	102 (Mild)	49 (Severe)
Post-assessment	90 (Profound)	126 (Severe)	51 (Profound)
1st Follow- up	87 (Profound)	124 (Severe)	50 (Profound)
2nd Follow- up	90 (Profound)	126 (Severe)	52 (Profound)
3rd Follow- up	76 (Severe)	110 (Mild)	49 (Severe)

C. Subjective rating of Mrs. B-7:

Ratings of the verbal scale are displayed at Table no-2.14.4.

Table no-2.14.4: General trend of subjective rating of Mrs. B-7

	Client's Subjective Rating Score	Care giver's Subjective Rating Score
Pre-assessment	7	7
Mid-assessment	8	
Post-assessment	7	7
1st Follow- up	7	
2nd Follow- up	7.5	
3rd Follow- up	8	8

Responsible Psychiatrist's comments:

At the last and follow-up session the responsible psychiatrist talked to Mrs. B-7. According to the psychiatrist evaluation/ remarks, she is still passing through emotional instability, rituals are persisting with ups and down. Trichotillomania is mostly controlled. Finally, the responsible psychiatrist reported 40-45% as improvement rating feedback.

Part-II: Presentation of findings in Tables and Graphs

Table no-2.15.1: Summary of Pre-assessment of group A & B

Category	Group-A	Group-B
Cognition	I am contaminated with dirt and germs, touching animals; became ill from contaminated (4 of 7);	I am contaminated with dirt and germs, touching animals and insects; touching dustbin, poor people, tree leafs, handshake with other and touching football; becoming ill from contaminated; excessive fear and preoccupation with avoiding dirt and germs; life is meaningless and worthless, world is dusty, life is finished and future is dark (6 of 7);
	I must do my work certain numbers, if I can not bad things will happen (5 of 7);	Avoiding insects, mosquito; easily bothered by certain sounds; intrusive nonsense sounds; nobody understands pain and nobody loves him/her; unwanted, worrisome and intrusive sexual thoughts and impulses (95%); thoughts about being or becoming a homosexual (95%); I am not a good student; I will not success my life; excessive fear, worry and preoccupation: having blasphemous thoughts; being punished for blasphemous thoughts, had no memory and quality; not qualified student; had a suicidal ideation and two times attempted to suicide with sleeping pill; bad things will happen as bad as doing so (90%); going to die, has a big disease and doing something embarrassing -95% (1 of 7);
	Nobody understand my pain, life is meaningless and worthless, world is dusty, life is finished, future is dark (6 of 7);	Lack of concentration and decision making capacity was extremely reduced and self esteem was low (7 of 7);
	Lack of concentration, difficulty in making decision, low self esteem (7 of 7);	When talks and play with other, will be contaminated; can not speak well; brain is going to be decrease slowly (2 of 7);
	Reassurance seeking behaviour; speaks alone; had no quality; My head has a bad thing; My head has another head (2 of 7);	

	If I go one step then I back two steps, I must getup the chair from the same side, if I can not do that danger will happen; I am concern with religious beliefs; hopeless about marital life; soap water going to abdomen and became sick and burning sensation felt all abdomen; can not touch children, wardrobe, bed, sofa set, window, door etc because of insects poison; all time advertisement and music was running my head, I will fail my exams; suicidal ideation; urge to collect useless things; preoccupation with symmetry, exactness and order; excessive concern with aligning papers, books, cloths, bag, toys, show pieces, household materials and other items a certain perfect way; preoccupation and excessive, illogical fear of harming self, harming fathers; doing something embarrassing; worry about losing things; worry about fathers remarriage (1 of 7);	
Emotion	Felt fear (6 of 7); hopeless, sad, worthless, distressed, restless, confused and vulnerable (7 of 7);	Felt lack of confidence 90-100%; fear, hopeless, sad, worthless, distressed, restless (7 of 7);
	Guilt feeling; no interest to do anything (2 of 7); irritated (4 of 7); frustrated about life; crying spell; hot tempered (1 of 7);	Guilt feeling (3 of 7); irritated (5 of 7); vulnerable; had no motivation and interest to do anything (4 of 7); crying spell, confused and anger (2 of 7);
Physiology	Drowsiness, palpitation, sweating, sleep difficulties, reduced appetite, dryness of throat, headache and loss of energy (7 of 7);	Drowsiness and vomiting tendency (3 of 7); palpitation, sleep difficulties, low appetite (7 of 7);
	Burning sensation all over the body (3 of 7); weight gradually reduced (2 of 7);	Excessive sweating, headache and loss of energy (5 of 7);
	Jerking all over the body, hot and pain in abdomen, dehydrations problem, felt	Dryness of throat, burning sensation all over the body and hot flushes in head (4 of 7);

	weak, hand and body tremor (1 of 7);	Hand and leg tremor, pain and burning sensation in the scalp (80%);
		Pain sensation in leg, chest pain (40%) and abdomen pain (1 of 7); weakness (6 of 7);
Behavioural response	Repeated washing, often performed in a ritualistic way (4 of 7);	Excessive, illogical and uncontrollable repeated cloth, doors, windows, balcony, lone, sandal, mobile, bag, money bag, tap, hand, plate, pot, floor etc. washing, often performed in a ritualistic way (5 of 7);
	Avoiding places feared for possible contamination, repeated showering or bathing (3 of 7);	Showering or bathing, often performed in a ritualistic way (4 of 7);
	Decreased activity level, withdrawal from social activity, lowered activity, non assertive (7 of 7);	Avoiding places such as toilet, dustbin, shoe self, others house, drain etc. feared for possible contamination (5 of 7);
	Repeating and rereading things (2 of 7);	Decreased activity level, withdrawal from social activity, non assertive (7 of 7);
	Checking stoves, locks, food pot, fan switches, windows over and over and doing certain activities in a particular number of times (6 of 7);	Rereading things, crying spell, pulling own hair from scalp, acts of self-damage or self-mutilation-picking skin -100% (1 of 7);
	Counting tiles, no quality of stage performance at all; writing often performed in a ritualistic way; bathing several time; can not bathing through a month: cleaning objects and household items by using with special cleansers and cleaning techniques; avoidance of objects considered contaminated; preoccupation with symmetry, exactness or order and doing certain activities in a particular number of times (1 of 7);	Doing certain activities in a particular number of times (6 of 7);
		Excessive, illogical and uncontrollable repeated checking stoves, tap, locks, fan and television switches, checking under door, bed, almira, midself, pen, pot, admit card and file over and over (4 of 7);

Social position	Disrupted social interaction decreased relationship with neighbors, relatives and family members (7 of 7);	Disrupted social interaction 90-100% (7 of 7),
	Annoyed with family members and decreased relationship with customers (1 of 7);	Decreased relationship with neighbors, relatives and family members (6 of 7);
		Can not talk and mix with other people (5 of 7);
		Annoyed with family members (2 of 7);
Occupational condition	Poor business and job performance (4 of 7);	Job loses (1 of 7);
	Decreased relationship with colleagues (5 of 7);	Had no interest about job and attention span and body strength reduced significantly (7 of 7);
	Lack of concentration about business task, lack of interest, decreased level of interest, reduced attention span and reduced body strength (7 of 7);	Had no interest about household activities (2 of 7);
	Can not do any household activities (2 of 7);	
	Decreased relationship with class mates and teachers; lack of concentration about study and loss of memory (1 of 7);	

Table no-2.15.1 shows the major symptoms that were found in the pre-assessment in different categories. The content that was frequently reported by the client was kept under each category. From the cognition, it was seen that almost all of the clients perceived their life as contaminated, polluted, dusty, meaningless, worthless, dark and finished. In the emotional symptoms, all of the clients of both groups had negative emotion. Anxious mood was prominent to all of the both groups of client. They also felt depressed, hopelessness, fear, worthlessness, irritated, guilt feeling, distressed, vulnerable and restlessness. In the physical reaction, all of clients of both groups had common complaints as palpitation, sweating, sleep difficulties, reduced appetite, dryness of throat and headache. They also have some complaints such as hot flushes and burning sensation all over the body, hand tremor and loss of energy. In the behavioural response categories, almost all of the clients of both groups had behavioural problem as repeated

washing, avoiding places feared for possible contamination, crying spell, decreased activity level, withdrawal from social activity, lowered activity, non assertive, seeking reassurance, repeated showering or bathing, repeating and rereading things, checking some aspects over and over, doing certain activities in a particular number of times, cleaning of the house in a ritualistic way. In the social position categories, all of the client's social position had changed such as disrupted social interaction, decreased relationship with neighbors, relatives, family members and friends. In the occupational condition categories, all of the clients had some problem as poor job performance, decreased relationship with colleagues, lack of interest, decreased level of interest, reduced attention span and reduced body strength.

Table no-2.15.2: Summary of Mid-assessment of group A & B

Category	Group-A	Group-B
Cognition	I am contaminated with dirt and germs, touching animals; becoming ill from contaminated (4 of 7) reduced up to 20 to 50%;	I am contaminated with dirt and germs, touching animals and insects; touching dustbin, poor people, tree leafs, handshake with other and touching football; becoming ill from contaminated; excessive fear and preoccupation with avoiding dirt and germs; life is meaningless and worthless, world is dusty, life is finished and future is dark (6 of 7) reduced a little bit up to 10%;
	I must do the work certain numbers, if I can not bad things will happen (5 of 7) reduced up to 10 to 70%;	Avoiding insects, mosquito; easily bothered by certain sounds; intrusive nonsense sounds not reduced (100%);
	Nobody understand my pain, life is meaningless and worthless, world is dusty, life is finished, future is dark (6 of 7) reduced up to 10 to 50%;	Nobody understands pain and nobody loves him/her now a day;
	Concentration level, decision making capacity and self esteem (7 of 7) increased up to 10 to 60%,	Unwanted, worrisome and intrusive sexual thoughts and impulses; thoughts about being or becoming a homosexual not reduced;
	Reassurance seeking behaviour (2 of 7) reduced up to 10%;	I am not a good student; I will not success my life reduced a little bit;
	Speaks alone; had no quality; My	Excessive fear, worry and

	head has a bad thing; My head has another head (2 of 7) reduced up to 70%;	preoccupation: having blasphemous thoughts; being punished for blasphemous thoughts were not reduced;
	"If I go one step then I back two steps, I must getup the chair from the same side, if I cant do the danger will happen" reduced up to 70%;	
	Hopeless about marital life reduced a little bit;	Had no memory and quality; not qualified student not reduced;
	She can touch children, wardrobe, bed, sofa set, window, door etc sometimes; all time advertisement and music was running my head reduced up to 55%;	Suicidal ideation reduced and he did not suicidal attempt now a day; bad things will happen as bad as doing so (90%) not reduced; going to die, has a big disease and doing something embarrassing -95% (1 of 7) were reduced a little bit up to 20%.
	Now a day he had no suicidal ideation; urge to collect useless things reduced up to 40%;	Concentration level and decision making capacity were not improved significantly and his self esteem was low also (7 of 7);
	Preoccupation with symmetry, exactness and order; excessive concern with aligning papers, books, cloths, bag, toys, show pieces, household materials and other items a certain perfect way reduced up to 20%;	When talks and play with other, will be contaminated; can not speak well not reduced; brain is going to be decrease slowly (2 of 7) reduced a little bit;
	Preoccupation and excessive, illogical fear of harming self, harming fathers reduced up to 50%;	
	Doing something embarrassing reduced a little bit; worry about losing things; worry about fathers remarriage not reduced;	
	She is going to die and fear to die reduced up to 40%; her feelings of senseless and loss of memory reduced up to 10%; "I am a bad looking person, everybody laughed to seem me" reduced up to 60%; "I have a bad disease", "I wish I will die" reduced up to 5%; "I have no rest, no satisfaction and seen many scenery in my brain when sleeping not reduced significantly; his income related thought were reduced up to	

	10% but he believe that he had a poor brain, his disease and medicine related thoughts were reduced up to 15%, I have a skin disease due to using soap reduced up to 20%;	
Emotion	Felt fear (6 of 7) hopeless, sad, worthless, distressed, restless, confused and vulnerable (7 of 7); irritated (4 of 7) reduced up to 15 to 50%;	Confidence level increased up to 5 to 10%; fear, hopeless, sad, worthless, distressed, restless (7 of 7) were reduced a little bit;
	Guilt feeling; no interest to do anything (2 of 7) now days; frustrated about life; crying spell; hot tempered (1 of 7) reduced a little bit;	Guilt feeling (3 of 7); irritated (5 of 7); vulnerable were not reduced; motivation level and interest to do anything (4 of 7) not increased significantly; crying spell also, confused and anger (2 of 7) not reduced;
Physiology	Drowsiness, palpitation, sweating, sleep difficulties, dryness of throat and headache (7 of 7) reduced up to10 to 50%;	Drowsiness reduced up to 5 to 10% and vomiting tendency (3 of 7) reduced up to 5%;
	Appetite pattern and energy level (7 of 7) increased up to10 to 50%;	Palpitation, sleep difficulties, low appetite (7 of 7) reduced up to 5 to 20%;
	Burning sensation all over the body (3 of 7) reduced up to 10 to 40%;	Excessive sweating reduced a little bit up to 20%, headache reduced up to 5 to 20% and energy level (5 of 7) increased a little bit;
	Jerking all over the body reduced up to 30%;	Dryness of throat reduced up to 20%, burning sensation all over the body and hot flushes in head (4 of 7) reduced up to 30%;
	Hot and pain in abdomen, dehydrations problem reduced up to 20%;	Hand and leg tremor; pain and burning sensation in the scalp reduced up to 10%;
		Pain sensation in leg not reduced; chest pain reduced up to 15 to 20%; and abdomen pain (1 of 7) reduced up 50%; weakness (6 of 7) not reduced;
Behaviour al response	Repeated washing, often performed in a ritualistic way (4 of 7) reduced up to 15 to 80%;	Excessive, illogical and uncontrollable repeated cloth, doors, windows, balcony, lone, sandal, mobile, bag, money bag, tap, hand, plate, pot, floor etc. washing, often performed in a ritualistic way (5 of 7) not reduced significantly;

	Avoiding places feared for possible contamination (3 of 7) reduced up to 5 to 55%,	Showering or bathing, often performed in a ritualistic way (4 of 7) not reduced;
	Repeated showering or bathing (3 of 7) reduced up to 25 to 40%;	Avoiding places such as toilet, dustbin, shoe self, others house, drain etc. feared for possible contamination (5 of 7) not reduced;
	Activity level (7 of 7) increased up to 5 to 50%;	Activity level not increased at all; withdraw from social activity now a day (100%); assertiveness problems (7 of 7) not reduced;
	Repeating and rereading things (2 of 7) reduced up to 15 to 40%;	Rereading things, crying spell, pulling own hair from scalp, acts of self-damage or self-mutilation-picking skin (1 of 7) not reduced;
	Checking stoves, locks, food pot, fan switches, windows over and over and doing certain activities in a particular number of times (6 of 7) reduced up to 10 to 50%;	Doing certain activities in a particular number of times (6 of 7) not reduced;
	Counting tiles reduced up to 80%;	Excessive, illogical and uncontrollable repeated checking stoves, tap, locks, fan and television switches, checking under door, bed, almira, midself, pen, pot, admit card and file over and over (4 of 7) not reduced significantly;
	Stage performance not improved; writing often performed in a ritualistic way now a day; she can bathing once a day; cleaning objects and household items by using with special cleansers and cleaning techniques not reduced; avoidance of objects considered contaminated reduced up to 20%;	Avoids social gathering now a day up to 80%;
	Preoccupation with symmetry, exactness or order (1 of 7) reduced up to 40%;	
	Withdraw from social activity (7 of 7) now days; assertiveness problems (7 of 7) not removed;	
Social position	Social interaction increased a little bit; relationship with neighbors, relatives and family members (7 of 7) increased up to 10 to 50%;	Social interaction (7 of 7) not increased significantly;
	Now a day she annoyed with her	Relationship with neighbors,

	father 50% and increased relationship with customers (1 of 7) a little bit;	relatives and family members (6 of 7) were not improved; can not talk and mix with other people (5 of 7) now days; annoyed with family members (2 of 7) now a day;
Occupational condition	Business and job performance (4 of 7) increased up to 15%;	Job loses (1 of 7); had no interest about job now a day but attention span and body strength (7 of 7) increased up to 10%; had no interest about household activities (2 of 7) now a day;
	Relationship with colleagues (5 of 7) increased up to 20 to 30%;	
	Concentration about business task not increased, attention span and body strength (7 of 7) increased up to 20%;	
	Can do some household activities (2 of 7); relationship with class mates and teachers also not increased; lack of concentration about study (1 of 7) increased up to 45%;	

Table no-2.15.2 contains the significant content of the both groups of client in their mid-assessment session and the content of the both groups of clients has been changed compared to the pre-assessment.

Table no-2.15.3: Summary of Post-assessment of group A & B

Category	Group-A	Group-B
Cognition	I am contaminated with dirt and germs, touching animals; becoming ill from contaminated (4 of 7) reduced up to 50 to 100%;	I am contaminated with dirt and germs, touching animals and insects; touching dustbin, poor people, tree leafs, handshake with other and touching football; becoming ill from contaminated; excessive fear and preoccupation with avoiding dirt and germs; life is meaningless and worthless, world is dusty, life is finished and future is dark (6 of 7) reduced a little bit up to 10%;
	I must do the work certain numbers, if I can not bad things will happen (5 of 7) reduced up to 80 to 100%;	Avoiding insects, mosquito; easily bothered by certain sounds; intrusive nonsense sounds not reduced (100%);
	Nobody understand my pain, life is meaningless and worthless,	Nobody understands pain and nobody loves him/her now a day;

	world is dusty, life is finished, future is dark (6 of 7) reduced up to 50 to 70%;	
	Concentration level, decision making capacity and self esteem (7 of 7) increased up to 30 to 90%;	Unwanted, worrisome and intrusive sexual thoughts and impulses; thoughts about being or becoming a homosexual not reduced;
	Reassurance seeking behaviour (2 of 7) reduced up to 50%;	I am not a good student; I will not success my life reduced up to 10%;
	Speaks alone; had no quality; My head has a bad thing; My head has another head (2 of 7) reduced up to 70%;	Excessive fear, worry and preoccupation: having blasphemous thoughts; being punished for blasphemous thoughts were not reduced;
	"If I go one step then I back two steps, I must getup the chair from the same side, if I cant do the danger will happen" reduced up to 99%;	Had no memory and quality; not qualified student not reduced;
	Hopeful about marital life;	Suicidal ideation reduced and he did not suicidal attempt now a day; bad things will happen as bad as doing so (90%) not reduced; going to die, has a big disease and doing something embarrassing -95% (1 of 7) were reduced a little bit up to 20%.
	She can touches children, wardrobe, bed, sofa set, window, door etc sometimes 50%; all time advertisement and music was running my head reduced up to 85%;	When talks and play with other, will be contaminated; can not speak well not reduced; brain is going to be decrease slowly (2 of 7) reduced a little bit;
	Suicidal ideation reduced up to 100%;	Concentration level not increased significantly and decision making capacity was increased a little bit and his self esteem was low also (7 of 7);
	Urge to collect useless things reduced up to 65%;	
	Preoccupation with symmetry, exactness and order; excessive concern with aligning papers, books, cloths, bag, toys, show pieces, household materials and other items a certain perfect way reduced up to 60%;	

	Preoccupation and excessive, illogical fear of harming self, harming fathers reduced up to 80%;	
	Doing something embarrassing reduced up to 50%; worry about losing things; worry about fathers remarriage reduced up to 80%;	
	She is going to die and fear to die reduced up to 50% to 80%; "I am a bad looking person, everybody laughed to seem me" reduced up to 70%; "I have a bad disease", "I wish I will die" reduced up to 50%; "I have no rest, no satisfaction and seen many scenery in my brain when sleeping not reduced significantly; his income related thought were reduced up to 30%; he believe that he had a brain but not good brain than other people, his disease and medicine related thoughts were reduced up to 30%; I have a skin disease due to using soap reduced up to 40%;	
Emotion	Felt fear (6 of 7) hopeless, sad, worthless, distressed, restless, confused and vulnerable (7 of 7); irritated (4 of 7) reduced up to 25 to 100%;	Confidence level increased up to 5 to 10%; fear, hopeless, sad, worthless, distressed, restless (7 of 7) were reduced up to 5 to10%;
	Guilt feeling now days; interest to do something (2 of 7) now days; now she cooks food and take care for her family; frustrated about life reduced; crying spell; hot tempered (1 of 7) reduced up to 60%;	Guilt feeling (3 of 7); irritated (5 of 7); vulnerable were up to 5 to10%; had a little bit motivation and interest to reading (4 of 7) now a day; crying spell also, confused and anger (2 of 7) not reduced;
Physiology	Drowsiness, palpitation, sweating, sleep difficulties, dryness of throat and headache (7 of 7) reduced up to 40 to 90%;	Drowsiness reduced up to up to 20% and vomiting tendency (3 of 7) reduced up to 50%;
	Appetite pattern and energy level (7 of 7) increased up to 50 to 100%;	Palpitation, sleep difficulties, low appetite (7 of 7) reduced up to 20 to 40%;
	Burning sensation all over the body (3 of 7) reduced up to 50 to 75%;	Excessive sweating reduced a little bit up to 20%, headache reduced up 20% and energy level (5 of 7) increased a little bit;

	Jerking all over the body reduced up to 40%;	Dryness of throat reduced up to 20%, burning sensation all over the body and hot flushes in head (4 of 7) reduced up to 30%;
	Hot and pain in abdomen, dehydrations problem reduced up to 40%;	Hand and leg tremor; pain and burning sensation in the scalp reduced up to 30%;
		Pain sensation in leg reduced up to 35%; chest pain reduced up to 25%; and abdomen pain (1 of 7) reduced up 70%; weakness (6 of 7) reduced a little bit;
Behavioural response	Repeated washing, often performed in a ritualistic way (4 of 7) reduced up to 50 to 100%;	Excessive, illogical and uncontrollable repeated cloth, doors, windows, balcony, lone, sandal, mobile, bag, money bag, tap, hand, plate, pot, floor etc. washing, often performed in a ritualistic way (5 of 7) not reduced significantly;
	Avoiding places feared for possible contamination (3 of 7) reduced up to 50 to 70%;	Showering or bathing, often performed in a ritualistic way (4 of 7) not reduced;
	Repeated showering or bathing (3 of 7) reduced up to 20 to 100%;	Avoiding places such as toilet, dustbin, shoe self, others house, drain etc. feared for possible contamination (5 of 7) reduced a little bit up to 10%;
	Activity level (7 of 7) increased up to 20 to 80%;	Increased activity level up to 15 to 20% but withdraw from social activity now a day; assertiveness problems (7 of 7) were not reduced;
	Repeating and rereading things (2 of 7) reduced up to 100%;	Rereading things, crying spell, pulling own hair from scalp, acts of self-damage or self-mutilation-picking skin (1 of 7) not reduced;
	Checking stoves, locks, food pot, fan switches, windows over and over and doing certain activities in a particular number of times (6 of 7) reduced up to 50 to 100%;	Doing certain activities in a particular number of times (6 of 7) not reduced;
	Counting tiles reduced up to 100%;	Excessive, illogical and uncontrollable repeated checking stoves, tap, locks, fan and television switches, checking under door, bed, almira, midself, pen, pot, admit card and file over and over (4 of 7) reduced up to 10%;

	Stage performance improved; writing often performed in a ritualistic way sometimes; she can bathing once a day; cleaning objects and household items by using with special cleansers and cleaning techniques not reduced; avoidance of objects considered contaminated reduced up to 60%;	Avoids social gathering now a day up to 80%;
	Preoccupation with symmetry, exactness or order (1 of 7) reduced up to 30%;	
	Withdraw from social activity (7 of 7) now days; assertiveness problems (7 of 7) not removed significantly;	
Social position	Social interaction increased up to 40 to 60%; relationship with neighbors, relatives and family members (7 of 7) increased up to 55 to 100%;	Social interaction (7 of 7) was improved a little bit up to 10%;
	Now a day she annoyed with her father 10% and increased relationship with customers (1 of 7) up to 50%;	Relationship with neighbors, relatives and family members (6 of 7) were not improved; can not talk and mix with other people (5 of 7) now days; annoyed with family members (2 of 7) now a day ;
Occupational condition	Business and job performance (4 of 7) increased up to 55%;	Now jobless for his problem (1 of 7); had no interest about job now a day but attention span and body strength (7 of 7) increased up to 15%; had no interest about household activities (2 of 7) now a day;
	Relationship with colleagues, friends and family members (5 of 7) increased up to 40 to 70%;	
	Concentration about business task increased up to 50 to 65%; attention span and body strength (7 of 7) increased up to 60%;	
	Can do some household activities (2 of 7); relationship with class mates and teachers also increased a little bit; lack of concentration about study (1 of 7) increased up to 45%;	

Table no-2.15.3 contains the significant content of the both groups of client in their post-assessment session and the content of the both groups of clients has been changed compared to the mid-assessment.

Table no-2.15.4: Summary of Follow-up assessment of group A & B

Category	Group-A	Group-B
Cognition	I am contaminated with dirt and germs, touching animals; becoming ill from contaminated (4 of 7) reduced up to 80 to 100%;	I am contaminated with dirt and germs, touching animals and insects; touching dustbin, poor people, tree leafs, handshake with other and touching football; becoming ill from contaminated; excessive fear and preoccupation with avoiding dirt and germs; life is meaningless and worthless, world is dusty, life is finished and future is dark (6 of 7) reduced a little bit up to 10%;
	I must do the work certain numbers, if I can not bad things will happen (5 of 7) reduced up to 80 to 100%;	Avoiding insects, mosquito; easily bothered by certain sounds; intrusive nonsense sounds not reduced (100%);
	Nobody understand my pain, life is meaningless and worthless, world is dusty, life is finished, future is dark (6 of 7) reduced up to 75 to 85%;	Nobody understands pain and nobody loves him/her now a day;
	Concentration level increased up to 50 to 85%; decision making capacity increased up to 60 to 70%; and self esteem (7 of 7) increased up to 50 to 90%;	Unwanted, worrisome and intrusive sexual thoughts and impulses; thoughts about being or becoming a homosexual not reduced;
	Reassurance seeking behaviour (2 of 7) reduced up to 70% to 80%;	I am not a good student; I will not success my life reduced up to 15%;
	Speaks alone; had no quality; My head has a bad thing; My head has another head (2 of 7) reduced up to 75 to 90%;	Excessive fear, worry and preoccupation: having blasphemous thoughts; being punished for blasphemous thoughts were not reduced;
	"If I go one step then I back two steps, I must getup the chair from the same side, if I cant do the danger will happen" reduced up to 99%;	Had no memory and quality; not qualified student not reduced;
	Hopeful about marital life;	Suicidal ideation reduced and he did not suicidal attempt now a day; bad things will happen as bad as doing so (90%) not reduced; going to die, has a big disease and doing something embarrassing -95% (1 of 7) were reduced a little bit up to 20%;

	She can touches children, wardrobe, bed, sofa set, window, door etc sometimes 50%; all time advertisement and music was running my head reduced up to 100%;	Concentration level increased up to 25% and decision making capacity increased a little bit up to 15% and his self esteem was low also (7 of 7);
	Suicidal ideation reduced up to 100%;	When talks and play with other, will be contaminated; can not speak well not reduced; brain is going to be decrease slowly (2 of 7) reduced a little bit;
	Urge to collect useless things reduced up to 75%;	
	Preoccupation with symmetry, exactness and order; excessive concern with aligning papers, books, cloths, bag, toys, show pieces, household materials and other items a certain perfect way reduced up to 90%;	
	Preoccupation and excessive, illogical fear of harming self, harming fathers reduced up to 100%;	
	Doing something embarrassing reduced up to 80%; worry about losing things; worry about fathers remarriage reduced up to 90%;	
	She is going to die and fear to die reduced up to 90%; "I am a bad looking person, everybody laughed to seem me" reduced up to 80%; "I have a bad disease", "I wish I will die" reduced up to 90%; "I have no rest, no satisfaction and seen many scenery in my brain when sleeping not reduced significantly; his income related thought were reduced up to 30%; he believe that he had a brain but not good brain than other people, his disease and medicine related thoughts were reduced up to 30%; I have a skin disease due to using soap reduced up to 40%.	
Emotion	Felt fear (6 of 7) reduced up to	Confidence level increased up to 5

	60 to 95%; hopeless, sad, worthless, distressed, restless, confused and vulnerable (7 of 7); irritated (4 of 7) reduced up to 25 to 100%;	to 10%; fear, hopeless, sad, worthless, distressed, restless (7 of 7) were reduced up to 5 to10%;
	Guilt feeling reduced now days; interest to do something (2 of 7) now days; now she cooks food and take care for her family; frustrated about life reduced; crying spell; hot tempered (1 of 7) reduced up to 80%;	Guilt feeling (3 of 7); irritated (5 of 7); vulnerable were up to 5 to10%; had a little bit motivation and interest to reading (4 of 7) now a day; crying spell also, confused and anger (2 of 7) not reduced;
Physiology	Drowsiness, palpitation, sweating, sleep difficulties, dryness of throat and headache (7 of 7) reduced up to 75 to 80%;	Drowsiness reduced up to up to 30 to 40% and vomiting tendency (3 of 7) reduced up to 70%;
	Appetite pattern and energy level (7 of 7) increased up to 90 to 100%;	Palpitation, sleep difficulties, low appetite (7 of 7) reduced up to 20 to 85%;
	Burning sensation all over the body (3 of 7) reduced up to 75 to 80%;	Excessive sweating reduced a little bit up to 30 to 40%; headache reduced up 30% and energy level (5 of 7) increased a little bit;
	Jerking all over the body reduced up to 80%;	Dryness of throat reduced up to 20%, burning sensation all over the body and hot flushes in head (4 of 7) reduced up to 30 to 35%;
	Hot and pain in abdomen, dehydrations problem reduced up to 80%;	Hand and leg tremor; pain and burning sensation in the scalp reduced up to 30%;
		Pain sensation in leg reduced up to 55%; chest pain reduced up to 35%; and abdomen pain (1 of 7) reduced up 75%; weakness (6 of 7) reduced a little bit;
Behavioural response	Repeated washing, often performed in a ritualistic way (4 of 7) reduced up to 85 to 100%;	Excessive, illogical and uncontrollable repeated cloth, doors, windows, balcony, lone, sandal, mobile, bag, money bag, tap, hand, plate, pot, floor etc. washing, often performed in a ritualistic way (5 of 7) not reduced significantly;
	Avoiding places feared for possible contamination (3 of 7) reduced up to 60 to 90%;	Showering or bathing, often performed in a ritualistic way (4 of 7) not reduced;
	Repeated showering or bathing (3 of 7) reduced up to 85 to	Avoiding places such as toilet, dustbin, shoe self, others house,

	100%;	drain etc. feared for possible contamination (5 of 7) reduced a little bit up to 10%;
	Activity level (7 of 7) increased up to 45 to 85%;	Increased activity level up to 15 to 25% but withdraw from social activity now a day; assertiveness problems (7 of 7) were not reduced;
	Repeating and rereading things (2 of 7) reduced up to 100%;	Rereading things, crying spell, pulling own hair from scalp, acts of self-damage or self-mutilation-picking skin (1 of 7) reduced up to 10%;
	Checking stoves, locks, food pot, fan switches, windows over and over and doing certain activities in a particular number of times (6 of 7) reduced up to 70 to 100%;	Doing certain activities in a particular number of times (6 of 7) not reduced;
	Counting tiles reduced up to 100%;	Excessive, illogical and uncontrollable repeated checking stoves, tap, locks, fan and television switches, checking under door, bed, almira, midself, pen, pot, admit card and file over and over (4 of 7) reduced up to 10%;
	Stage performance improved; writing often performed in a ritualistic way sometimes; she can bathing once a day; cleaning objects and household items by using with special cleansers and cleaning techniques reduced 100%; avoidance of objects considered contaminated reduced up to 90%;	Avoids social gathering now a day up to 80%;
	Preoccupation with symmetry, exactness or order (1 of 7) reduced up to 70%;	
	Withdraw from social activity (7 of 7) now days; assertiveness problems (7 of 7) reduced up to 35%;	
Social position	Social interaction increased up to 50 to 70%; relationship with neighbors, relatives and family members (7 of 7) increased up to 55 to 100%;	Social interaction (7 of 7) was improved a little bit up to 10%;

	Now a day she annoyed with her father 10% and increased relationship with customers (1 of 7) up to 50%;	Relationship with neighbors, relatives and family members (6 of 7) were not improved; can not talk and mix with other people (5 of 7) now days; had liked to live alone now a day; annoyed with family members (2 of 7) now a day ;
Occupational condition	Business and job performance (4 of 7) increased up to 60 to 75%;	Now jobless for his problem (1 of 7); had no interest about job now a day but attention span and body strength (7 of 7) increased up to 25%; had interest about study now a day but no interest about household activities (2 of 7) now a day;
	Relationship with colleagues, friends and family members (5 of 7) increased up to 50 to 80%;	
	Concentration about business task increased up to 60%; attention span and body strength (7 of 7) increased up to 70%;	
	Now engaged and involved in household activities (2 of 7); relationship with class mates and teachers also increased up to 50%; lack of concentration about study (1 of 7) increased up to 50%;	

Table no-2.15.4 contains the significant content of the both groups of client in their follow-up assessment session and the content of the both groups of clients has been changed compared to the post-assessment.

Comparison of pre, mid, post and follow-up assessment of group A & B

Table no-16: Total number of clients mentioned the problems in pre assessment and percentage of reduction/ increase of problems found in mid, post and follow-up assessment (in terms of cognition)

Group No	Total number of clients mentioned the problems in Pre-assessment	Reduction/increase in Mid-assessment	Reduction/ increase in Post-assessment	Reduction/ increase in Follow-up assessment
Group-A	I am contaminated with dirt and germs, touching animals; became ill from contaminated (4 out of 7)	Reduced up to 20 to 50%	Reduced up to 50 to 100%	Reduced up to 80 to 100%
	I must do the work certain numbers, if I can not bad things will happen (5 out of 7)	Reduced up to 10 to 70%	Reduced up to 80 to 100%	Reduced up to 80 to 100%
	Nobody understand my pain, life is meaningless and worthless, world is dusty, life is finished, future is dark (6 out of 7)	Reduced up to 10 to 50%	Reduced up to 50 to 70%	Reduced up to 75 to 85%
	Lack of concentration, difficulty in making decision, low self esteem (7 out of 7)	Increased up to 10 to 60%	Increased up to 30 to 90%	Increased up to 50 to 90%
	Reassurance seeking behaviour (2 out of 7)	Reduced up to 10%	Reduced up to 50%	Reduced up to 70% to 80%
	Speaks alone; had no quality; My head has a bad thing; My head has another head (2 out of 7)	Reduced up to 70%	Reduced up to 70%	Reduced up to 75 to 90%
	If I go one step then I back two steps, I must getup the chair from the same side, if I can not do that danger will happen(1 out of 7)	Reduced up to 70%	Reduced up to 99%	Reduced up to 99%
	Hopeless about marital life (1 out of 7)	Reduced a little bit	Hopeful about marital life	Hopeful about marital life
	Can not touch children, wardrobe, bed, sofa set, window, door etc because of insects poison; all time advertisement and music was running my head(1 out of 7)	Reduced up to 55%	Reduced up to 85%	Reduced up to 100%
	Suicidal ideation(1 out of 7)	Now a day he had no suicidal ideation	Reduced up to 100%	Reduced up to 100%
	Urge to collect useless things(1 out of 7)	Reduced up to 40%	Reduced up to 65%	Reduced up to 75%

	Preoccupation with symmetry, exactness and order; excessive concern with aligning papers, books, cloths, bag, toys, show pieces, household materials and other items a certain perfect way(1 out of 7)	Reduced up to 20%	Reduced up to 60%	Reduced up to 90%
	Preoccupation and excessive, illogical fear of harming self, harming fathers(1 out of 7)	Reduced up to 50%	Reduced up to 80%	Reduced up to 100%
	Doing something embarrassing; worry about losing things; worry about fathers remarriage (1 out of 7)	Not reduced	Reduced up to 50% and 80%	Reduced up to 80% and 90%
	She is going to die and fear to die(1 out of 7)	Reduced up to 40%	Reduced up to 50% to 80%	Reduced up to 90%
	I am a bad looking person, everybody laughed to seem me (1 out of 7)	Reduced up to 60%	Reduced up to 70%	Reduced up to 80%
	"I have a bad disease", "I wish I will die" (1 out of 7)	Reduced up to 5%	Reduced up to 50%	Reduced up to 90%
	I have no rest, no satisfaction and seen many scenery in my brain when sleeping(1 out of 7)	Not reduced significantly	Not reduced significantly	Not reduced significantly
	I have a skin disease due to using soap(1 out of 7)	Reduced up to 20%	Reduced up to 40%	Reduced up to 40%
Group-B	I am contaminated with dirt and germs, touching animals and insects; touching dustbin, poor people, tree leafs, handshake with other and touching football; became ill from contaminated; excessive fear and preoccupation with avoiding dirt and germs; life is meaningless and worthless, world is dusty, life is finished and future is dark (6 out of 7)	Reduced a little bit up to 10%	Reduced a little bit up to 10%	Reduced a little bit up to 10%
	Avoiding insects, mosquito; easily bothered by certain sounds; intrusive nonsense sounds (1 out of 7)	Not reduced (100%)	Not reduced (100%)	Not reduced (100%)
	Nobody understands pain and nobody loves him/her (1 out of 7)	Nobody understands pain and nobody loves him/her now a day	Nobody understands pain and nobody loves him/her now a day	Nobody understands pain and nobody loves him/her now a day
	Unwanted, worrisome and intrusive sexual thoughts and impulses (95%); thoughts about being or becoming a homosexual (95%) (1	Not reduced	Not reduced	Not reduced

	out of 7)			
	I am not a good student; I will not success my life (1 out of 7)	Reduced a little bit;	Reduced up to 10%;	Reduced up to 15%;
	Excessive fear, worry and preoccupation: having blasphemous thoughts; being punished for blasphemous thoughts (1 out of 7)	Not reduced	Not reduced	Not reduced
	Had no memory and quality; not qualified student (1 out of 7)	Not reduced	Not reduced	Not reduced
	Had a suicidal ideation and two times attempted to suicide with sleeping pill; bad things will happen as bad as doing so (90%) (1 out of 7)	Suicidal ideation reduced and he did not suicidal attempt now a day; bad things will happen as bad as doing so (90%) not reduced	Not reduced	Not reduced
	Going to die, has a serious disease and doing something embarrassing -95% (1 out of 7)	Reduced a little bit up to 20%	Reduced a little bit up to 20%	Reduced a little bit up to 20%
	Lack of concentration and decision making capacity was extremely reduced and self esteem was low (7 out of 7)	Concentration level and decision making capacity were not improved significantly and his self esteem was low also	Concentration level not increased significantly and decision making capacity was increased a little bit and his self esteem was low also	Concentration level increased up to 25% and decision making capacity increased a little bit up to 15% and his self esteem was low also
	When talks and play with other, will be contaminated; can not speak well; brain is going to be decrease slowly (2 out of 7)	Reduced a little bit	Reduced a little bit	Reduced a little bit

Table no-17: Total number of clients mentioned the problems in pre assessment and percentage of reduction/ increase problems found in mid, post and follow-up assessment (in terms of emotional responses)

Group No	Total number of clients mentioned the problems in Pre-assessment	Reduction/ increase in Mid-assessment	Reduction/ increase in Post-assessment	Reduction/increase in Follow-up assessment
Group-A	Felt fear (6 out of 7); hopeless, sad, worthless, distressed, restless, confused and vulnerable (7 out of 7)	Reduced up to 15 to 50%	Reduced up to 25 to 100%	Reduced up to 25 to 100%
	Guilt feeling; no interest to do anything (2 out of 7); irritated (4 out of 7); frustrated about life; crying spell; hot tempered (1 out of 7)	Reduced a little bit	Reduced up to 60%	Reduced up to 80%
Group-B	Felt lack of confidence 90-100% (7 out of 7)	Increased up to 5 to 10%	Increased up to 5 to 10%	Increased up to 5 to 10%
	Fear, hopeless, sad, worthless, distressed, restless (7 out of 7)	Reduced a little bit	Reduced up to 5 to10%	Reduced up to 5 to10%
	Guilt feeling (3 out of 7); irritated (5 out of 7); vulnerable(4 out of 7)	Not reduced	Reduced up to 5 to10%	Reduced up to 5 to10%
	No motivation and interest to do anything (4 out of 7)	Not increased significantly	A little bit motivation and interest to reading (4 of 7) now a day;	A little bit motivation and interest to reading (4 of 7) now a day;
	Crying spell, confused and anger (2 out of 7)	Not reduced	Not reduced	Not reduced

Table no-18: Total number of clients mentioned the problems in pre assessment and percentage of reduction /increase problems found in mid, post and follow-up assessment (in terms of physiological response)

Group No	Total number of clients mentioned the problems in Pre-assessment	Reduction/ increase in Mid-assessment	Reduction/ increase in Post-assessment	Reduction/ increase in Follow-up assessment
Group-A	Drowsiness, palpitation, sweating, sleep difficulties, dryness of throat and headache (7 out of 7)	Reduced up to10 to 50%	Reduced up to 40 to 90%	Reduced up to 75 to 80%
	Reduced appetite and loss of energy (7 out of 7)	Increased up to10 to 50%	Increased up to 50 to 100%	Increased up to 90 to 100%
	Burning sensation all over the body (3 out of 7); weight gradually reduced (2 out of 7)	Reduced up to 10 to 40%	Reduced up to 50 to 75%	Reduced up to 75 to 80%
	Jerking all over the body (1 out of 7)	Reduced up to 30%	Reduced up to 40%	Reduced up to 80%
	Hot and pain in abdomen, dehydrations problem, felt weak, hand and body tremor (1 out of 7)	Reduced up to 20%	Reduced up to 40%	Reduced up to 80%
Group-B	Drowsiness and vomiting tendency (3 out of 7)	Drowsiness reduced up to 5 to 10% and vomiting tendency reduced up to 5%	Reduced up to up to 20% and 50%	Drowsiness reduced up to 30 to 40% and vomiting tendency reduced up to 70%
	Palpitation, sleep difficulties and low appetite (7 out of 7)	Reduced up to 5 to 20%	Reduced up to 20 to 40%	Reduced up to 20 to 85%
	Excessive sweating (5 out of 7)	Reduced a little	Reduced a little	Reduced a little

		bit up to 20%	bit up to 20%	bit up to 30 to 40%
	Headache (5 out of 7)	Reduced up to 5 to 20%	Reduced up 20%	Reduced up 30%
	Loss of energy (5 out of 7)	Increased a little bit	Increased a little bit	Increased a little bit
	Dryness of throat (4 out of 7)	Reduced up to 20%	Reduced up to 20%	Reduced up to 20%
	Burning sensation all over the body and hot flushes in head (4 out of 7)	Reduced up to 30%	Reduced up to 30%	Reduced up to 30 to 35%
	Hand and leg tremor, pain and burning sensation in the scalp -80% (4 out of 7)	Reduced up to 10%	Reduced up to 30%	Reduced up to 30%
	Pain sensation in leg, chest pain -40% (1 out of 7)	Reduced up to 15 to 20%	Reduced up to 35% and 25%	Reduced up to 55% and 35%
	Abdomen pain (1 out of 7)	Reduced up 50%	Reduced up 70%	Reduced up 75%
	Weakness (6 out of 7)	Not reduced	Reduced a little bit	Reduced a little bit

Table no-19: Total number of clients mentioned the problems in pre assessment and percentage of reduction /increase problems found in mid, post and follow-up assessment (in terms of behavioural response)

Group No	Total number of clients mentioned the problems in Pre-assessment	Reduction/ increase in Mid-assessment	Reduction/ increase in Post-assessment	Reduction/ increase in Follow-up assessment
Group-A	Repeated washing, often performed in a ritualistic way (4 out of 7)	Reduced up to 15 to 80%	Reduced up to 50 to 100%	Reduced up to 85 to 100%
	Avoiding places feared for possible contamination(3 out of 7)	Reduced up to 5 to 55%	Reduced up to 50 to 70%	Reduced up to 60 to 90%
	Repeated showering or bathing (3 out of 7)	Reduced up to 25 to 40%	Reduced up to 20 to 100%	Reduced up to 85 to 100%
	Decreased activity level(7 out of 7)	Increased up to 5 to 50%	Increased up to 20 to 80%	Increased up to 45 to 85%
	Repeating and rereading things (2 out of 7)	Reduced up to 15 to 40%	Reduced up to 100%	Reduced up to 100%
	Checking stoves, locks, food pot, fan switches, windows over and over and doing certain activities in a particular number of times (6 out of 7)	Reduced up to 10 to 50%	Reduced up to 50 to 100%	Reduced up to 70 to 100%
	Counting tiles(1 out of 7)	Reduced up to 80%	Reduced up to 100%	Reduced up to 100%
	Quality of stage performance not at all; writing often performed in a ritualistic way; bathing several time; can not bathing through a month; cleaning objects and household items by using with special cleansers and cleaning techniques; avoidance of objects considered contaminated (1 out of 7)	Reduced up to 20%	Reduced up to 60%	Reduced up to 90%

	Preoccupation with symmetry, exactness or order (1 out of 7)	Reduced up to 40%	Reduced up to 30%	Reduced up to 70%
	Withdrawal from social activity, lowered activity, non assertive (7 out of 7)	Not removed	Not removed significantly	Reduced up to 35%
Group-B	Excessive, illogical and uncontrollable repeated cloth, doors, windows, balcony, lone, sandal, mobile, bag, money bag, tap, hand, plate, pot, floor etc. washing, often performed in a ritualistic way (5 out of 7)	Not reduced significantly	Not reduced significantly	Not reduced significantly
	Showering or bathing, often performed in a ritualistic way (4 out of 7)	Not reduced	Not reduced	Not reduced
	Avoiding places such as toilet, dustbin, shoe self, others house, drain etc. feared for possible contamination (5 out of 7)	Not reduced	Reduced a little bit up to 10%	Reduced a little bit up to 10%
	Decreased activity level(7 out of 7)	Not increased at all	Increased up to 15 to 20%	Increased up to 15 to 25%
	Withdrawal from social activity, non assertive (7 out of 7)	Withdraw from social activity now a day (100%); assertiveness problems not reduced	Withdraw from social activity now a day (100%); assertiveness problems not reduced	Withdraw from social activity now a day (100%); assertiveness problems not reduced
	Rereading things, crying spell, pulling own hair from scalp, acts of self-damage or self-mutilation-picking skin -100%(1out of 7)	Not reduced	Not reduced	Reduced up to 10%
	Doing certain activities in a particular number of times(6 out of 7)	Not reduced	Not reduced	Not reduced
	Excessive, illogical and uncontrollable repeated checking stoves, tap, locks, fan and television switches, checking under door, bed, almira, midself, pen, pot, admit card and file again and again (4 of 7)	Not reduced significantly	Reduced up to 10%	Reduced up to 10%
	Avoids social gathering (2 out of 7)	Avoids social gathering now a day up to 80%	Up to 80%	Up to 80%

Table no-20: Total number of clients mentioned the problems in pre assessment and percentage of reduction /increase of problems found in mid, post and follow-up assessment (in terms of social position)

Group No	Total number of clients mentioned the problems in Pre-assessment	Reduction /increase in Mid-assessment	Reduction /increase in Post-assessment	Reduction /increase in Follow-up assessment
Group-A	Disrupted social interaction(7 out of 7)	Increased up to 10 to 50%	Increased up to 40 to 60%	Increased up to 50 to 70%
	Decreased relationship with neighbors, relatives and family members (7 out of 7)	Increased up to 10 to 50%	Increased up to 55 to 100%	Increased up to 55 to 100%
	Annoyed with family members -100% (1 out of 7)	Reduced up to 50%	Reduced up to 90%	Reduced up to 90%
	Decreased relationship with customers (1 of 7)	Increased a little bit	Increased up to 50%	Increased up to 50%
Group-B	Disrupted social interaction 90-100% (7 out of 7)	Not increased significantly	Improved a little bit up to 10%	Improved a little bit up to 10%
	Decreased relationship with neighbors, relatives and family members (6 out of 7)	Not improved	Not improved	Not improved
	Can not talk and mix with other people (5 out of 7) Annoyed with family members (2 out of 7)	Can not talk and mix with other people now days; annoyed with family members now a day	Can not talk and mix with other people now days; annoyed with family members now a day	Can not talk and mix with other people now days; had liked to live alone now a day; annoyed with family members now a day

Table no-21: Total number of clients mentioned the problems in pre assessment and percentage of reduction /increase of problems found in mid, post and follow-up assessment (in terms of occupational condition)

Group No	Total number of clients mentioned the problems in Pre-assessment	Reduction /increase in Mid-assessment	Reduction /increase in Post-assessment	Reduction /increase in Follow-up assessment
Group-A	Poor business and job performance (4 out of 7)	Increased up to 15%	Increased up to 55%	Increased up to 60 to 75%
	Decreased relationship with colleagues (5 out of 7)	Increased up to 20 to 30%	Increased up to 40 to 70%	Increased up to 50 to 80%
	Lack of concentration about business task, lack of interest, decreased level of interest, reduced attention span and reduced body strength (7 out of 7)	Increased up to 20%	Concentration about business task increased up to 50 to 65%; attention span and body strength increased up to 60%	Increased up to 60% and 70%
	Can not do any household activities (2 out of 7), decreased relationship with class mates and teachers; lack of concentration about study and loss of memory (1 out of 7)	Increased up to 45%	Increased up to 45%	Increased up to 50%
Group-B	Job loses (1 out of 7)	Now jobless for his problem	Now jobless for his problem	Now jobless for his problem
	Not interested about job and attention span and body strength reduced significantly (7 out of 7)	Increased up to 10%	Increased up to 15%	Increased up to 25%
	Not interested about household activities (2 out of 7)	Not interested about household activities now a day	Not interested about household activities now a day	Not interested about household activities now a day

Improvement/reduction of symptoms of each client of group-A and group-B on different aspects are given in the following Table No-22 and 23.

Table No-22: Improvement/reduction of symptoms of each client of group-A on different aspects

No. of client	Content/category	Clients mentioned the problems (in percentage) in pre assessment	Percentage of reduction/ improvement of problems found in the last assessment
A-1	Cognitive	60 to 100%	Reduced up to 40 to 100%
	Emotional	70 to 100%	Reduced up to 25 to 100%
	Physiological	50 to 100%	Reduced up to 75 to 100%
	Behavioural	40 to 100%	Reduced up to 35 to 100%
	Social	50 to 100%	Improved up to 10 to 100%
	Occupational	80 to 100%	Improved up to 50 to 80%
A-2	Cognitive	80 to 100%	Reduced up to 70 to 90%
	Emotional	90 to 100%	Reduced up to 75%
	Physiological	75 to 100%	Reduced up to 60 to 80%
	Behavioural	70 to 100%	Reduced up to 50 to 85%
	Social	80 to 100%	Improved up to 70%
	Occupational	90 to 100%	Improved up to 70 to 80%
A-3	Cognitive	70 to 100%	Reduced up to 60 to 85%
	Emotional	50%	Reduced up to 15%
	Physiological	50 to 90%	Reduced up to 70 to 80%
	Behavioural	70 to 100%	Reduced up to 60 to 95%
	Social	60 to 100%	Improved up to 60%
	Occupational	80 to 90%	Improved up to 75%
A-4	Cognitive	50 to 90%	Reduced up to 60 to 90%
	Emotional	90 to 100%	Reduced up to 60 to 80%
	Physiological	50 to 70%	Reduced up to 75 to 80%
	Behavioural	80 to 100%	Reduced up to 60 to 85%
	Social	100%	Improved up to 50 to 70%
	Occupational	100%	Improved up to 50 to 70%
A-5	Cognitive	50 to 80%	Reduced up to 80 to 100%
	Emotional	50 to 60%	Reduced up to 85%
	Physiological	70%	Reduced up to 60 to 80%
	Behavioural	70%	Reduced up to 80 to 85%
	Social	40 to 50%	Improved up to 65%
	Occupational	70%	Improved up to 50 to 85%
A-6	Cognitive	80 to 100%	Reduced up to 30 to 100%
	Emotional	70 to 100%	Reduced up to 40%
	Physiological	70 to 100%	Reduced up to 40 to 60%
	Behavioural	50 to 100%	Reduced up to 20 to 30%
	Social	50 to 100%	Improved up to 20%
	Occupational	80 to 90%	Improved a little bit
A-7	Cognitive	80 to 100%	Reduced up to 50 to 100%
	Emotional	90%	Reduced up to 80%
	Physiological	90 to 100%	Reduced up to 50 to 85%
	Behavioural	90 to 100%	Reduced up to 35 to 80%
	Social	90 to 100%	Improved up to 55%
	Occupational	95 to 100%	Improved up to 50 to 65%

Table No- 23: Improvement/reduction of symptoms of each client of group-B on different aspects

No. of client	Content/category	Clients mentioned the problems (in percentage) in pre assessment	Percentage of reduction/ improvement of problems found in the last assessment
B-1	Cognitive	90 to 100%	Not reduced
	Emotional	80 to 100%	Not reduced
	Physiological	80 to 100%	Reduced up to 5 to 50%
	Behavioural	90 to 100%	Not reduced
	Social	100%	Not improved at all
	Occupational	100%	Not improved
B-2	Cognitive	70 to 80%	Reduced up to 10 to 30%
	Emotional	50 to 100%	Reduced up to 5 to 20%
	Physiological	75%	Reduced up to 20%
	Behavioural	70 to 90%	Reduced up to 10 to 20%
	Social	80 to 100%	Improved up to 10%
	Occupational	50%	Not improved significantly
B-3	Cognitive	70 to 100%	Reduced up to 15 to 25%
	Emotional	50%	Reduced up to 10%
	Physiological	70 to 90%	Reduced up to 20 to 40%
	Behavioural	70 to 90%	Reduced up to 25%
	Social	50 to 80%	Not improved significantly
	Occupational	80 to 90%	Improved up to 15% now a day
B-4	Cognitive	90 to 100%	Not reduced
	Emotional	95 to 100%	Not reduced
	Physiological	85 to 100%	Reduced up to 30%
	Behavioural	90 to 100%	Not reduced at all
	Social	95%	Not improved significantly
	Occupational	90%	Improved up to 25%
B-5	Cognitive	95 to 100%	Reduced a little bit up to 20%
	Emotional	90 to 100%	Not reduced
	Physiological	95 to 70%	Reduced up to 5 to 10%
	Behavioural	95 to 100%	Not reduced
	Social	80 to 100%	Not improved
	Occupational	100%	Not improved
B-6	Cognitive	85%	Reduced up to 30%
	Emotional	85 to 90%	Reduced up to 20%
	Physiological	70 to 100%	Reduced up to10 to 55%
	Behavioural	95 to 100%	Reduced up to 10 to 25%
	Social	95%	Not improved significantly
	Occupational	80%	Not improved
B-7	Cognitive	100%	Reduced up to 15%
	Emotional	95%	Reduced up to 5 to 10%
	Physiological	40 to 100%	Reduced up to 25 to 75%
	Behavioural	60 to 100%	Reduced up to 10%
	Social	100%	Not improved significantly
	Occupational	100%	Not improved significantly

Table no-24: Outcome of intervention of group A & B in terms of the severity of Anxiety scale score

SEV/ASS	PROFOUND		SEVERE		MODERATE		MILD		BELOW C.P	
	G-A	G-B	G-A	G-B	G-A	G-B	G-A	G-B	G-A	G-B
Pre-assessment	5	6	0	1	1	0	1	0	0	0
Mid-assessment	1	4	1	2	2	0	3	1	0	0
Post-assessment	0	4	3	2	0	0	4	0	0	0
1st Follow-up	0	3	0	2	1	0	5	0	0	0
2nd Follow-up	0	3	0	2	0	0	5	0	0	0
3rd Follow-up	0	3	0	2	0	0	6	0	0	0

(**Note:** Case A-6 did not attend the follow-up sessions, case B-2 did not attend the follow-up sessions and case B-5 did not attend the post and follow-up sessions)

Table no-25: Outcome of intervention of group A & B in terms of the severity of Depression scale score

SEV/ASS	SEVERE		MODERATE		MILD		MINIMAL	
	G-A	G-B	G-A	G-B	G-A	G-B	G-A	G-B
Pre-assessment	2	2	2	1	2	2	1	2
Mid-assessment	0	3	0	0	4	3	3	1
Post-assessment	0	3	1	1	0	1	6	1
1st Follow-up	0	2	0	2	0	1	6	0
2nd Follow-up	0	3	0	0	0	1	6	1
3rd Follow-up	0	2	0	1	0	1	6	1

(**Note:** Case A-6 did not attend the follow-up sessions, case B-2 did not attend the follow-up sessions and case B-5 did not attend the post and follow-up sessions)

Table no-26: Outcome of intervention of group A & B in terms of the severity of OCD scale score

SEV/ASS	PROFOUND		SEVERE		MODERATE		MILD	
	G-A	G-B	G-A	G-B	G-A	G-B	G-A	G-B
Pre-assessment	4	4	3	3	0	0	0	0
Mid-assessment	1	3	4	3	1	1	1	0
Post-assessment	1	3	0	1	2	2	4	0
1st Follow-up	0	3	0	2	2	0	4	0
2nd Follow-up	0	3	0	0	1	2	5	0
3rd Follow-up	0	2	0	2	0	1	6	0

(**Note:** Case A-6 did not attend the follow-up sessions, case B-2 did not attend the follow-up sessions and case B-5 did not attend the post and follow-up sessions)

Now these and other findings are also presented in graphs-

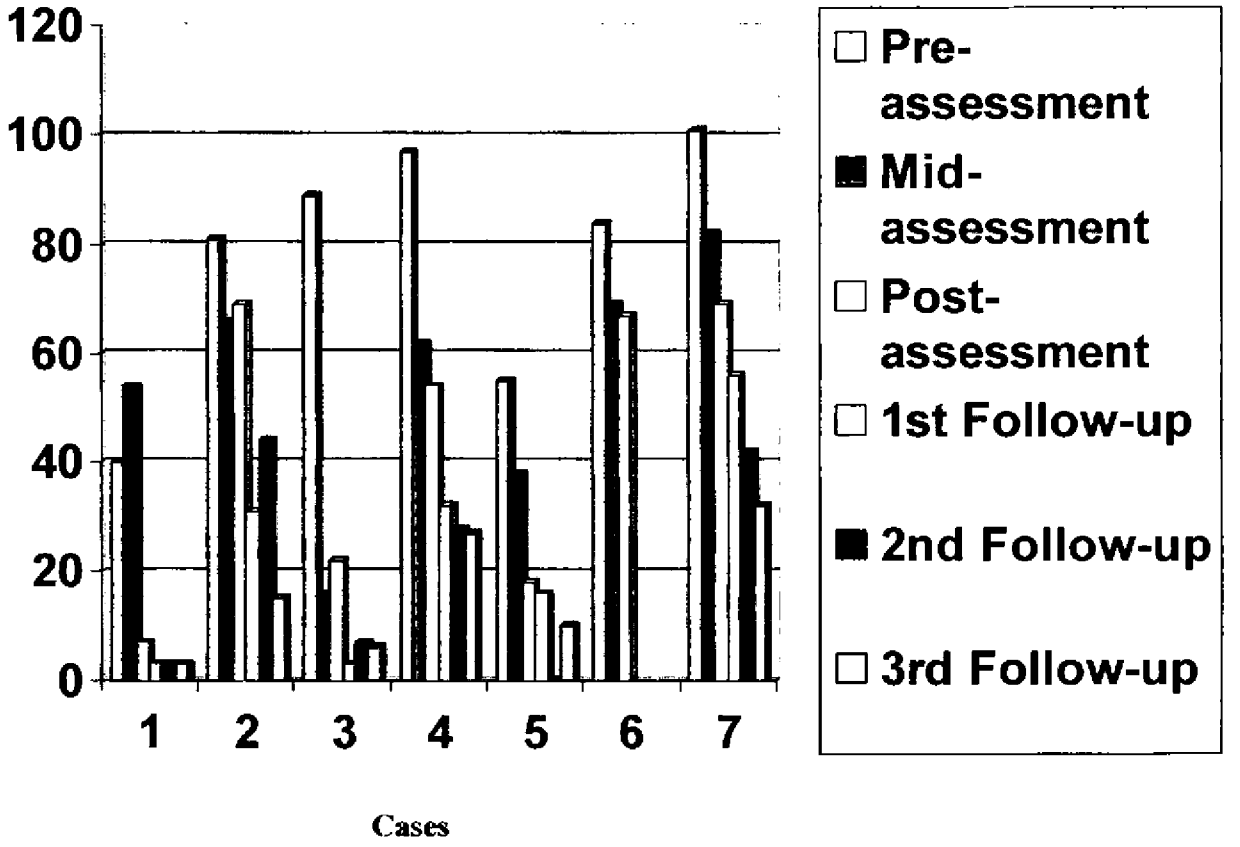

Figure- 4: Outcome of the Psychological Intervention: Scores of Anxiety Scale in different phases of Group-A

Figure-4 illustrates the scores of Anxiety scale (AS) in the pre-assessment session, in the mid-assessment session, in the post-assessment session and in the three follow-up sessions, which indicates change or progress in the level of anxiety in different phases. (Profound=78-135+, severe=67-77, moderate=55-66, normal=54 and less and the cut-off point is 47.5)

(**Note:** Case A-6 did not attend the follow-up sessions)

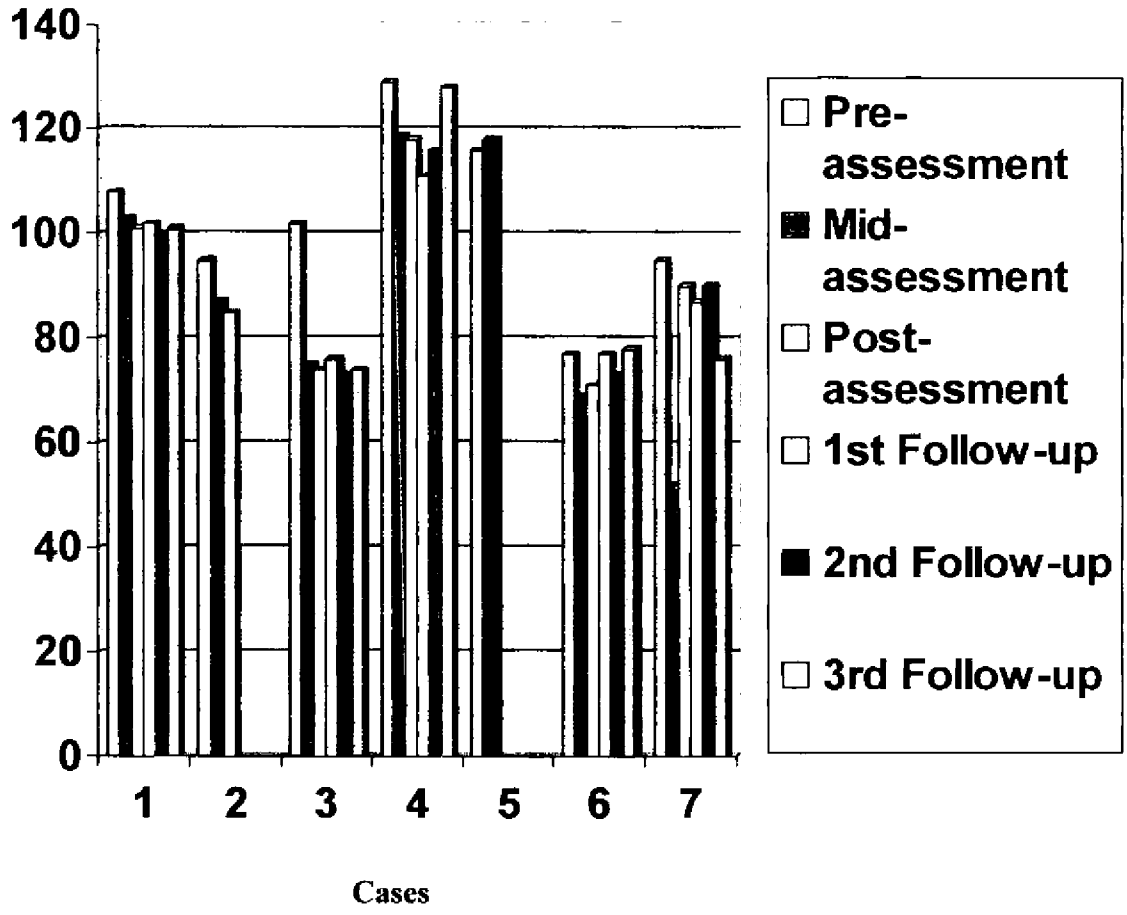

Figure-5: Outcome of the Psychological Intervention: Scores of Anxiety Scale in different phases of Group-B

Figure-5 illustrates the scores of Anxiety scale (AS) in the pre-assessment session, in the mid-assessment session, in the post-assessment session and in the three follow-up sessions, which indicates change or progress in the level of anxiety in different phases. (Profound=78-135+, severe=67-77, moderate=55-66, normal=54 and less and the cut-off point is 47.5)

(**Note:** Case B-2 did not attend the follow-up sessions and case B-5 did not attend the post and follow-up sessions)

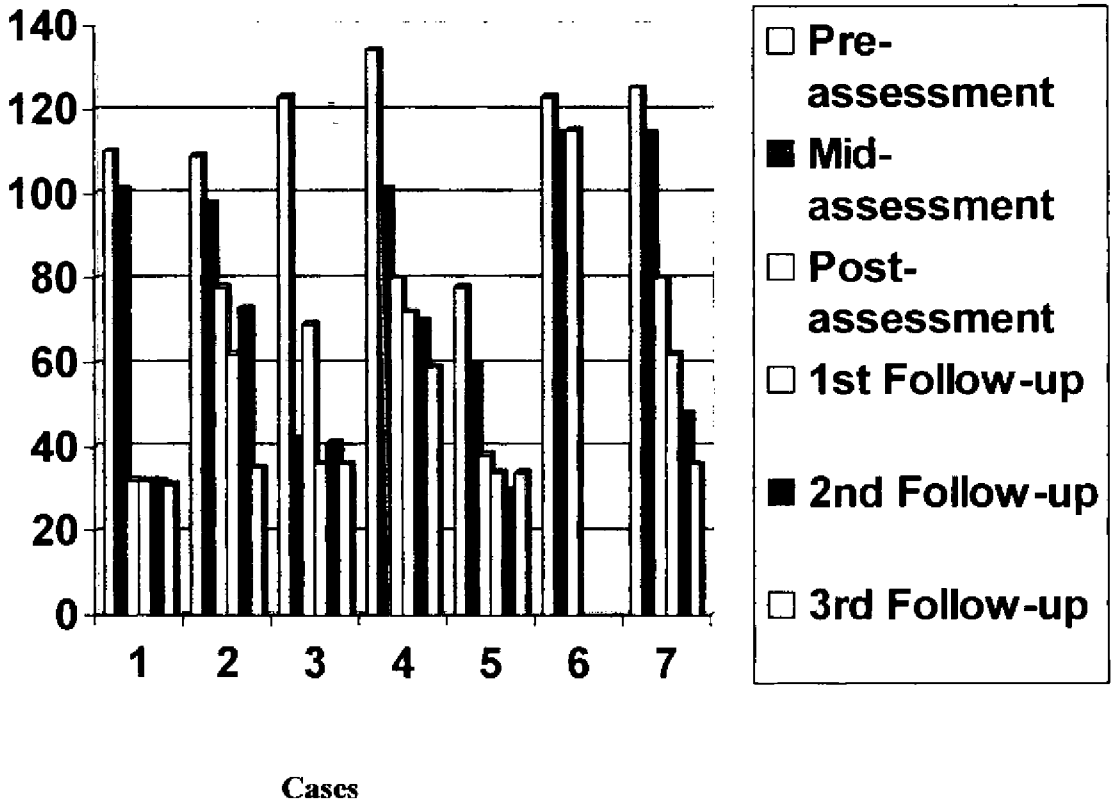

Figure-6: Outcome of the Psychological Intervention: Scores of Depression Scale in different phases of Group-A

Figure-6 illustrates the scores of Depression scale (DS) in the pre-assessment session, in the mid-assessment session, in the post-assessment session and in the three follow-up sessions, which indicates change or progress in the level of depression in different phases. (Severe=124-150, moderate=115-123, mild=101-114, minimal=30-100 and the cut-off point is 94)

(**Note:** Case A-6 did not attend the follow-up sessions)

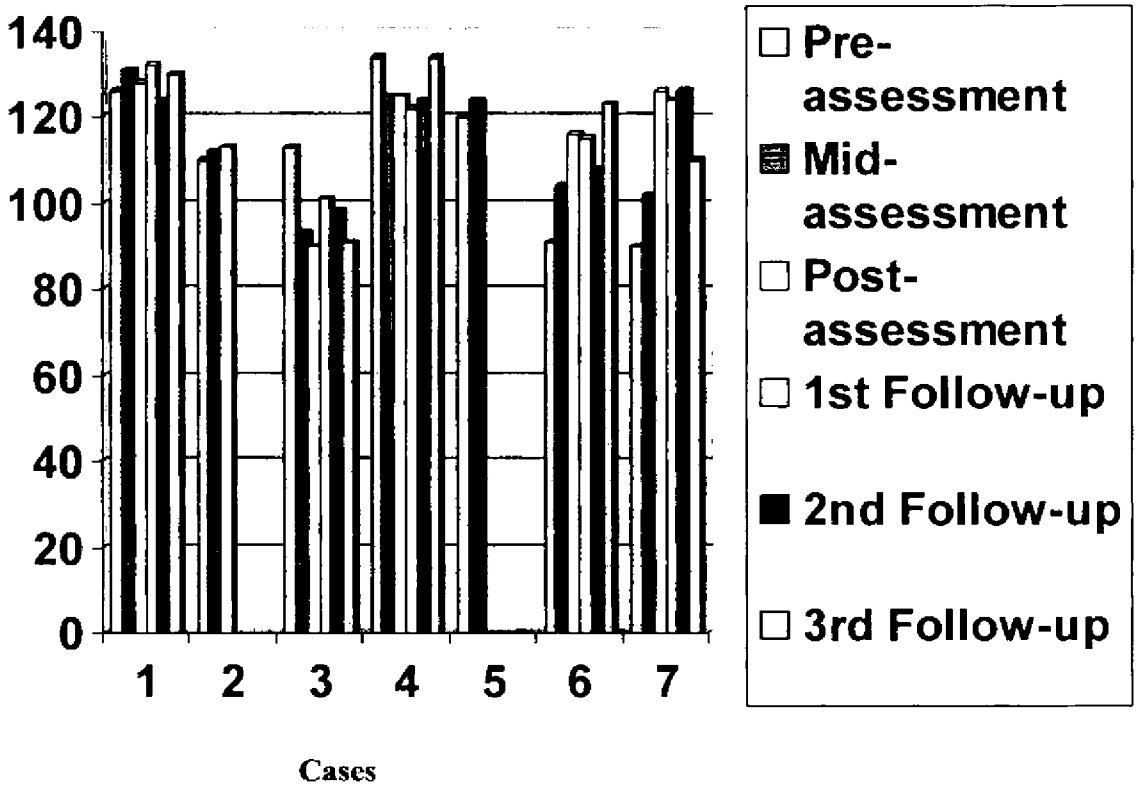

Figure-7: Outcome of the Psychological Intervention: Scores of Depression Scale in different phases of Group-B

Figure-7 illustrates the scores of Depression scale (DS) in the pre-assessment session, in the mid-assessment session, in the post-assessment session and in the three follow-up sessions, which indicates change or progress in the level of depression in different phases. (Severe=124-150, moderate=115-123, mild=101-114, minimal=30-100 and the cut-off point is 94)

(**Note:** Case B-2 did not attend the follow-up sessions and case B-5 did not attend the post and follow-up sessions)

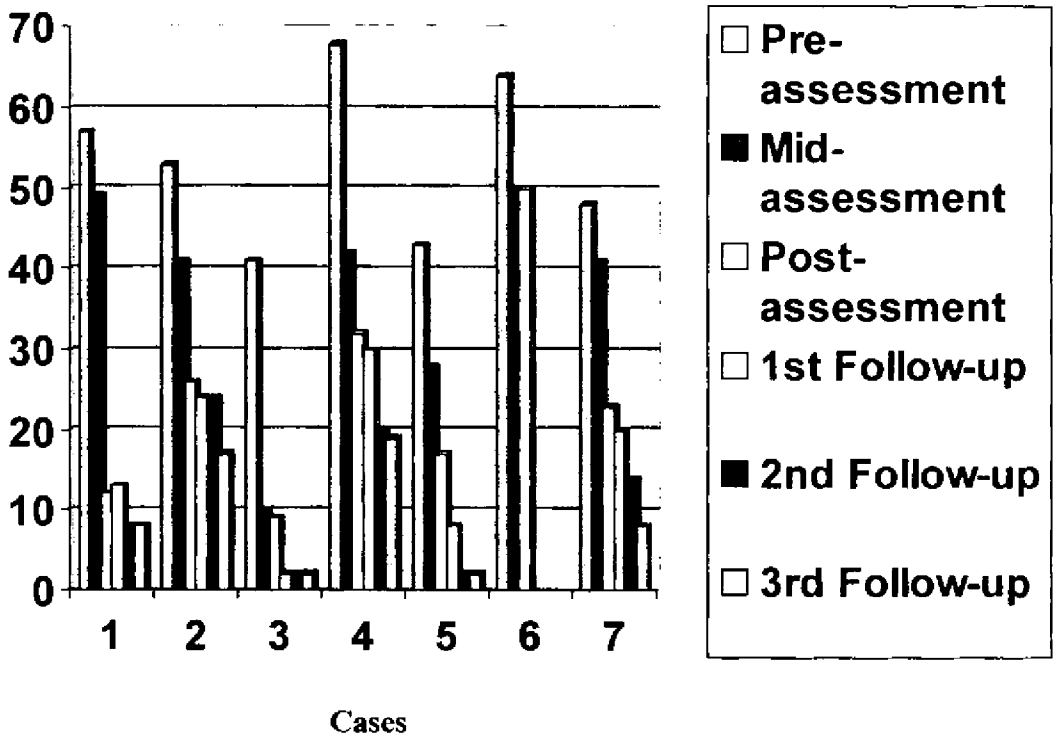

Figure-8: Outcome of the Psychological Intervention: Scores of Dhaka University Obsessive compulsive Scale in different phases of Group-A

Figure-8 illustrates the scores of Dhaka University Obsessive compulsive Scale (DUOCS) in the pre-assessment session, in the mid-assessment session, in the post-assessment session and in the three follow-up sessions, which indicates change or progress in the level of OCD in different phases. (Profound=50 and above, severe=41-49, moderate=24-40, mild=up to 23, and the cut-off point is 17)

(**Note:** Case A-6 did not attend the follow-up sessions)

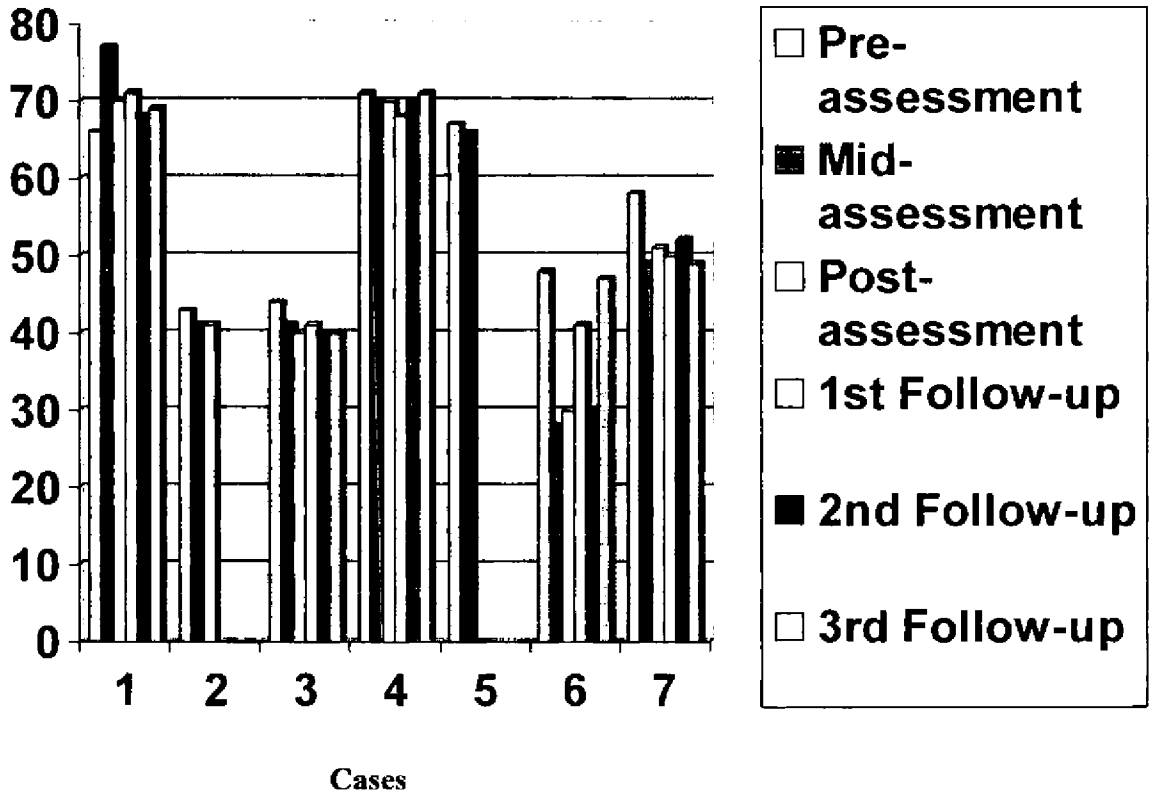

Figure-9: Outcome of the Psychological Intervention: Scores of Dhaka University Obsessive compulsive Scale in different phases of Group-B

Figure-9 illustrates the scores of Dhaka University Obsessive compulsive Scale (DUOCS) in the pre-assessment session, in the mid-assessment session, in the post-assessment session and in the three follow-up sessions, which indicates change or progress in the level of OCD in different phases. (Profound=50 and above, severe=41-49, moderate=24-40, mild=up to 23, and the cut-off point is 17)

(**Note:** Case B-2 did not attend the follow-up sessions and case B-5 did not attend the post and follow-up sessions)

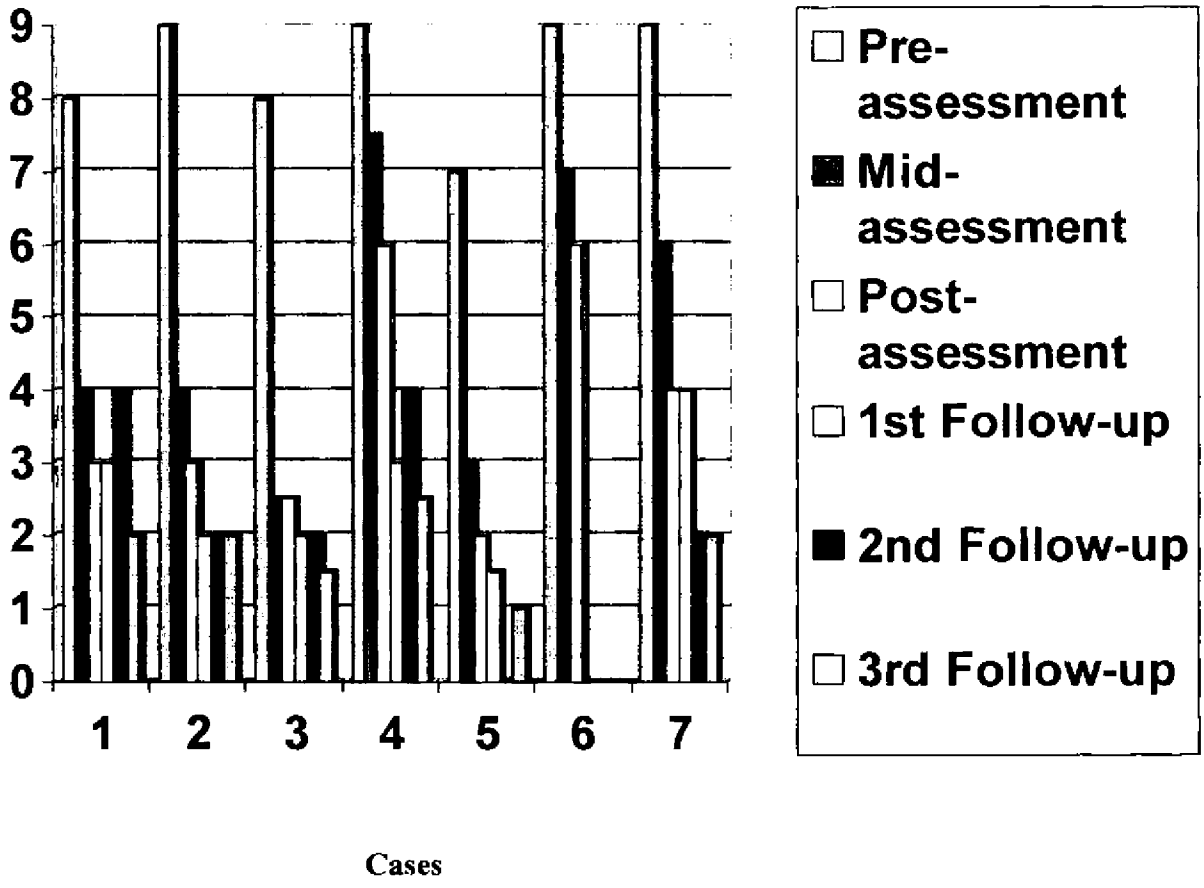

Figure-10: Outcome of the Psychological Intervention: Scores of Subjective rating of the clients on problem severity in different phases of Group-A

Figure-10 illustrates the scores of subjective rating of their problem severity in 11 point rating scale in the pre-assessment session, in the mid-assessment session, in the post-assessment session and in the three follow-up sessions, where 'o' indicates no problem, '1' indicates lowest level of problem, '5' indicates moderate level of problem and '10' indicates highest level of problem.

(**Note:** Case A-6 did not attend the follow-up sessions)

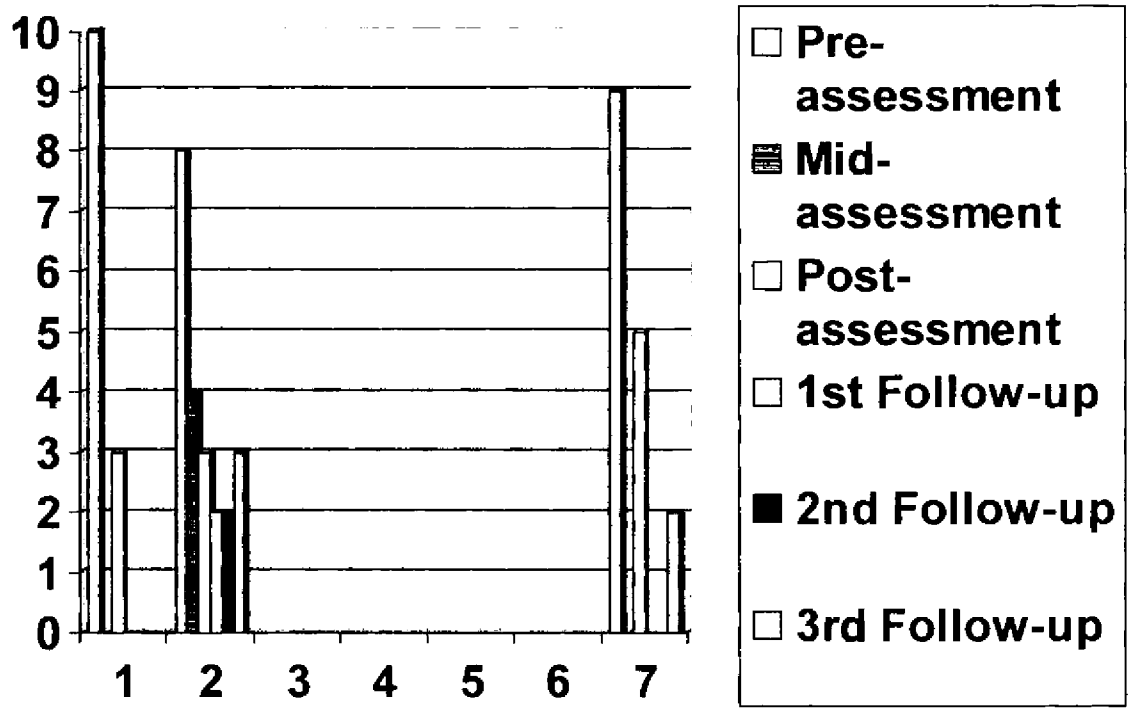

Figure-11: Outcome of the Psychological Intervention: Scores of Subjective rating of the care giver on problem severity in different phases of Group-A

Figure-11 illustrates the scores of subjective rating of their problem severity in 11 point rating scale in the pre-assessment session, in the mid-assessment session, in the post-assessment session and in the three follow-up sessions, where 'o' indicates no problem, '1' indicates lowest level of problem, '5' indicates moderate level of problem and '10' indicates highest level of problem.

(**Note:** Case A-1, the care giver did not attend the mid and follow-up sessions; case A-7, the care giver did not attend the mid and 1st and 2nd follow-up sessions and case A-3, 4, 5, 6; the care giver did not attend the sessions.)

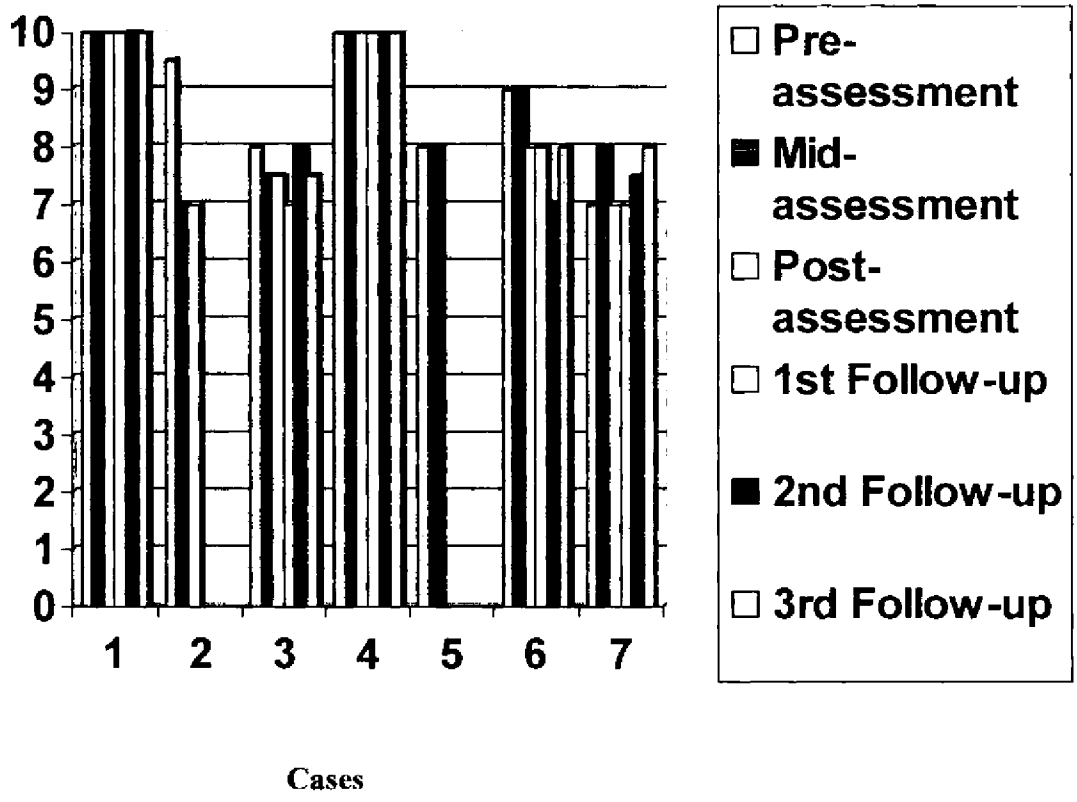

Figure-12: Outcome of the Psychological Intervention: Scores of Subjective rating of the clients on problem severity in different phases of Group-B

Figure-12 illustrates the scores of subjective rating of their problem severity in 11 point rating scale in the pre-assessment session, in the mid-assessment session, in the post-assessment session and in the three follow-up sessions, where 'o' indicates no problem, '1' indicates lowest level of problem, '5' indicates moderate level of problem and '10' indicates highest level of problem.

(**Note:** Case B-2 did not attend the follow-up sessions and case B-5 did not attend the post and follow-up sessions)

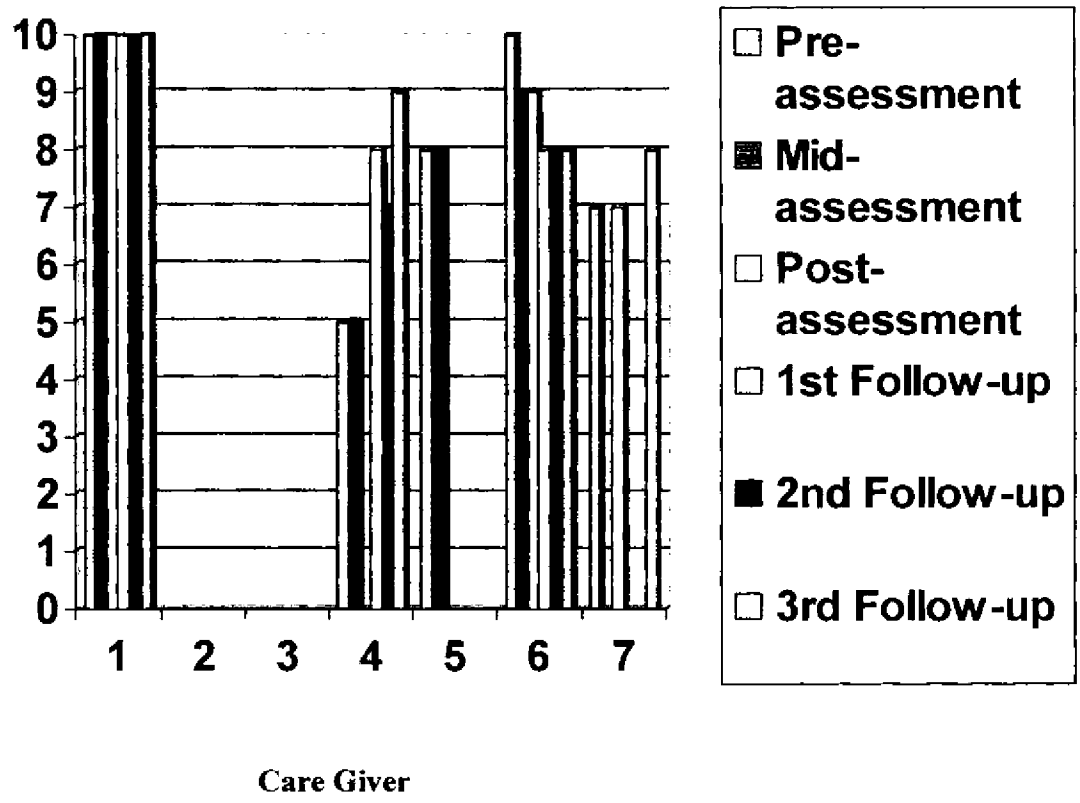

Figure-13: Outcome of the Psychological Intervention: Scores of Subjective rating of the care giver on problem severity in different phases of Group-B

Figure-13 illustrates the scores of subjective rating of their problem severity in 11 point rating scale in the pre-assessment session, in the mid-assessment session, in the post-assessment session and in the three follow-up sessions, where 'o' indicates no problem, '1' indicates lowest level of problem, '5' indicates moderate level of problem and '10' indicates highest level of problem.

(**Note:** Case B-4, the care giver did not attend the post-assessment session; case B-5 did not attend the post and follow-up sessions; case B-7, the care giver did not attend the mid, 1st and 2nd follow-up sessions and case B-2 and B-3, the care giver did not attend the sessions.)

Chapter-4

DISCUSSION

DISCUSSION

This chapter has been divided into four sections. In the first section the summary of the main findings was presented and in the second section implications of the research findings in the context of Bangladesh were discussed. In the third section the difficulties faced by the researcher were mentioned and in the fourth section limitations of the current research were focused.

Section-1:

4.1: Discussion on major findings:

The present study was conducted to see the effectiveness of cognitive behaviour therapy on patients with obsessive compulsive disorder. For the fulfillment of the objective 14 OCD clients were selected by maintaining the inclusion and exclusion criterion. Among them, 7 clients were selected randomly for Group-A (Experimental Group). The rest of 7 clients were included in Group-B Control Group). Group- A received structured cognitive-behaviour therapy whereas; Group-B did not receive CBT but after three follow up sessions these 7 clients were referred for receiving CBT. All of the clients from both groups were assessed following the same structure. Pre-assessment measures were done for both groups with three semi-structured interview sessions and mid-assessment sessions were also done for both groups with one interview session. After completing the baseline measurement, interventions were applied on group-A for about 7-10 sessions (7-10 weeks). The pre, mid, post and follow-up assessments were done through in-depth interview, psychometric scale application, 11-point subjective rating scale, observation, client's and care giver's rating and responsible psychiatrist's evaluation. The findings of the study evaluated the two groups of clients by comparing their pre, mid, post and follow-up assessment findings. All of their presenting problems were categorized under the following headings-

- Cognitive
- Emotional
- Physiological
- Behavioural
- Social and

- Occupational

The changes reported were from their cognitive level which was included in their cognitive reaction. Therefore, the discussion on the effectiveness of CBT, was made in four ways-

- First-the effectiveness of CBT on pharmacologically treatment resistant OCD patients
- Second-compare the functional level changes of the clients of non responders to medication before, mid and after receiving CBT treatment
- Third-compare the functional level changes of the clients of non responders to medication (who did not receive CBT) between before, mid and after measure
- Fourth-compare the functional level changes between the clients of nonresponders to medication who received CBT and the non responders who did not receive CBT

In case of cognitive changes, it was seen from the findings (Table no-2.15.1) that in the initial assessment, clients from group-A and B showed many types of OCD symptoms. From the mid, post and follow-up assessment session it was seen that changes occurred in the content. For example, in group-A, 57% (4 out of 7) clients stated that they were contaminated with dirt and germs, touching animals; became ill from contaminated but in the follow-up session, their recurrent intrusive thought reduced up to 80 to 100%.71% (5 out of 7) stated that "I must do the work certain numbers, if I can not do bad things will happen". All clients of group-A reported lack of concentration, difficulty in making decision, low self esteem in the initial sessions but in the follow-up sessions their concentration level, decision making capacity and self-esteem increased up to 50 to 90%. In group-B, 86% (6 out of 7) clients stated that they were contaminated with dirt and germs, touching animals and insects; touching dustbin, poor people, tree leafs, handshake with other and touching football; becoming ill from contamination; excessive fear and preoccupation with avoiding dirt and germs; life is meaningless and worthless, world is dusty, life is finished and future is dark but in the follow-up sessions, their recurrent intrusive thought reduced a little bit up to 10%. All clients of group-B said that lack of concentration, difficulty in making decision, low self esteem but in the follow-up sessions, their concentration level increased up to 25% and decision making capacity increased a little bit up to 15% and self esteem was low. 14% (1 out of 7) clients mentioned symptoms like avoiding insects, mosquito; easily bothered by certain sounds;

intrusive nonsense sounds; nobody understands pain and nobody loves him/her; unwanted, worrisome and intrusive sexual thoughts and impulses (95%); thoughts about being or becoming a homosexual (95%); excessive fear, worry and preoccupation: having blasphemous thoughts; being punished for blasphemous thoughts, had a suicidal ideation and two times attempted to suicide with sleeping pill; bad things will happen as bad as doing so (90%); going to die, has a big disease and doing something embarrassing -95% but in the follow-up session, their thoughts reduced a little bit.

In case of emotional reaction, all of the clients from group-A and B reported they felt fear, hopeless, sad, worthless, distressed and restless. In the follow-up sessions, it was seen that in group-A, 86% (6 out of 7) clients reported their fear feeling reduced up to 60 to 95%. All clients of group-A stated that their hopeless, sad, worthless, distressed, restless, confused and vulnerable reduced up to 25 to 100%. From the group-B, all clients stated that their confidence level increased up to 5 to 10%; fear, hopeless, sad, worthless, distressed, restless reduced also 5 to10%.

All of the clients from group-A and B reported drowsiness, palpitation, sleep difficulties and low appetite in the pre-assessment session but in the follow-up measure it was seen that, in group-A, all of the clients mentioned their drowsiness, palpitation, sweating, sleep difficulties, dryness of throat and headache reduced up to 75 to 80% and their appetite pattern and energy level increased up to 90 to 100%. 43% (3 out of 7) clients stated that their burning sensation all over the body reduced up to 75 to 80%; jerking all over the body and hot and pain in abdomen and dehydrations problem reduced up to 80%. In group-B, all of the clients reported that their palpitation and sleep difficulties reduced up to 20 to 85%; 43% of them stated that their drowsiness reduced up to 30 to 40% and vomiting tendency reduced up to 70%. 71% of them mentioned that their excessive sweating reduced a little bit up to 30 to 40%; headache reduced up 30% and energy level increased a little bit. 57% of them added that their dryness of throat reduced up to 20%, burning sensation all over the body and hot flushes in head reduced up to 30 to 35%; hand and leg tremor; pain and burning sensation in the scalp reduced up to 30%. 14% (1 out of 7) clients stated that their pain sensation in leg reduced up to 55%; chest pain reduced up to 35% and abdomen pain reduced up 75%.

In case of behavioural response, in group-A, 57% (4 out of 7) clients stated washing rituals; 43% (3 out of 7) mentioned that avoiding places feared for possible contamination, repeated showering or bathing. 28% of them stated that repeating and rereading things and 86% of them added that checking compulsion.14% (1 out of 7) clients reported that counting tiles, no quality of stage performance at all; writing often performed in a ritualistic way; bathing several time; can not bath through a month; cleaning rituals; avoidance of objects considered contaminated; preoccupation with symmetry, exactness or order and doing certain activities in a particular number of times. But in the follow-up sessions, their behavioural problems reduced significantly. Their washing rituals reduced up to 85 to 100%; avoidance reduced up to 60 to 90%; repeated showering or bathing reduced up to 85 to 100% and activity level increased up to 45 to 85%. They also mentioned that their repeating and rereading things reduced up to 100%; checking compulsion reduced up to 70 to 100%; counting tiles reduced up to 100% and their stage performance improved satisfactory level; cleaning rituals reduced 100% and preoccupation with symmetry, exactness or order reduced up to 70%. In group-B, 71% (5 out of 7) clients mentioned that their washing rituals and contamination obsession.14% of them mentioned that rereading things, pulling own hair from scalp, acts of self-damage or self-mutilation-picking skin -100% and 57% of them mentioned checking compulsion. In the follow-up session, they mentioned that their washing rituals and contamination obsession not reduced significantly.14% of them stated that their rereading things, pulling own hair from scalp, acts of self-damage or self-mutilation-picking skin reduced up to 10%; and 57% of them mentioned checking compulsion reduced up to 10%.

In case of social position, all of the client's social interaction was disrupted and their relationship with neighbors, relatives and family members decreased. But in the follow-up session, in group-A, 7 of them mentioned that their social interaction increased up to 50 to 70% and relationship with neighbors, relatives and family members increased up to 55 to 100%. In group-B, social interaction was improved a little bit up to 10% and their relationship with neighbors, relatives and family members were not improved.

Similar feature was found in occupational condition. Both groups of clients mentioned that their occupational condition was damaged in the initial session. But in the follow-up

sessions, in group-A, their occupational condition improved up to 80%. In group-B, their occupational condition did not improve significantly.

4.1.1: Rating scale scores:

Clients and their care givers can give the most appropriate feedback about any treatment. In this study, feedback about treatment effectiveness was collected from clients and their care givers. The feedback was collected by the use of an 11-point rating scale. From their report, the degree of severity decreased gradually in both groups and effectiveness of the psychological treatment was evident. In the first session, ratings of their psychological symptoms were severe (10). But in the last session and follow-up sessions, the rating changed to the positive direction (1/2) (Fig-10 and 11). The results indicate that, their OCD symptoms decreased substantially following treatment, as reported by the client's and their care givers. Verbal report of all these persons clearly pointed to the effectiveness of psychotherapy, particularly cognitive behaviour therapy.

4.1.2: Anxiety scale scores:

It was interesting to find that at the initial stage of treatment most of the clients suffered from mild to profound level of anxiety; but their anxiety level decreased significantly following psychological treatment (Fig-4). It was found that, in the initial level 71% (5 out of 7) of the clients with OCD suffered from profound level of anxiety. In the follow-up sessions anxiety scores of all the seven clients of experimental group were found to be mild.

Similar feature was found in the responsible psychiatrist evaluation format.

4.1.3: Depression scale scores:

It was observed that at the initial stage of treatment most of the clients suffered from minimal to severe level of depression; but their depression level decreased significantly following psychological treatment (Fig-6). It was found that, in the initial level 28% (2 out of 7) of the clients with OCD suffered from severe level, 28% suffered from moderate level and 28% suffered from mild level of depression. In the follow-up sessions the depression levels of six clients of experimental group were found to be minimal.

4.1.4: DUOCD scale scores:

It was found that at the initial stage of treatment most of the clients suffered from severe to profound level of OCD symptoms; but their OCD symptoms decreased significantly following psychological treatment (Fig-8). It was found that, in the initial level 57% (4 out of 7) of the clients suffered from profound level and 43% (3 out of 7) clients suffered from severe level of OCD symptoms. In the follow-up sessions six clients of experimental group were found to have mild OCD symptoms.

4.1.5: Responsible psychiatrist's evaluation:

In this study, feedback about treatment effectiveness was collected from responsible psychiatrist. Responsible psychiatrist's stated that in group-A, improvement level reached up to 65-90% and in group-B, improvement level was found up to 5-45%.

4.1.6: Observational reports:

It was also interesting to see the improvement in observational reports of the researcher about appearance and behaviour, facial expression, eye contact, body posture and body movement, speech and mood of the clients with respect to their presenting problems, during the first session, during the last session of psychological treatment (CBT) and during the follow-up session.

4.1.7: Applied treatment techniques and their description with research evidence:

From the defining criteria of CBT it reveals that CBT is structured and directive therapy, brief and time-limited, a collaborative effort between the therapist and the client and it is aimed to make the client become a therapist. CBT is based on the idea that how we think (cognition), how we feel (emotion) and how we act (behavior) all interact together. Specifically, our thoughts determine our feelings and our behavior. Therefore, negative thoughts can cause us distress and result in problems.

OCD is a complex condition that is difficult to treat. CBT seems to be the most promising non-medication-based treatment approach (Piacentini, Bergman and Jacobs, 2002). Cognitive treatment has been shown to be at least as effective as behavioural treatment (Van Oppen et al., 1995), and integrated cognitive behavioural treatment has

been found to be effective in the treatment of obsessional ruminations (Freeston et al., 1997).

CBT is a type of psychotherapy that has been shown to be highly effective for OCD. The goal of CBT is two-fold: to change thoughts and behaviours. The cognitive portion involves the identification and analysis of unhelpful and unrealistic thoughts, which are then challenged. In behavioural portion, the therapist and client work together to change the compulsive behaviours. This typically includes techniques such as ERP, also called exposure and ritual prevention (EX/RP) and ERP are two cornerstones in the treatment of OCD (Seligman and Rosenhan, 1995).

Over 40 years of published research has led to the wide consensus among researchers and clinicians that CBT is an effective treatment for OCD. Exposure-based treatments have the largest evidence-base to support their use for OCD. EXRP which includes elements of CT appears to be most effective, with over 80% of patients experiencing significant improvements with treatment. EXRP is recommended as the first-line treatment for OCD, with pure CT as a second choice alternative (Williams, Powers and Foa, 2009).

There is extensive research showing that the most effective treatment for OCD is a very specific set of CBT techniques (Tom Corboy, 2009).

In both adults and children, the specific psychological technique most strongly associated with good outcome in studies of CBT is exposure and response prevention, which has response rates of up to 85% in patients who complete the therapy (Foa and Goldstein, 1978).

A case study using only one patient suggested that CBT was effective in reducing symptoms (Rosenblatt, 1997). A second larger study using 12 people with OCD found that CBT produced a significant reduction in symptoms that was similar to what would be expected with treatment with SSRIs (Taylor and Koback, 2000).
It is well known that intervention for OCD works best if a co-therapist can be engaged (Castle et al., 1994). The present researcher engaged client's care givers as a co-therapist with inform consent for reducing client's problems.

From the OCD client group, it was seen that CBT works within a short period if the client actively participate in the session. From group-A, two young male and one female client reported significant changes in their symptoms only after mid assessment sessions. But another two male and female client mentioned that they did not notice significant changes in their symptoms only after mid assessment sessions. It was also seen that some of the clients needed more sessions to be involved in the CBT sessions. One female client required 7 sessions to complete formulation for her problem where in the treatment plan, 3 sessions were for pre-assessment. For two clients the researcher could not maintain the structure of the CBT sessions though it was highly recommended by the CBT therapist.

In this study, it was found that there is a significant positive change in experimental group and no significant positive change was found in control group, which means that the problems that the experimental group suffered decreased after psychotherapy. Whereas for the control group, their problems did not decrease significantly. So, this finding also suggests that, psychological intervention can bring some positive changes in the symptoms of OCD clients.

Choosing the most effective psychotherapy for a mental health condition to be treated or being treated as well as reassessing the effectiveness over time of the psychotherapy being used is an important part of an initial and ongoing treatment plan.

The present study developed a guideline for the CBT therapist for the treatment of OCD. From the results of the study it was found that CBT could bring a positive change among the OCD patients and therefore, it can be concluded that CBT is effective in treating patients with OCD and that medicine resistance patients could reduce their symptoms if CBT is given with medicine.

Section-2:

4.2: Implication of the results of this research:

The present research explored the overall mental health conditions of OCD clients in Bangladesh. Very few research has been conducted and in-depth exploration of the clients of OCD was not done in the context of Bangladeshi population. So, the present study was an important study to see the effectiveness of CBT on patients with OCD and

this study developed a guideline for the CBT therapist for the treatment of OCD clients. In Bangladesh, multidisciplinary team work is necessary for OCD client.

Section-3:

4.3: Difficulties faced by the researcher:

In conducting this research, the researcher faced the following difficulties:

- It was very difficult for the researcher to arrange a single room. Sometimes the researcher used class room, ECT room, assistant registers, register and medical officer's room, where sessions were interrupted frequently. As a result, the researcher did not maintain therapy time appropriately.
- The study setting was not controlled from all types of interference such as presence of other clients, sound of talking etc.
- The clients were not exposed to structured mental health service like CBT. It acted as a barrier for some of them to be involved in the therapeutic activities.

Section-4:

4.4: Limitations of the research:

There were some limitations of the present research which were mentioned below:

- The sample size was small; 7 clients were in experimental group and 7 clients were in control group. So, the findings of this study can not be generalized for all sorts of OCD clients.
- The researcher acted as the therapist role, so there was a chance to create subjective biasness from the researcher. Although the researcher tried to control her data collection methods from subjective biasness, very sincerely and with the help of the supervisor.
- In the present research, only adults were selected and child clients were not included. Hence the results from the data can not be applied to all OCD clients.

Chapter-5

SUMMARY AND CONCLUSION

SUMMARY AND CONCLUSION

The present research was carried out to investigate the effectiveness of cognitive behaviour therapy on patients with obsessive compulsive disorder. Written permission to collect data was taken from the authority of the Psychiatry outpatient and/ or inpatient department of Bangabandhu Sheik Mujib Medical University (BSMMU) in Dhaka and Dhaka Medical College Hospital (DMCH). In BSMMU, the clients were collected from the weekly allocation meeting and in DMCH, the clients were collected from outpatients departments. The clients were referred by a Psychiatrist to the researcher. After the referral of the 14 clients covering all of the inclusion criteria were selected for the present research. All the clients were divided randomly into two groups. 7 clients were in group-A, they were non responders to medication and received CBT and other 7 clients were in group-B, they were also non responders to medication but they continue medication and received no CBT. Clients who suffered from OCD at least for two years and received only medication as treatment and have no experience of receiving CBT are known as non responders to medication clients. The researcher took informed consent from the subjects verbally and explained the purpose of the present research to them. Moreover, it was explained to each participant about how they could cooperate in the research. The confidentiality of the data given by them was also promised by the researcher. Pre-assessment measures were done for both groups with three semi-structured interview sessions and mid-assessment sessions were also done for the both groups with one interview session. After completing the baseline measurement, interventions were applied on group-A for about 7-10 sessions (7-10 weeks). Finally, three follow-up measurements were also taken for one month and 15 days interval after the termination for group-A but 1 client did not want to continue their 2nd and 3rd follow up participation in the study. Also three follow-up measurements were taken for one month and 15 days interval after the termination for group-B but 1 client did not want to continue their 2nd and 3rd follow up participation in the study.

Results were analyzed quantitative and qualitatively for each group separately and also between groups. From the content analysis of the data, it was found that symptoms of OCD and other mental health problems of the clients of group-A reduced up to a

considerable level than Group-B. The present study developed a guideline for the CBT therapist for the treatment of OCD.

The following results were found in the clients of Group-A:

- Reduced the feature/symptoms of the OCD and overall improvement reflected by the self report of the clients and his/her caregivers.
- Improvement in the level of anxiety, depression and OCD.
- Functional level of the clients in six areas- cognitive, emotional, physiological, behavioural, social and occupational changed in the positive direction.
- Improvements were also noticed by the client's external response (which were collected by therapist's observation), comments on therapy session and responsible psychiatrist's evaluation.

From the results of the study it was found that CBT could bring a positive change among the OCD patients and therefore, it can be concluded that medicine resistance patients could reduce their symptoms if CBT is given with medicine.

It is difficult to generalize and confirm the findings based on a small sample. However, to see the more significant improvement-

- It requires more sessions.
- It requires appropriate therapeutic setting.
- It is necessary to ensure more follow-up sessions for relapse prevention.
- It needs to provide responsible caregiver's support.

Chapter-6

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Chapter-7

APPENDICES

APPENDICES

Appendix- 7.1

গবেষণায় অংশগ্রহণের সম্মতিপত্র

(ব্যক্তিগত চিকিৎসা প্রদানকারী নমুনা দলের জন্য)

আমি **জেসমিন আক্তার**, ঢাকা বিশ্ববিদ্যালয়ের ক্লিনিক্যাল সাইকোলজি বিভাগের এম.ফিল ২য় পর্বে অধ্যয়নরত একজন ছাত্রী । পাঠ্যক্রমের অংশ হিসেবে আমি বাতিক বাধ্যতাধর্মী রোগীদের মানসিক স্বাস্থ্যের উপর একটি গবেষণা করছি । আমার গবেষণার শিরোনাম- **'বাতিক বাধ্যতাধর্মী রোগীদের ক্ষেত্রে জ্ঞানীয়-আচরনগত চিকিৎসার কার্যকারিতা''**। আমি আপনার মানসিক স্বাস্থ্য অবস্থা উন্নতির লক্ষ্যে গবেষণার অংশ হিসেবে আপনাকে মনোবৈজ্ঞানিক সেবা প্রদান করতে আগ্রহী। এই তথ্যগুলো শুধুমাত্র গবেষনার কাজে ব্যবহার করা হবে এবং ব্যক্তিগত সকল তথ্য গোপন রাখা হবে । তবে গবেষণায় অংশগ্রহণ করা বা না করা একান্তই আপনার ইচ্ছার উপর নির্ভরশীল । আর আপনি ইচ্ছুক হলে আমি আমার মানসিক স্বাস্থ্যসেবা প্রদানের কাজটি শুরু করতে পারি । এক্ষেত্রে নিম্নে আপনার স্বাক্ষর বা মৌখিক অনুমতি একান্ত কাম্য।

আপনার সহযোগিতার জন্য ধন্যবাদ ।

অনুমতি প্রদান করা হলো

স্বাক্ষর (গবেষণায় অংশগ্রহণকারী)

গবেষণায় অংশগ্রহণের সম্মতিপত্র

(নিয়ন্ত্রিত নমুনা দলের জন্য)

আমি **জেসমিন আক্তার**, ঢাকা বিশ্ববিদ্যালয়ের ক্লিনিক্যাল সাইকোলজি বিভাগের এম.ফিল ২য় পর্বে অধ্যয়নরত একজন ছাত্রী । পাঠ্যক্রমের অংশ হিসেবে আমি বাতিক বাধ্যতাধর্মী রোগীদের মানসিক স্বাস্থের উপর একটি গবেষণা করছি । আমার গবেষণার শিরোনাম- **'বাতিক বাধ্যতাধর্মী রোগীদের ক্ষেত্রে জ্ঞানীয়-আচরনগত চিকিৎসার কার্যকারিতা"**। এ গবেষাণার উদ্দেশ্যকে সামনে রেখে, আমি আপনার মানসিক স্বাস্থ্যের বর্তমান অবস্থা জানতে চাই। তবে গবেষণার উপাত্ত সংগ্রহ শেষ না হওয়া পর্যন্ত আমি আপনাকে সাইকোথেরাপি প্রদান করতে পারব না । এক্ষেত্রে আপনার দেয়া তথ্যগুলো শুধুমাত্র গবেষনার কাজে ব্যবহার করা হবে এবং ব্যক্তিগত সকল তথ্য গোপন রাখা হবে । তবে গবেষণায় অংশগ্রহণ করা বা না করা একান্তই আপনার ইচ্ছার উপর নির্ভরশীল । আর আপনি ইচ্ছুক হলে আমি আমার গবেষণার উপাত্ত সংগ্রহের কাজটি শুরু করতে পারি । এক্ষেত্রে নিম্নে আপনার স্বাক্ষর বা মৌখিক অনুমতি একান্ত কাম্য।

আপনার সহযোগিতার জন্য ধন্যবাদ ।

অনুমতি প্রদান করা হলো

স্বাক্ষর (গবেষণায় অংশগ্রহণকারী)

Appendix- 7.2

উদ্বেগ বা Anxiety পরিমাপনের মানক (দীবা ও বেগম, ২০০৪)

এই বিবৃতিগুলো আপনার ক্ষেত্রে প্রযোজ্য কি না যাচাই করাই আমাদের উদ্দেশ্য। লক্ষ্য করুন প্রতিটি বিবৃতির পাশেই সম্ভাব্য পাঁচ ধরণের উত্তর দেয়া আছে। এগুলো হলো-' একেবারেই হয় না','খুব সামান্য হয়', 'মোটামুটি হয়', অনেক বেশী হয়'। প্রশ্নমালায় প্রদত্ত বামপার্শ্বের বিবৃতিগুলো পড়ে গত এক মাসের মধ্যে এই বিবৃতি গুলো আপনার ক্ষেত্রে কতটা প্রযোজ্য তা বিবৃতির ডানপার্শ্বের সম্ভাব্য পাঁচটি উত্তরের যেটি প্রযোজ্য সেটির ঘরে টিক (√) চিহ্ন দিয়ে নির্দেশ করুন। এই পাঁচটি উত্তরের থেকে যে কোন একটিকে বেছে নিন এবং সবগুলো প্রশ্নের উত্তর দিন। অনুগ্রহ করে লক্ষ্য করুন সবগুলো বিবৃতির উত্তর দিয়েছেন কি না। আপনার সহযোগীতার জন্য ধন্যবাদ।

বিবৃতিসমূহ	একেবারেই হয় না (০)	খুব সামান্য হয় (১)	মোটামুটি হয় (২)	বেশী হয় (৩)	অনেক বেশী হয় (৪)
১. আমার ঘনঘন শ্বাস পড়ে					
২. আমার দমবন্ধবোধ হয়					
৩. আমার বুক ভার ভার লাগে					
৪. আমার বুক ধড়ফড় করে					
৫. আমি বুকে ব্যথা অনুভব করি					
৬. আমার গা/হাত-পা শিরশির করে					
৭. আমার হাত/পা কাঁপে					
৮. আমার হাত/পা অবশ লাগে					
৯. আমার হাত-পা জ্বালাপোড়া করে					
১০. আমার মাথা ঝিমঝিম করে					
১১. আমার মাথা ঘোরে					
১২. আমার মাথা ব্যথা করে					
১৩. আমার মাথা থেকে গরম ভাপ ওঠে					
১৪. আমার গলা শুকিয়ে যায় ও পিপাসা লাগে					
১৫. আমি অসুস্থ হয়ে যাবো এমন মনে হয়					
১৬. আমি আমার স্বাস্থ্য নিয়ে চিন্তিত থাকি					
১৭. আমি দুর্বলবোধ করি					
১৮. আমার হজমে অসুবিধা হয়					
১৯. আমার পেটে অস্বস্তি লাগে					
২০. আমার বমি বমি লাগে					
২১. আমার খুব ঘাম হয় (গরমের জন্য নয়)					
২২. আমি আরাম করতে পারি না					
২৩. আমার সামাজিক পরিবেশে কথা বলতে অসুবিধা হয়					
২৪. একই বিষয় নিয়ে আমার বারবার চিন্তা হয়					
২৫. আমার খুব খারাপ কিছু ঘটবে বলে আশংকা হয়					
২৬. আমি প্রায়ই দুঃচিন্তাগ্রস্থ থাকি					
২৭. আমি প্রায়ই চমকে ওঠি					
২৮. আমি বিচলিত ও সন্ত্রস্তবোধ করি					
২৯. আমার আত্মনিয়ন্ত্রন হারাবার ভয় হয়					
৩০. আমি এত নার্ভাস বা উত্তেজিত বোধ করি যে মনে হয় আমার সবকিছু এলোমেলো হয়ে যাচ্ছে					
৩১. আমি ধৈর্য ধরতে পারি না					
৩২. আমি সিদ্ধান্তহীনতায় ভুগি					
৩৩. আমার আত্মবিশ্বাসের অভাববোধ হয়					
৩৪. একটা বিষয়ের প্রতি মনোযোগ দিয়ে রাখা আমার জন্য বেশ কষ্টকর					
৩৫. আমার মনে হয় আমি এখনই মারা যাচ্ছি					
৩৬. আমার মৃত্যু ভয় হয়					

54 & less = Mild; 55 to 66= Moderate; 67 to 77= Severe; 78 to 135 & above= Profound. Cut of point =47.5

Appendix- 7.3

বিষন্নতা পরিমাপক (উদ্দিন ও রহমান, ২০০৫)

নিচের বিবৃতি গুলো পড়ে গত এক সপ্তাহের মধ্যে এই বিবৃতি গুলো আপনার ক্ষেত্রে কতটা প্রযোজ্য তা বিবৃতির পার্শ্বের সম্ভাব্য পাঁচটি উত্তরের যেটি প্রযোজ্য সেটির ঘরে টিক(√) চিহ্ন দিয়ে নির্দেশ করুন। আপনাকে সরাসরি এই পাঁচটি উত্তর থেকে যে কোন একটিকে বেছে নিতে হবে এবং সবগুলো প্রশ্নের উত্তর দিতে হবে। অনুগ্রহ করে লক্ষ্য করুন সবগুলো বিবৃতির উত্তর দিয়েছেন কি না।

বিবৃতিসমূহ	একেবারেই প্রযোজ্য নয়	প্রযোজ্য নয়	মাঝামাঝি	কিছুটা প্রযোজ্য	পুরোপুরি প্রযোজ্য
১. আমার অশান্তি লাগে।					
২. ইদানিং আমি মনমরা থাকি।					
৩. আমার ভবিষ্যত অন্ধকার।					
৪. ভবিষ্যতে আমার অবস্থা দিন দিন আরো খারাপ হবে।					
৫. আমার সব শেষ হয়ে গেছে।					
৬. আমি মনে করি যে, জীবনটা বর্তমানে খুব বেশী কষ্টকর।					
৭. বর্তমানে আমি অনুভব করি যে মানুষ হিসাবে আমি সম্পূর্ণ ব্যর্থ					
৮. আমি কোথাও আনন্দ-ফুর্তি পাই না।					
৯. নিজেকে খুব ছোট মনে হয়।					
১০. সবকিছুতে আমার আত্মবিশ্বাস কমে গেছে।					
১১. আমার মনে হয় মানুষ আমাকে করুণা করে।					
১২. জীবনটা অর্থহীন।					
১৩. প্রায়ই আমার কান্না পায়।					
১৪. আমি প্রায়ই বিরক্ত বোধ করি।					
১৫. আমি কোন কিছুতেই আগ্রহ পাই না।					
১৬. আমি ইদানিং চিন্তা করতে ও সিদ্ধান্ত নিতে পারি না।					
১৭. আমি আজকাল অনেক কিছুতেই মনোযোগ দিতে পারি না।					
১৮. আমি আগের মতো মনে রাখতে পারি না।					
১৯. আমি দূর্বল বোধ করি এবং অল্পতেই ক্লান্ত হয়ে পড়ি।					
২০. আমি এখন কম ঘুমাই।					
২১. আমি এখন বেশী ঘুমাই।					
২২. আমার মেজাজ খিটখিটে হয়ে গেছে।					
২৩. আমার ক্ষুধা কমে গেছে।					
২৪. আমার ক্ষুধা বেড়ে গেছে।					
২৫. আমার ওজন কমে গেছে (ইচ্ছাকৃতভাবে ওজন নিয়ন্ত্রণের চেষ্টা করার ফলে নয়)।					
২৬. আমার মনে হয় যে আমার কাজকর্মের গতি কমে গেছে।					
২৭. হাসির কোন ঘটনা ঘটলেও আমি আর হাসতে পারি না।					
২৮. যৌন বিষয়ে আমার আগ্রহ কমে গেছে।					
২৯. সামাজিক কাজকর্মে আগের মতো অংশগ্রহণ করতে পারি না।					
৩০. শিক্ষা বা পেশাগত কাজকর্ম আগের মতো করতে পারি না।					

Total: ____

94+ = Depressed; 30-100 = Minimal; 101-114 = Mild; 115-123 = Moderate; 124-150 = Severe

Appendix- 7.4

Dhaka University Obsessive Compulsive Scale

নিচের বিবৃতির বিষয়গুলো আপনার মধ্যে কি পরিমানে অথবা কি মাত্রায় আছে তা বিবৃতিগুলোর পাশের ৫টি ঘরের যে কোন একটিতে টিক্ চিহ্ন (√) দিয়ে প্রকাশ করুন ।

	একেবারেই নেই ০	খুবই সামান্য ১	সামান্য ২	একটু বেশী ৩	অনেক বেশী ৪
১. আমার মাথায় ধর্ম নিয়ে নানান ধরনের অদ্ভুত এবং বাজে চিন্তা আসে যা আমি চাইলেও থামাতে পারি না।					
২. পবিত্র স্থানকে অপবিত্র করছি এমন কল্পনা বা ছবি আসে মনে, আমি চাইলেও তা মন থেকে সরাতে পারিনা।					
৩. নাস্তিকতাবাদী চিন্তা আমার মনের মধ্যে এত বার বার আসতে থাকে যে মনে হয় আমার ঈমান (সৃষ্টিকর্তার প্রতি বিশ্বাস) নেই বা নষ্ট হয়ে গেছে।					
৪. সারাক্ষণ সন্দেহ হয় আমি বুঝি নাপাক, নোংরা, বা অশুচি হয়ে গেছি।					
৫. সারাক্ষণ মনে হয় আমার গায়ে-হাতে ময়লা বা জীবাণু লেগে আছে।					
৬. কোন কিছু পরিষ্কার করার সময় অনেকবার বা অনেক সময় লাগিয়ে দুই, যদিও বুঝি এতবার ধোয়ার দরকার নেই, কিন্তু না ধুয়ে পারি না।					
৭. পরিষ্কার পরিচ্ছন্নতার জন্য আমাকে প্রচুর পরিমান সাবান বা ডিটারজেন্ট পাউডার ব্যবহার করতে হয়।					
৮. যেখানে নোংরা থাকতে পারে ঐসব স্থান সম্পর্কে আমি অতিরিক্ত সচেতন থাকি এবং বারবারই এড়িয়ে চলি।					
৯. আমার গায়ে কারো স্পর্শ লাগলে আমি গোসল বা পরিষ্কার না হওয়া পর্যন্ত অশান্তিতে ভুগতে থাকি।					
১০. গোসল করতে আমার প্রচুর সময় এমনকি কয়েক ঘন্টাও লেগে যায়।					
১১. কোন কাজ করার মাঝে যদি আমার মনে চিন্তা আসে যে আমি নাপাক হয়ে গেছি, তাহলে আমি তৎক্ষনাৎ গোসল বা পরিচ্ছন্ন হতে যাই।					
১২. বিভিন্ন জিনিস আমি বারবার পরীক্ষা করে দেখি।					
১৩. নামাজ /উপাসনা করতে গেলে সন্দেহ লাগে হয়তো সুরা /শ্লোক ঠিকমত পড়া হয়নি, তখন আবার পড়ি, এভাবে অনেক সময় লেগে যায়।					
১৪. হিসাব করতে আমার খুব অসুবিধা হয়, শুধু মনে হয় বুঝি গোনায় ভুল হয়ে গেল।					
১৫. আমার মনের মত না হওয়া পর্যন্ত আমি একই কাজ বারবার করতে থাকি।					
১৬. বিভিন্ন জিনিস আমি একটি নির্দিষ্ট সংখ্যক বার গুনি।					
১৭. প্রাত্যহিক কাজ করতে আমার প্রচুর সময় লাগে বা প্রায় কোন কাজই সময় মত করতে পারি না।					
১৮. কোন কাজ করার সময় যদি আমার নিখুঁতভাবে ধারাবাহিকতায় কোন ছেদ পড়ে বা বিঘ্ন ঘটে তবে সে কাজটি আমাকে আবার প্রথম থেকে শুরু করতে হয়।					
১৯. আমি বুঝি আমি এমন কিছু আচরণ করি যা অতিরিক্ত এবং অপ্রয়োজনীয়, কিন্তু তারপরও না করে পারি না।					
২০. কিছু কিছু ব্যাপার নিয়ে আমি অতিরিক্ত খুঁতখুঁতে বলে অন্যরা প্রায়ই আমার উপর বিরক্ত হয়।					

Total Score = [ ] = 00 + + + +

Cutoff score = 17
up to 23 Mild
24 to 40 Moderate
41 to 49 Severe
50 and above Profound

Developed By
Md. Kamruzzaman Mozumder
Supervised by Dr. Roquia Begum
Dept. of Clinical Psychology, DU

Appendix- 7.5

Adult Initial Assessment Form

Adult Personal History

Case No:

Client's Name: **Client Code:** **Reg.no:**

Age:

Gender: **Education:** **Occupation:**

Date of Birth: **Religion:**

Address:

Mobile/Phone No:

Diagnosis:

Duration of the Problem:

Duration of the received Pharmacological Treatment:

Last received Medication:

Name	Dose	Dates

Maritul Status:

- Single
- Divorce in process

Length of time_____

- Unmarried, living together

Length of time_____

- Legally married

Length of time_____

- Separated

Length of time_____

- Divorced

Length of time_____

- Widowed

Length of time_____

- Annulment

Length of time_____

Total number of marriages_____

Family Information:

Relationship	Name	Age	Living		Living with the Client	
			Yes	No	Yes	No
Mother						

Father						
Spouse						
Children						

Significant Others (Brothers, Sisters, Grandparents, Step-relatives, Half-relatives)

Relationship	Name	Age	Living		Living with the Client	
			Yes	No	Yes	No

Family Strengths/support:

Family Stressors/problems:

Recent changes:

Changes desired:

Comment on family circumstances:

Assessment of current relationship: Good Fair Poor

Parental Information:
Mother remarried: Number of times_____
Parents have even been separated Father remarried: Number of times_____
Parents ever divorced

Presenting Problem:

Signs and Symptoms (DSM based):

- Cognitive:
- Behavioural:
- Emotional
- Physiological:
- Social:
- Occupational:

History of presenting problem:
Events, precipitating factors or incidents leading to need for services:

Frequency/Duration/Severity of symptoms:

Critical Incidence:

Family mental health history:

Childhood and Adolescent history:
(Developmental milestones, past behavioural concerns, environment, abuse, school, social, mental health)

Are there special, unusual or traumatic circumstances that affected the client's development:

Yes No

If yes, which types of child abuse? Sexual Physical Verbal

Abuse was as Victim Perpetrator

Other childhood issues: Neglect Inadequate nutrition

Other (Specify) _____

Social Relationships:

Social Strengths/support:

Social Stressors/problems:

Recent changes:

Changes desired:

Sexual Orientation:
Sexual Dysfunctions? No Yes (describe) _____

Any current or history of being as sexual perpetrator? No Yes (describe)
_____

Cultural/Ethnic history:

Cultural Strengths/support:
Cultural Stressors/problems:
Beliefs/practices to incorporate into therapy:

Spiritual/Religious history:

Strengths/support:
Stressors/problems:
Beliefs/practices to incorporate into therapy:

Recent changes:

Changes desired:

Legal history:

Status/ impact/ stressors:

Educational history:

School: Number of years_____
College: Number of years_____
Graduate: Number of years_____
Vocational: Number of years_____

Other training_____

Strength:

Weaknesses:

Employment/ Vocational history:

Employer	Dates	Title	Reason left the job	How often miss work?

Strengths/support:

Stressors/problems:

Leisure/ Recreational history:

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

Strengths/support:

Recent changes:

Changes desired:

Chemical use history:

Name of Drugs	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No

Counseling/ Prior treatment history:

Information about client (Past and Present):

	No	Yes	When	Purpose	Reaction or overall experience
Counseling/ Psychiatric treatment					
Suicidal thoughts/ attempts					
Drug/ Alcohol treatment					
Hospitalizations					
Involvement with self-help groups (e.g. AA,NA)					

Information about family/ significant others (Past and Present):

	No	Yes	When	Purpose	Reaction or overall experience
Counseling/ Psychiatric treatment					
Suicidal thoughts/ attempts					
Drug/ Alcohol treatment					
Hospitalizations					
Involvement with self-help groups (e.g. AA,NA)					

Observation of therapist about the client:

Mental status	N/A or OK	Slight	Moderate	Severe
Appearance				
Posture				
Body movements				
Speech				
Attitude				
Affect				
Perception				
Cognitive				
Judgment				
Thought content				

Appendix- 7.6

Responsible Psychiatrist's Evaluation/ Remarks (After------ psychotherapeutic sessions)

Group: Experimental/ Control ✓
Client age: 43
Living area: Khaja Dewan, Dhaka
Placement: DMCH

Subjective evaluation /remarks about the client progress:

Pt states that obsessional rituals has gone away, magical thinking also has slowed down but obsessional thought is still persisting in mild intensity. He is working normally & problem in relationship is also much better in position.

Objective evaluation /remarks about the client progress:

75% improvement..

Name of the Psychiatrist: Dr. Khaleda Begum
Signature:

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রেজিষ্ট্রার
মানসিক রোগ বিভাগ
ঢাকা মেডিকেল কলেজ হাসপাতাল

Responsible Psychiatrist's Evaluation/ Remarks
(After------ psychotherapeutic sessions)

Group: Experimental/ Control
Client age: ৩৫
Living area: Dhaka
Placement: BSMMU

Subjective evaluation /remarks about the client progress:

Improving

Objective evaluation /remarks about the client progress:

Assessment for improvement

Name of the Psychiatrist: Dr. Mohsin Ali Shah
Signature:

Dr. Mohsin Ali Shah
Assistant Professor
Department of Psychiatry
Bangabandhu Sheikh Mujib Medical University
Dhaka

Responsible Psychiatrist's Evaluation/ Remarks
(After----- psychotherapeutic sessions)

Group: Experimental/ Control ✓
Client age: 29 yrs.
Living area: Mughbazar, Dhaka
Placement: DMCH

Subjective evaluation /remarks about the client progress:

Pt has developed the controlled over rumination. Emotionally now she is stable, can perform his daily activities smoothly.

Objective evaluation /remarks about the client progress:

80% improvement

Name of the Psychiatrist: Dr. Khaleda Begum
Signature:

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মানসিক রোগ বিভাগ
ঢাকা মেডিকেল কলেজ হাসপাতাল

Responsible Psychiatrist's Evaluation/ Remarks
(After------ psychotherapeutic sessions)

Group: Experimental/ Control ✓
Client age: 32 yrs.
Living area: Concord lake City, Khilkhet
Placement: DMCH.

Subjective evaluation /remarks about the client progress:

On entry of the session, she was very much obsessed along ē the rituals. She was severely depressed also. Now the intensity of obsessive thoughts & rituals is moderate to mild & still a bit depressed & anxious.

Objective evaluation /remarks about the client progress:

(65-70) %. improvement

Name of the Psychiatrist: Dr. Khaleda Begum
Signature:

ডাঃ খালেদা বেগম
রেজিষ্ট্রার
মানসিক রোগ বিভাগ

Responsible Psychiatrist's Evaluation/ Remarks
(After------ psychotherapeutic sessions)

Group: Experimental/ Control ✓
Client age: 20 yrs.
Living area: Azimpur, Dhaka
Placement: DMCH

Subjective evaluation /remarks about the client progress:

As stated by patient he is alright & has full control over his mind. There is no unwanted thinking & was prevailing in the past. Emotionally stable & can resume his daily activities.

Objective evaluation /remarks about the client progress:

90% improvement

Name of the Psychiatrist: Dr. Khaleda Begum
Signature:

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মানসিক রোগ বিভাগ
ঢাকা মেডিকেল কলেজ [illegible]

Responsible Psychiatrist's Evaluation/ Remarks
(After------ psychotherapeutic sessions)

Group: Experimental/ Control ✓
Client age: 20
Living area: Dhaka
Placement: DMCH

Subjective evaluation /remarks about the client progress:

On starting of the session, she was severely obsessed & intensive rituals. Now, she is much better & stable regarding her emotional status; rumination & rituals has become mild in intensity.

Objective evaluation /remarks about the client progress:

(65-70)% improved

Name of the Psychiatrist: Dr. Khaleda Begum
Signature:

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মানসিক রোগ বিভাগ
ঢাকা মেডিকেল কলেজ হাসপাতাল

Responsible Psychiatrist's Evaluation/ Remarks
(After------ psychotherapeutic sessions)

Group: Experimental/ Control ✓
Client age: 34 yrs.
Living area: Khilgaon, Dhaka
Placement: DMCH

Subjective evaluation /remarks about the client progress:

Pt states that he has no improve-ment in his disease procen or symptoms, occasional improvement is poorly sus-tained which makes him frustrated. He does not maintain his daily activities properly & in time.

Objective evaluation /remarks about the client progress:

20% improvement (regarding emotional state)

Name of the Psychiatrist: Dr. Khaleda Begum
Signature:

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Responsible Psychiatrist's Evaluation/ Remarks
(After------ psychotherapeutic sessions)

Group: Experimental/ Control ✓
Client age: 20 yrs.
Living area: Lalbag, Dhaka
Placement: DMCH

Subjective evaluation /remarks about the client progress:

previously patient represented ē Obsessive ruminations along ē some physical complaints. At present this somatic complaints are subsided but obsessional features are persisting, emotionally also a bit depressed.

Objective evaluation /remarks about the client progress:

35% improvement

Name of the Psychiatrist: Dr. Khaleda Begum
Signature:

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ঢাকা মেডিকেল কলেজ হাসপাতাল

Responsible Psychiatrist's Evaluation/ Remarks
(After------ psychotherapeutic sessions)

Group: Experimental/ Control ✓
Client age: 20
Living area: Dhaka
Placement: BSMMU

Subjective evaluation /remarks about the client progress:

Not No satisfactory improvement

Objective evaluation /remarks about the client progress:

Emotional stability improvement

Name of the Psychiatrist:
Signature:

Dr. Mohsin Ali Shah
Assistant Professor
Department of Psychiatry
Bangabandhu Sheikh Mujib Medical University
Dhaka

Responsible Psychiatrist's Evaluation/ Remarks
(After----- psychotherapeutic sessions)

Group: Experimental/ Control ✓
Client age: 21 yrs.
Living area: Dhaka
Placement: DMCH.

Subjective evaluation /remarks about the client progress:

Still she is emotionally unstable & impulsive outburst. Rituals are a bit slow but fluctuating intensity.

Objective evaluation /remarks about the client progress:

40% improvement.

Name of the Psychiatrist: Dr. Khaleda Begum
Signature:

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মানসিক রোগ বিভাগ
ঢাকা মেডিকেল কলেজ হাসপাতাল

Responsible Psychiatrist's Evaluation/ Remarks
(After------ psychotherapeutic sessions)

Group: Experimental/ Control ✓
Client age: 28 yrs
Living area: Badda, Dhaka
Placement: DMCH

Subjective evaluation /remarks about the client progress:

Still she is having through emotional instability, residuals are persisting & ups & down. Trichotillomania is mostly controlled.

Objective evaluation /remarks about the client progress:

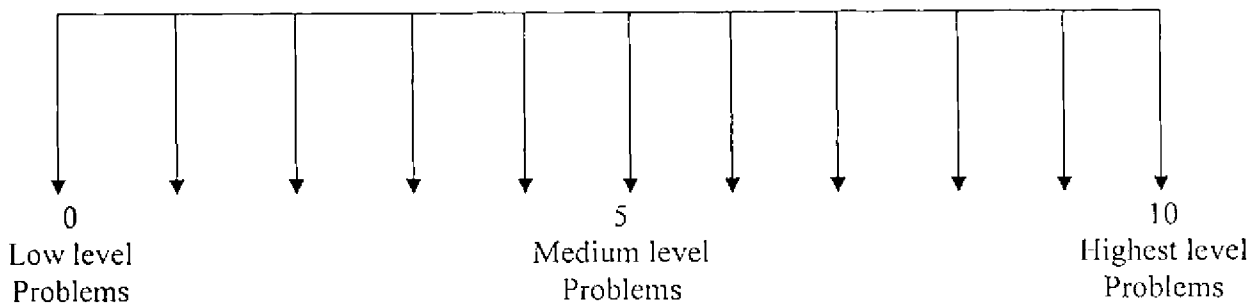
Regarding OCD - improvement is 40%-45%

Name of the Psychiatrist:
Signature: Dr. Khaleda Begum

ডাঃ খালেদা বেগম
রেজিষ্ট্রার
মানসিক রোগ বিভাগ
ঢাকা মেডিকেল কলেজ হাসপাতাল

Appendix- 7.7

11 Point verbal rating scale



Appendix- 7.8

Demographic data sheet

Demographic Data of Group-A

SL No	Client Code	Hospital	Age	Sex	Education	Occupation	Marital Status	Socio economic status	Duration of the problems	Current medicine status	Major OCD symptoms
1	A1	Dhaka Medical College Hospital (DMCH)	43	M	X	Business	M	Lower middle class	18	Clofranil, Oleanz, Prodep, Pase	Concern with religious beliefs; contaminated with dirt and germs, touching animals; became ill from contaminated; repeated washing, often performed in a ritualistic way; counting tiles; avoiding places feared for possible contamination; repeated showering or bathing; repeating and rereading things; checking stoves and fan switches over and over and doing certain activities in a particular number of times;
2	A2	Bangabandhu Sheikh Mujib Medical University (BSMMU)	37	F	S.S.C	House Wife	M	Middle class	25	Clofranil, Oleanz, Prodep	Contaminated with dirt, germs and poison, touching insects; became ill from contaminated; going to die by touching insects; must do the work specific numbers; repeated washing, showering and bathing often performed in a ritualistic way; avoiding places feared for possible contamination and poison explosion; checking gas stoves, locks, food pot and taking medicine over and over;
3	A3	DMCH	28	M	X	Private job	UM	Lower middle class	18	Telazine, Xionil, Prodep	Contaminated with dirt and germs, touching others ; must do the work certain numbers; avoiding places feared for possible contamination; checking stoves, locks and fan switches over and over;
4	A4	DMCH	32	F	BA	House Wife	M	Upper middle class	25	Clofranil, Relafin, Sizodon, Perkinil, Disopan, Inj. Fluanxol Depot	Contaminated with dirt and germs; becoming ill from contaminated; must do the work specific numbers; repeated washing, reading aojubillah and writing often performed in a ritualistic way; doing certain activities in a particular number of times;
5	A5	DMCH	20	M	Hons.2nd yrs	Student	UM	Upper middle class	5	Clofranil, Prodep	Must do the work certain numbers; all time advertisement and music was running head; bathing several time and doing certain activities in a particular number of times;

6	A6	DMCH	21	M	X	Business	UM	Lower middle class	7	Tab. Oleanz, Amafranil, Amit/Amilin, Prodep, Lozicum	Have no rest in brain when sleeping, see many scenery when sleeping, no satisfaction when sleeping; never can not income and bear parents; repeated showering or bathing for hot flushes; checking locks over and over; preoccupation with symmetry, exactness or order and doing certain activities in a particular number of times;
7	A7	DMCH	20	F	X	Student	UM	Middle class	5	Inj. Clopixol Depot,Perkinil,Rclafin, Sedil, Lopez ,Gepin, Indever, Laxxena, Vitamin B Complex	Urge to collect useless things; preoccupation with symmetry, exactness and order; excessive concern with aligning papers, books, cloths, bag, toys, show pieces, houschold materials and other items a certain perfect way; preoccupation and excessive, illogical fear of harming self, harming fathers; doing something embarrassing; worry about losing things; worry about fathers remarriage; uncontrollable houschold materials washing, often performed in a ritualistic way but can not bathing between a month; cleaning of objects, houschold items; use of special cleansers and cleaning techniques; avoidance of objects considered contaminated; checking over and over physical surroundings- locks, stoves, windows; doing certain activities in a particular number of times;

It is seen from that 4 clients were male and 3 clients were female. All the clients of Group-A were come from lower middle class to upper middle class family. Their age ranged from 21 to 43. Among the clients one had graduation, one passed S.S.C, and one client was Hons. Student and the other four had gone to school up to class-X.

Demographic Data of Group-B

SL No	Client Code	Hospital	Age	Sex	Education	Occupation	Marital Status	Socio economic status	Duration of the problems	Current medicine status	Major OCD symptoms
1	B1	DMCH	38	M	H.S.C	Unemployed	UM	Lower middle class	18	Clofranil, Citapram, Sizodon, Perkinil, Zolium	Contaminated with dirt and germs, touching animals and insects; became ill from contaminated; excessive fear and preoccupation with avoiding dirt and germs, insects, mosquito; easily bothered by certain sounds; intrusive nonsense sounds; repeated washing, showering or bathing, often performed in a ritualistic way; avoiding places feared for possible contamination; rereading things; checking stoves, tap, locks and fan switches over and over and doing certain activities in a particular number of times;
2	B2	DMCH	28	M	S.S.C	Electrician	UM	Lower middle class	3	Clofranil, Epilim Chrono, Olanep	Contaminated with dirt and germs, excessive fear and preoccupation with avoiding dirt and germs; unwanted, worrisome and intrusive sexual thoughts and impulses; thoughts about being or becoming a homosexual; repeated showering or bathing, often performed in a ritualistic way; avoiding places feared for possible contamination, checking tap, locks and fan switches over and over and doing certain activities in a particular number of times;
3	B3	DMCH	20	M	Hons.2nd yrs	Student	UM	Middle class	5	Clofranil	Worry and preoccupation: having blasphemous thoughts; being punished for blasphemous thoughts; repeated checking locks, pen, admit card and file over and over and doing certain activities in a particular number of times;
4	B4	BSMMU	20	M	Hons.1st yrs	Student	UM	Upper middle class	4	Prodep, Epiclon	Contaminated with dirt and germs, touching dustbin, poor people, tree leafs, handshake with other and touching football; becoming ill from contaminated; excessive fear and preoccupation with avoiding dirt and germs; repeated cloth, doors, windows, balcony,

											lone, sandal, mobile, bag, money bag, tap etc. washing and cleaning, often performed in a ritualistic way; showering or bathing, often performed in a ritualistic way; avoiding places such as toilet, dustbin, shoe self, others house, drain etc. feared for possible contamination;
5	B5	DMCH	40	F	X	House Wife	M	Middle class	5	Clofranil, Ticlon, Aluctin, Napa extra	Contaminated with dirt, becoming ill from contaminated; excessive fear and preoccupation with avoiding dirt; repeated washing, often performed in a ritualistic way, avoiding places feared for possible contamination, checking stoves, tap, locks, fan and television switches, checking under door, bed, almira and midself over and over and doing certain activities in a particular number of times;
6	B6	DMCH	21	F	X	Unemployed	UM	Middle class	5	Prodep, Xionil, Aripra	Contaminated with dirt and germs, becoming ill from contaminated; excessive fear and preoccupation with avoiding dirt; repeated washing and bathing, often performed in a ritualistic way; avoiding places feared for possible contamination, checking stoves and pot over and over and doing certain activities in a particular number of times;
7	B7	DMCH	28	F	BA	Student	M	Middle class	11	Clofranil, Relafin, Rispolux, Lonazep	Contaminated with dirt and germs, becoming ill from contaminated; excessive fear and preoccupation with avoiding dirt; repeated hand, plate, pot, floor, cloth washing and bathing, often performed in a ritualistic way; avoiding places feared for possible contamination; pulling own hair from scalp; acts of self-damage or self-mutilation-picking skin; doing certain activities in a particular number of times;

It is seen that 4 clients were male and 3 clients were female. All the clients of Group-B were come from lower middle class to upper middle class family. Their age ranged from 20 to 40. Among the clients one had graduation, one passed H.S.C, one passed S.S.C, two clients were Hons. Student and the other two had gone to school up to class-X.

Appendix- 7.9

Session- 1

1. Welcome greetings and therapist self-introduction
2. Explaining the therapeutic process (Motivational work)
3. Explaining the issues of confidentiality
4. Demographic data of the client
5. Mood checking, including objective scores
6. Setting the agenda (and providing a rationale for doing so)
7. Discussion of the issues on agenda

a) Exploring the problems related to obsession and compulsion (Onset, type, duration, frequency, situation/reason for the start, triggering situations)

b) Exploring presenting psychological problems in the following areas: (Pre-assessment)

- **Cognitive**
- **Emotional**
- **Behavioural**
- **Physiological**
- **Social**
- **Occupational**

8. Use of psychometric tools (OCD scale, anxiety scale, depression scale)
9. Educating the client about his/her disorder
10. Summarization of the session
11. Setting of homework (If necessary)
12. Feedback on the session

Session-2

1. Short review of the previous session and checking mood

2. Explore the reaction to the last session

3. Setting the agenda
   - Review of homework
   - Continuing pre-assessment
   - Gathering additional information
   - History taking
   - Summary and feedback

4. Discussion of issues on the agenda:
   - Explore the problem in five areas: cognitive, affective, physical, behavioural and social aspects
   - Use of psychometric scale to identify the problems
   - History taking:

   A. History of present illness

   B. Family history:
      - Relationship among family members
      - Social position of family
      - Family history of mental illness: Absent/present (1st degree/2nd degree)

      If present,

      Disorder:

      Treatment received:

      Outcome:

   C. Personal history (Birth history, child hood, schooling and education, occupational history, marital history, sexual history)

5. Setting new homework
6. Summarization of the session and feedback

Session-3

1. Short review of the previous session and checking mood

2. Explore the reaction to the last session

3. Setting the agenda
   - Review of homework
   - Continuing pre-test measure and history taking
   - Exploring underlying psychological issues
   - Setting new homework
   - Summary and feedback

4. Discussion of issues on the agenda:

   - History taking (past medical history, past psychiatric history)
   - Exploring underlying psychological issues (explaining relationship among automatic thoughts, affects and behaviours ; identify automatic thoughts more precisely)

5. Use of psychometric scale

6. Identifying emotions using mood chart

7. Setting new homework

8. Summarization of the session and feedback

Session-4

1. Short review of the previous session and checking mood

2. Explore the reaction to the last session

3. Setting the agenda
   - Review of homework
   - Sharing formulation
   - Setting new homework
   - Summary and feedback

4. Discussion of issues on the agenda

5. Use of psychometric scale

6. Setting new homework

7. Summarization of the session and feedback

Session-5

1. Short review of the previous session and checking mood

2. Explore the reaction to the last session

3. Setting the agenda
   - Review of homework
   - List out the most distressing thoughts
   - Set therapeutic goal collaborately
   - Set treatment plan and share it with the client

- Setting new homework
- Summary and feedback

4. Discussion of issues on the agenda

5. Use of psychometric scale

6. Setting new homework

7. Summarization of the session and feedback

Session (6-7)

1. Short review of the previous session and checking mood

2. Explore the reaction to the last session

3. Setting the agenda
   - Review of homework
   - Implementing CBT and behavioural techniques according to the clients need
   - Setting new homework
   - Monitoring progress

4. Discussion of issues on the agenda

5. Use of psychometric scale

6. Setting new homework

7. Summarization of the session and feedback

Session-8

1. Short review of the previous session and checking mood

2. Explore the reaction to the last session

3. Setting the agenda

   - Review of homework
   - Mid-assessment
   - Implementing CBT and behavioural techniques according to the clients need
   - Setting new homework
   - Monitoring progress

4. Discussion of issues on the agenda

   - Exploring presenting psychological problems in the following areas: (Mid-assessment)

   - **Cognitive**
   - **Emotional**
   - **Behavioural**
   - **Physiological**
   - **Social**
   - **Occupational**

5. Use of psychometric scale

6. Setting new homework

7. Summarization of the session and feedback

Session (9-11)

1. Short review of the previous session and checking mood

2. Explore the reaction to the last session

3. Setting the agenda
   - Review of homework
   - Implementing CBT and behavioural techniques according to the clients need
   - Setting new homework
   - Monitoring progress

4. Discussion of issues on the agenda

5. Use of psychometric scale

6. Setting new homework

7. Summarization of the session and feedback

Session – 12

1. Short review of the previous session and checking mood

2. Explore the reaction to the last session

3. Setting the agenda
   - Review of homework
   - Monitoring progress
   - Post-assessment
   - Implementing CBT and behavioural techniques

- Setting new homework
- Give two follow up date
- Feedback

4. Discussion of issues on the agenda

5. Setting new homework

6. Summarization of the session and feedback

Session (13-15)

1. Short review of the previous session and checking mood

2. Explore the reaction to the last session

3. Setting the agenda
   - Review of homework
   - Monitoring progress
   - Implementing CBT and behavioural techniques
   - Final summary and feedback
   - Termination of the session

4. Discussion of issues on the agenda

5. Summarization of the session and feedback

Appendix- 7.10

হোমওয়ার্ক প্লান

সেশন-১ঃ

১. সেশনে কি কি লক্ষ্য নিয়ে কথা বলবেন তা নিয়ে ভাবুন।
২. গত সেশনে যে বিষয়গুলো নিয়ে আলোচনা হয়েছিল তা একবার পড়ুন।
৩. আগামী সেশনে কথা বলার বিষয়টি ঠিক করুন।
৪. প্রাত্যহিক কার্যকলাপের ফর্মটি পুরন করুন।

সেশন-২ঃ

১. সেশনে কি কি লক্ষ্য নিয়ে কথা বলবেন তা নিয়ে ভাবুন।
২. সেশন নোটগুলো দিনে একবার করে পড়ুন।
৩. উদ্বেগ মোকাবিলার ফর্মটি পুরন করুন।
৪. পরিহারকৃত লক্ষণসমূহের তালিকাটি পুরন করুন।
৫. অপ্রত্যাশিত ও অনাহূত চিন্তাগুলো লিখুন।

সেশন-৩ঃ

১. সেশন নোটগুলো দিনে একবার করে পড়ুন।
২. প্রাত্যহিক ধৌতকরন ফর্মটি পুরন করুন।
৩. প্রাত্যহিক চেকিং ফর্মটি পুরন করুন।
৪. অনুভূতির তালিকাটি মনোযোগ দিয়ে পড়ুন।
৫. অপ্রত্যাশিত ও অনাহূত চিন্তার সাথে অনুভূতি,আচরন ও কাজের সম্পর্ক দেখুন।

সেশন-৪ঃ

১. যতবার সম্ভব সেশন নোটগুলো পড়ুন।
২. ফরমুলেশন মডেলটি পড়ুন।
৩. ডিটিআর চার্টের ৬ নং কলাম পর্যন্ত পুরন করুন।

সেশন-৫ঃ

১. যতবার সম্ভব সেশন নোটগুলো পড়ুন।
২. ফরমুলেশন মডেলটি পড়ুন।
৩. ডিটিআর চার্টটি পুরন করুন।
৪. প্রয়োজন অনুযায়ী মনোবৈজ্ঞানিক চিকিৎসা পদ্ধতি/ কৌশল অনুসরন করুন।

সেশন (৬-১১) ঃ

১. ফরমুলেশন মডেলটি আবার পড়ুন।
২. যতবার ইচ্ছে সেশন নোটগুলো পড়ুন।
৩. সেশনের শুরু থেকে আজকের দিন পর্যন্ত আপনার মানসিক স্বাস্থ্য/ চিন্তাভাবনা এবং আচরনগত সমস্যার মধ্যকার পরিবর্তনগুলো খেয়াল করুন।
৪. প্রয়োজন অনুযায়ী মনোবৈজ্ঞানিক চিকিৎসা পদ্ধতি/ কৌশল অনুসরন করুন।
৫. প্রাত্যহিক কার্যকলাপের ফর্মটি পুরন করুন।
৬. কাল্পনিক মোকাবিলার ফর্মটি পুরন করুন।
৭. উদ্বেগ মোকাবিলার ফর্মটি পুরন করুন।
৮. পরিহারকৃত লক্ষণসমূহের তালিকাটি পুরন করুন।
৯. প্রাত্যহিক ধৌতকরন ফর্মটি পুরন করুন।
১০. প্রাত্যহিক চেকিং ফর্মটি পুরন করুন।
১১. সেশন শুরুর এবং শেষের দিকের মানসিক অবস্থা এবং আচরনগত পরিবর্তন ধরে রাখার জন্য আপনার করণীয় সম্পর্কে লিখুন।

সেশন (১২-১৫) ঃ

১. সেশন নোটগুলো মনোযোগ দিয়ে পড়ুন।
২. সেশনের শুরু থেকে আজকের দিন পর্যন্ত আপনার মানসিক স্বাস্থ্য/ চিন্তাভাবনা এবং আচরনগত সমস্যার মধ্যকার পরিবর্তনগুলো খেয়াল করুন।
৩. আপনি কিভাবে সেশনের কাজ চালিয়ে যাবেন তার পরিকল্পনা করুন।
৪. প্রয়োজন অনুযায়ী মনোবৈজ্ঞানিক চিকিৎসা পদ্ধতি/ কৌশল অনুসরন করুন।
৫. সেশন শুরুর এবং শেষের দিকের মানসিক অবস্থা এবং আচরনগত পরিবর্তন ধরে রাখার জন্য আপনার করণীয় সম্পর্কে লিখুন।

সেশন শেষ করার মানসিক প্রস্তুতি নিন।

Appendix- 7.11

Additional CBT techniques for the sessions

- Advantages and disadvantages analysis
- Behavioural experiments
- Activity monitoring and scheduling
- Distraction
- Relaxation
- Graded Exposure
- Reinforcement
- Exposure
- Modeling
- Response prevention
- Systematic desensitization
- Imaginal exposure
- Avoidance-reduction
- Thought-stopping
- Thought-switching
- Thought-control
- Habituation training

Appendix- 7.12

Session Materials

দুটো সেশনের মধ্যকার সম্পর্ক স্থাপন

১. গত সেশনের কোন বিষয়টি আপনার কাছে গুরুত্বপূর্ণ মনে হয়েছিল? সেশনটিতে শিক্ষণীয় যা ছিল একটু সংক্ষেপে বলুন।

২. গত সেশনে এমন কিছু নিয়ে কি আমরা আলোচনা করেছি যা আপনার জন্য বিরক্তিকর ছিল? অথবা এমন কোন বিষয় যা আপনার বলতে ইচ্ছে করেনি?

৩. গত সপ্তাহটা আপনার কেমন কেটেছে? অন্যান্য সপ্তাহের সঙ্গে তুলনা করলে গত সপ্তাহে আপনার মানসিক অবস্থা কেমন ছিল?

৪. গত সপ্তাহে এমন কোন গুরুত্বপূর্ণ কিছু কি ঘটেছে যা নিয়ে আলোচনা করা দরকার?

৫. গত সপ্তাহে সেশনের বাইরে সেশনের জন্য কি কাজ করেছেন?/না করে থাকলেও সেটা কি?

৬. আজকের এজেন্ডাতে আমরা কোন সমস্যা নিয়ে আলোচনা করতে পারি?

প্রতিদিনের কাজের তালিকা

সময়	রবিবার	সোমবার	মঙ্গলবার	বুধবার	বৃহস্প্রতিবার	শুক্রবার	শনিবার
সকাল ৬-৭							
৭-৮							
৮-৯							
৯-১০							
১০-১১							
১১-১২							
দুপুর ১২-১							
১-২							
২-৩							
৩-৪							
বিকাল ৪-৫							
৫-৬							
৬-৭							
৭-৮							
৮-৯							
৯-১০							
১০-১১							
১১-১২							

পরিহারকৃত লক্ষণসমুহের তালিকা

০= আমি কখনো পরিহার করিনা
৫০= আমি মোটামুটি অর্ধেক সময় পরিহার করে চলি
৭৫= আমি বেশিরভাগ সময় পরিহার করে চলি
১০০= আমি যে কোন মূল্যে সম্পূর্ণভাবে পরিহার করে চলি

পরিহারকৃত পরিবেশ/অবস্থা, ব্যক্তিবর্গ, স্থানসমূহ, জিনিসপত্র অথবা চিন্তাসমূহ	পরিহারের মাত্রা(০-১০০)
১.	
২.	
৩.	
৪.	
৫.	
৬.	
৭.	
৮.	
৯.	
১০	

Source: Hyman,B & Pedrick,C.(1999). The OCD workbook, New Harbinger, Publications,Inc.

উদ্বেগ মোকাবিলার ফর্ম

তারিখ	পরিস্থিতি	যে উদ্বেগ মোকাবিলার প্রচেষ্টা চালিয়েছে	অনুভূতি/যন্ত্রণা (.....)	অনুভূতি/যন্ত্রণার মাত্রা(০-১০০)

কাল্পনিক মোকাবিলার ফর্ম

তারিখ	অনুভূতি/যন্ত্রণা (.....)	অনুভূতি/যন্ত্রণার মাত্রা(০-১০০)	কাল্পনিক মোকাবিলার মোট সময়

প্রাত্যহিক ধৌতকরন ফর্ম

(সাবান এবং পানি দিয়ে হাত ধোয়া, ঝর্ণা দিয়ে গোসল করা, শুকনো কাপড়/কাগজ দিয়ে হাত ধোয়া, সাধারন পানি দিয়ে গোসল করা, অন্য কিছু দিয়ে হাত ধোয়া, অন্যান্য.....)

তারিখ	ধৌতকরনের ঘটনা	ধৌতকরনেরমোট সময়	প্রতিদিন ধোয়ার মোট সংখ্যা	অনুভূতি/যন্ত্রণার মাত্রা(০-১০০)

দৈনিক চেকিং ফর্ম

(তালা, গ্যাসের চুলা, ফ্যানের সুইচ, পানির কল, জানালা, শরীরের রক্তচাপ এবং অন্যান্য..... চেক করা)

তারিখ	চেক করার ঘটনা	চেক করার মোট সময়	দৈনিক চেক করার মোট সংখ্যা	অনুভূতি/যন্ত্রণার মাত্রা(০-১০০)

অনুভূতির তালিকা

	সুখ	দুঃখ	রাগ	ভীতি	সন্দেহ	শক্তিশালী	দূর্বল
	সন্তুষ্টি	খারাপ	বিরক্ত	নার্ভাস	অস্বস্তি	শক্ত	একঘেয়েমি
নিম্ন মাত্রা	পরিতৃপ্তি	মূল্যহীন	মেজাজ গরম	অনিশ্চিত	অস্বাচ্ছন্দ্য	নিরাপদ	অনিশ্চিত
	খুশি	ছোট	আতঙ্কিত	সাহসহীন	বিব্রত	নিশ্চিত	নড়বড়ে
	প্রফুল্ল	কষ্ট	হতাশ	অস্বাচ্ছন্দ্য	এলোমেলো	সক্ষম	নিরাপত্তাহীন
মধ্যম মাত্রা	উদ্যমী/তৎপর	প্রচন্ড বেদনা	খিটখিটে	নিরাপত্তাহীন	জটিল	বিশ্বাসী	অসহায়
	আনন্দিত	যন্ত্রণা	উত্তেজিত/বিক্ষুব্দ	খিটখিটে	উল্টাপাল্টা	আত্ম বিশ্বাসী	অযোগ্য
	আনন্দে আত্মহারা	বিধস্ত	ক্রুদ্ব	ভয়	ঝামেলার্পূণ	গবল	দুর্বল
উচ্চ মাত্রা	প্রচন্ড উল্লাসিত	বিষন্ন	উত্তেজিত	আতন্ক	ফাদে আটকানো	অতিরিক্ত শক্তিশালী	শক্তিহীন/অক্ষম
	উত্তেজিত	নিরাশ	ক্রোধোন্মত্ত	ভীতি	হতভম্ব/হতবুদ্ধ	ক্ষমতাবান	অসহায়

অকার্যকর চিন্তার রেকর্ড (ডিটিআর)

তারিখ/ সময়	পরিস্থিতি	উদ্দীপক	অনাহূত চিন্তা	আবেগ/অনুভূতি	অনাহূত চিন্তার ব্যাখ্যা	অনাহূত চিন্তার বিপরীতে আপনি কি করে থাকেন	ফলাফল/ অনুভূতি
	কোন পরিস্থিতিতে আপনার মধ্যে অপ্রত্যাশিত ও অস্বস্তিকর চিন্তা আসে বা একই আচরন করেন তা লিখুন।	কোন কাজ/ ঘটনা/ চিন্তা আপনার মধ্যে অপ্রত্যাশিত চিন্তা বা অস্বস্তিকর অবস্থা তৈরী করছে তা লিখুন।	এর ফলে আপনার মনে কি ধরনের অনাহূত চিন্তা আসছে তা লিখুন।	১. এই চিন্তাটা করে আপনার কি অনুভূতি হচেছ? (অসহায় লাগা, রাগ লাগা, কষ্ট লাগা অথবা অন্য কিছু) ২. এই অনুভূতি কত তীব্রভাবে (০-১০০) লাগছে?	অনাহূত চিন্তা সম্পর্কে আপনি কি মনে করেন তা লিখুন।	১. অনাহূত চিন্তা গুলোর কোন বিকল্প হতে পারে কি? ২. প্রতিটি প্রতিক্রিয়াতে আপনি কতটুকু বিশ্বাস করেন (০-১০০)?	১. আচরনটি করার পর এখন আপনি কেমন বোধ করছেন? ২. এই এই অনুভূতি কত তীব্র (০-১০০)?

Appendix- 7.13

Psycho Education Format

বাতিক বাধ্যতাধর্মী বৈকল্য (OCD) সম্পর্কে প্রাথমিক ধারনা

বাতিক বাধ্যতাধর্মী বৈকল্য (OCD) একটি মানসিক স্বাস্থ্য সমস্যা। এটি মূলত একটি উদ্বেগজনিত রোগ। গবেষণায় দেখা গেছে, সাধারন জনসংখ্যার ৩% এর জীবনের যেকোন সময় এই রোগে আক্রান্ত হওয়ার সম্ভাবনা রয়েছে। ১৯৯১ সালে আমেরিকায় একটি গবেষণায় দেখা গেছে, ২-৩% ব্যক্তি এ রোগে ভোগে এবং ছেলেদের চেয়ে মেয়েদের মধ্যে এরোগে আক্রান্তদের সংখ্যা বেশি।

এই রোগের প্রধান প্রধান বৈশিষ্ট্যগুলো নিম্নরুপঃ-

১. একই চিন্তা, ছবি বা কল্পনা বারবার মনে আসা

২. একই কাজ বারবার করা

৩. ব্যক্তি সচেতনভাবে চিন্তা বা কল্পনা এড়িয়ে যেতে চায় বা একই কাজ বারবার করা থেকে নিজেকে বিরত রাখতে চায়, কিন্তু কিছুতেই নিজেকে আটকাতে পারেনা

৪. রোগ সংক্রমনের ভয় বা জীবাণূদ্বারা আক্রান্ত হওয়ার ভয়

৫. বারবার হাত ধোয়া, কাপড় ধোয়া, থালাবাসন ধোয়া অর্থাৎ পরিষ্কার পরিচ্ছন্নতার বাতিক

৬. কোন বিশেষ জিনিস এড়িয়ে চলা

৭. কোন জিনিস সঠিকভাবে করা হয়েছে কিনা তা বারবার পরীক্ষা করে দেখা যেমন-তালা,গ্যাসের চুলা,পানির কল ইত্যাদি জিনিস বারবার পরীক্ষা করে দেখা

৮. কোন কাজ একটি নিদিষ্ট সংখ্যকবার করা ইত্যাদি।

চিকিৎসাঃ

বিভিন্ন গবেষণায় দেখা গেছে, বাতিক বাধ্যতাধর্মী বৈকল্য (OCD) চিকিৎসার ক্ষেত্রে বিভিন্ন প্রকার ঔষধ সেবনের সাথে সাথে সাইকোথেরাপির যথেষ্ট কার্যকারিতা রয়েছে। ১৯৮০ সালের এক গবেষণায় দেখা গেছে, বাতিক বাধ্যতাধর্মী বৈকল্য (OCD) তুলনামূলকভাবে একটি দূর্লভ রোগ এবং এ রোগ ভালো হওয়ার হার কম। কিন্তু বর্তমানে নিয়মিত ঔষধ সেবনের পাশাপাশি সাইকোথেরাপি গ্রহন করলে এই রোগ অনেকাংশে কমানো সম্ভব। ১৯৯৬ সালের একটি গবেষণায় দেখা গেছে, নিয়মিত ঔষধ সেবনের পাশাপাশি সাইকোথেরাপি গ্রহন করে ৩০০ জন রোগীর মধ্যে ২২৮ জন রোগীর তাৎপর্যপূর্ণ উন্নতি হয়েছে।